

# **National Health Insurance in South Africa**

**SAPPF submissions on the Green Paper on National Health Insurance**



## CONTENTS

PART 1: COMMENTARY ON THE GREEN PAPER.....	1
Preamble .....	1
A. INTRODUCTORY COMMENTARY .....	1
B. DETAILED COMMENTARY .....	5
2. Introduction .....	5
3. Problem Statement.....	10
4. The Burden of Disease in South Africa.....	14
5. Quality of Healthcare .....	14
6. Healthcare Expenditure in South Africa.....	15
7. Distribution of financial and human resources.....	17
8. Medical Schemes Industry .....	18
9. Out of pocket payments and co-payments .....	18
10. History of proposals on healthcare facing reform in South Africa .....	19
11. National Health Insurance .....	19
12. Principles of National Health Insurance in South Africa .....	20
13. Objectives of National Health Insurance .....	22
14. Socioeconomic benefits of National Health Insurance.....	22
15. Economic Impact Modelling .....	23
16. The three dimensions of universal coverage.....	23
17. Population Coverage under National Health Insurance .....	24
18. The re-engineered primary healthcare system .....	24
19. Healthcare benefits under National Health Insurance .....	25
20. Accreditation of providers of healthcare services .....	26
21. The Office of Healthcare Standards Compliance (OHSC).....	27
22. Accreditation Standards.....	28
23. Payment of providers under National Health Insurance .....	28
24. Healthcare Coding Systems and Reimbursement.....	29
25. Unit of Contracting Providers of Healthcare Services .....	30
26. Principal funding mechanisms of National Health Insurance .....	31
27. The role of co-payments under National Health Insurance .....	32
28. How much will National Health Insurance cost.....	33
29. The establishment of the National Health Fund.....	36

30. The Role of Medical Schemes .....	38
31. Registration of the population.....	39
32. Information systems for National Health Insurance.....	39
33. Migration from the Current Health System into the National Health Insurance Environment .....	39
CONCLUSION .....	40
APPENDIX A: THE PRIVATE HEALTHCARE SECTOR: COMMENTS AND RECOMMENDATIONS .....	41
COMMENTS ON PRIVATE HEALTH CARE.....	41
1. Introduction .....	41
2. Health care financing is already highly redistributive.....	41
3. Fundamental difference between public and private expenditure.....	41
4. Human resource discrepancies and excess capacity are overstated.....	42
5. Private health care is a highly regulated environment.....	42
6. The private sector is not over-priced.....	43
7. The private sector is not responsible for the poor performance of the public sector .....	43
8. The medical schemes industry is not unsustainable .....	44
9. The diversion of funds from private sector to public sector is unjustified.....	47
10. Reforming the private sector will promote universal access to health care .....	48
11. Recommendations.....	49
Establishment of large single or multi-specialty group practices.....	49
Private hospitals tendering for clinical case-load provided by these group practices..	49
Establishment of alternative reimbursement models.....	49
Using GPs to conduct the “specialist orchestra” .....	49
Training of clinical nursing assistant and other categories of health workers, including those that work in the PHC setting.....	50
Encouraging retired doctors to return to practice .....	50
Termination of RWOPS.....	50
Establishing correctly constructed DSP networks .....	50
Use of PPPs and contracting to provide services to the public sector .....	51
Further consolidation of medical schemes.....	51
APPENDIX B: ANNEXURES .....	53

# National Health Insurance in South Africa

## SAPPF submissions on the Green Paper on National Health Insurance

The SAPPF submission is in three parts:

1. **Commentary on the Green Paper**
2. **Appendix A: The private health care sector: comments and recommendations**
3. **Appendix B: Annexures**

### **Part 1: Commentary on the Green Paper**

#### **Preamble:**

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 about 2500 specialists representing most specialist disciplines. The Constitution's commitment to access to health care and our humanity compels us, within the constraints of resources, to work towards quality universal access to health care for all of our citizens.

The National Department of Health (DOH) published the draft Policy on National Health Insurance (NHI) in the *Government Gazette* on 12 August 2011 (the Green Paper), and invited interested persons to submit comments and representations on the Green Paper. It is pursuant to this invitation that these submissions are made.

We note the contents of the Green Paper, and welcome the opportunity to participate in this 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. We are conscious of the fact that the health care sector faces significant challenges, and is 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.

We believe that NHI's impact on the economy, its cost and the details of the intended model must be substantively addressed by DOH in partnership with National Treasury and other role players, and published 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 the South African people. Reforms should thus only be pursued if they are practically implementable and affordable.

Specialists obviously play a vital role in any health system, and will need to play such a role under any reformed health care system that is adopted in South Africa. It is, for example, 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. It is therefore important that the role of specialists is

considered and provided for in any health reform proposal. As a body that represents specialists, many of whom have a wealth of experience in the health sector, SAPPF is well-placed to comment on the proposals in the Green 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 Green Paper followed by Appendix A, which focuses on the role of the private sector and makes certain recommendations in respect of this sector.

## **A. Introductory Commentary**

The Green 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.

The primary question is whether the proposals contained in the Green Paper will have the desired effect. In other words, will the proposals have the net effect of addressing the issues identified in the document? In our submission, the Green Paper does not convincingly demonstrate that the interventions suggested in the document are the best means of addressing the issues facing health care in this country or, in fact, that the interventions are likely to succeed in addressing those issues.

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 Green Paper to improve health care service delivery in the public sector. It is, however, important to emphasise that these needed reforms are 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. Put differently, much of the Green Paper talks to the reform of the public health service and does not relate to the funding model that is NHI. As the Centre for Development and Enterprise (CDE) recently observed in its report entitled "Reforming Healthcare in South Africa: What role for the private sector?" (November 2011) (the CDE 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" (at pg. 11).

It is important to note, at the outset, that a great deal of necessary detail is absent from the Green Paper. This absence of detail limits our ability to comment substantively on the proposals contained in the Green Paper, as well as to provide relevant and detailed commentary in this public process.

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 Green 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 Green Paper recognises that management failings are a weakness within the public sector but does not explain how NHI aims to address this fundamental issue.

The Green Paper also does not provide a formal definition of NHI, and does not include any meaningful detail as to how NHI will be modeled within the South African context. In addition, it fails to provide any detail as to how the NHI Fund will operate on a national and provincial level or how the Fund will engage with the private health care sector.

Some of the other important areas canvassed in the Green Paper on which more detail is required include the following:

- (a) The so-called comprehensive benefit package to which persons will have access under NHI, which in turn impacts on costing of NHI.
- (b) The cost of NHI, with specific reference to the administrative costs related to its implementation, operation, monitoring, staffing, IT needs and related matters.
- (c) The continuing role of the private health care system, with specific detail pertaining to the role of private medical schemes.
- (d) The requirements for accreditation of service providers.
- (e) The manner in which reimbursement levels will be determined for purposes of NHI.
- (f) The manner in which co-payments will operate in respect of both accredited and non-accredited providers.
- (g) The envisaged treatment protocols and referral system under NHI.
- (h) The nature, function, operation and models of the intended public-private partnerships (PPPs), and the role of other government departments in the design and regulation thereof.
- (i) The manner in which public sector capacity will be enhanced so as to both improve the quality of public health care and to enable efficient contracting with NHI participants.
- (j) The mechanisms by which managerial performance within the health care sector is intended to be monitored, measured and made accountable.
- (k) The principles and rules by which the NHI Fund will be regulated and assessed.
- (l) The role of DOH and the provincial departments of health in the regulation and implementation of NHI.
- (m) The approach to the procurement of health care and other services by the NHI Fund.
- (n) The legal reforms, and legislative amendments, required for the implementation of NHI, and in particular how NHI will involve the restructuring of the provincial departments of health (if at all).

It is unfortunate that many of the issues contained in the Green Paper are only addressed at a theoretical level, with little detail and financial modeling provided.

Aside from our concerns in relation to the lack of detail, SAPPF has several key concerns arising from the Green Paper. These concerns, which are explained in more detail below, may be summarised as follows:

- (a) We do not accept the Green 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 Green Paper portrays the private health sector in a very negative light. It, for example, inaccurately 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, the private health sector is a national asset that should be nurtured while seeking 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 the most 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. The only obstacle to the achievement of substantive universal access is the improvement of swift 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.

- (e) The Green Paper does not engage in any meaningful economic impact modeling 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 needed health care reforms. The Green 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 currently facing access to health care in this country. Moreover, it is doubtful that the sophisticated and 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 or a mandatory contribution to NHI) may thus have negative unintended consequences for the economy due to shrinking disposable income.
- (h) Serious human resource constraints exist that militate 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 deliberately recruit each other's health human resources.
- (i) The Green Paper does not adequately explain the envisaged role for private medical schemes under NHI. There is a risk that, under NHI, medical scheme membership numbers will dwindle, medical schemes will close, and that those who currently receive treatment in the private sector will thus be forced to turn to an under-performing public sector for their health care needs. This will place an additional burden on the already struggling public sector.
- (j) SAPPF does not support the accreditation of individual doctors. Doctors hold professional qualifications and are registered with a statutory body (the HPCSA), and it is thus unnecessary, and an imprudent use of resources, to require individual doctors to obtain accreditation in order to participate in NHI.
- (k) The Green Paper does not require that service provider accreditation and contracting and the reimbursement function of NHI will be performed by institutions that are independent of DOH. This independence is necessary to avoid conflicts of interest with DOH's role as a provider of health care services.
- (l) The Green Paper should explicitly acknowledge the fundamental principle that any determination of reimbursement levels must enable service providers to cover their costs and to make a reasonable return on investment.
- (m) The Green Paper envisages the use of a risk adjusted capitation model for service provider reimbursement. Such a model carries the risk of encouraging under-servicing. Case-based reimbursement models for specialists assume that specialists work in private hospitals and will therefore share in the disbursements. These model are therefore inappropriate for specialists who are independent contractors and do not have a business relationship with private hospitals.
- (n) The Green Paper should provide for the reimbursement of non-accredited service providers who provide emergency medical treatment to persons who cannot afford such treatment.

The Green 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 health care users. In this regard, the establishment of NHI as proposed in the Green Paper triggers a number of constitutional concerns. In particular, the implementation of NHI may:

- (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 service providers' rights to property (section 25) and freedom of trade, occupation and profession (section 22); and
- (c) infringe the rights to freedom of association of those who prefer to associate through private medical schemes (as opposed to compulsory association envisaged under NHI) (section 18).

A further potential legal difficulty is that the Green Paper appears to envisage the centralisation of health care regulation and delivery. It seems to suggest a shift from provincial autonomy of health care budgets and the ability of the provinces to determine health-specific policy at provincial level, in favour of a national authority. This is not only inconsistent with international trends (which suggest that decentralised decision-making is the best means to advance access to health care) but may give rise to constitutional difficulties. We note, in this regard, that health services are an area of concurrent national and provincial competence under the Constitution (see Schedule 4 to the Constitution).

## **B. Detailed Commentary:**

1. The stated intention of NHI is to promote equity and efficiency in the delivery of health care services, although the Green Paper does not explain how these important and laudable goals will be attained through the proposed NHI model.

We now proceed to set out our detailed comments on the Green Paper. For ease of reference, we follow the order in which the issues are canvassed in the Green 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 Green Paper.

### **2. Introduction**

- 2.1. The introduction to the Green Paper, and the Paper more generally, may be read to suggest that the fundamental cause of poor service provision and performance in the health care sector is the existence of the so-called two-tier system of health care. It suggests that the mere existence of the private sector has somehow caused the poor performance in the public service. This is an inaccurate and misleading characterisation of the private sector, which in fact plays a very positive role in alleviating pressure on the public sector by providing care, including primary care, to a significant portion of South Africa's population.
- 2.2. The Green Paper's repeated criticism of the private sector means that it places insufficient emphasis on the substantive problems facing health care and, in particular, the dire state of public health. It is also inappropriate for a Green Paper which seeks to fundamentally transform South African health care to reduce such an important issue to a criticism of the private sector. The failings within South Africa's health care system are far more complex and need to be engaged with in a constructive manner.
- 2.3. DOH has itself acknowledged the need for significant public sector reform in its 10-point plan for health care reform (National Department of Health Strategic Plan 2010/11-2012/13 of February 2010). In addition, we note that the Development Bank of South Africa (DBSA) has recently

identified several failings within the public health care system. The DBSA's draft report entitled "A Roadmap for the reform of the South African health system: Draft Final Report", dated 8 November 2008, stated that:

"A central finding of this assessment is that the health system is performing poorly as a consequence of factors under the control of government. Furthermore, and more important than financial resources, the most important factor related to poor leadership and structural weaknesses in the institutional framework.... One potential explanation for South Africa's poor health status could lie in funding levels made available to the public system. However, the evidence does not support this finding." (At pg. 15)

It must be noted that the DBSA process was undertaken in partnership with stakeholders across the health care system, and resulted in some important recommendations necessary for health care reform.

- 2.4. Paragraph 1 of the Green Paper states that, "NHI will ensure that everyone has access to appropriate, efficient and quality health services" (see also paragraph 2). This is a significant commitment to the South African people, and one that should be supported by the body of (and ancillary research underpinning) the Green Paper. Unfortunately, a reading of the Green Paper provides no comfort that NHI will achieve these noble goals.
- 2.5. In addition, we point out that critical terms such as "appropriate", "efficient" and "quality" as used in the Green 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 health services". This is necessary in order to monitor progress towards achieving this ambitious goal.
- 2.6. Paragraph 3 takes issue with the current two-tier system that characterises the South African health care sector, in terms of which those with financial means are able to purchase private care at their own expense, thus securing health care choices not available to the majority of South Africans. This paragraph also makes the claim that the current funding arrangement of medical schemes: "only benefits those who are employed and who are subsidised by their employers". In this regard, it must be noted that:
  - (a) Private medical insurance constitutes a voluntary spend and is over and above tax contributions that are used to fund, amongst other things, the public health care system.
  - (b) Approximately 16.2% (at the least) of the South African people (or 8.3 million people) are beneficiaries of medical schemes and thus currently receive private health care. These people (and, as explained below, others who make use of private health care) are therefore not dependent on the public health care sector. The private health care industry therefore frees up vital resources within the public health sector and alleviates the burden on that sector.
  - (c) The medical scheme population is broadly divided into two categories of persons, namely, members and dependents (collectively, beneficiaries). A significant number of dependents (which number more than half of the entire medical scheme population) are not employed. Most of these unemployed individuals are children and students who would otherwise rely on the public health system.
  - (d) The provisions of the Medical Schemes Act, 1998 (the MSA) specify who qualifies for membership of a medical scheme, and the prescribed minimum benefit (PMB) regime provided for in regulation 8 of the Regulations in terms of the MSA (GNR 1262 in

*Government Gazette* 20556 of 20 October 1999, as amended) stipulates how a medical scheme must be structured in terms of minimum benefits. Argument can be advanced that these regulatory restrictions are themselves barriers to constructing alternative models, and extending cover to lower income populations by establishing benefit options with limited benefits (particularly given the breadth of the conditions currently included as PMBs).

- (e) Current policy in the public health care system is that persons that earn above a prescribed threshold may not access free health care services, but must pay for those services at the prescribed rate as determined by DOH. If such persons do not make use of medical schemes, they face the real risk of severe financial hardship.
- 2.7. It is therefore, in our submission, inaccurate to claim that the current two-tier system only benefits persons who receive health care in the private sector, as both policy and law limit access in both the public and private sector. In fact, DOH's Uniform Patient Fee Schedule (UPFS) Policy of 2006 states that the subsidies in the public health service are structured in such a way that those earning above a certain threshold must pay in full or in part for public services so as "to encourage those individuals to take out medical aid" (Appendix H to the UPFS Policy, page 3). It is, with respect, illogical for DOH to seek to blame the failure of the public health system on the existence of the private sector but at the same time for official DOH policy to encourage membership of medical schemes by those that can afford such membership.
- 2.8. Paragraph 4 makes the claim that available financial and human resources are heavily skewed in favour of the minority of South Africans who can afford private care. The Green Paper therefore suggests that the current system is inequitable and discriminates unfairly against the poor. It is claimed that NHI will address this inequity and create a fairer system of sustainable health care that will provide universal coverage. In this regard, we note that:
- (a) No actual figures are provided as to the human resources split between the public and private sector. This is concerning in circumstances in which the available research varies greatly in quantifying the important human resources split. Some of the available research indicates that this split is not as dramatic as may at first seem to be the case (see paragraph 7.1 below) and that the numbers of health professionals within the private sector are equally limited. Current figures obtained through Government's Personnel and Salary Administration System (PERSAL) suggest that the majority of human resources are found within the public health care sector. For example, of the total of 156 030 nurses in the country, 120 023 work in the public sector (77%). These figures roughly match the patient demographic split between the public and private sector, and accordingly are not out of sync with that split. Moreover, a consideration of comparative international ratios of health workers per population suggests that South Africa has national shortages in most categories of health workers. (See Econex Health Reform Note 7 "Updated GP and Specialist Numbers for SA" of October 2010; and Econex Health Reform Note 8 "The Human Resource Supply Constraint: The Case of Doctors" of November 2010.) There is a need for more detailed research on these issues.
  - (b) More importantly, the Green Paper provides no detail as to how NHI will address the limitation on resources in the public and private sectors. It does not, for example, engage with how private health care professionals can assist in addressing the shortage of human resources in both sectors. While we are aware that DOH has recently published a draft human resources strategy (Human Resources of Health South Africa 2030: Consultation Document V5 of August 2011 (the draft HR Strategy)), and we welcome this development, that draft strategy seems to have been developed without

taking into account the specific needs of the proposed NHI. While South Africa is, irrespective of the implementation of NHI, obviously in dire need of more and better quality health human resources, it is also clear that the NHI model will have specific implications for the human resources requirement. It is therefore unfortunate that neither the Green Paper nor the draft HR Strategy engage in a comprehensive analysis of the human resource requirements arising from NHI and how those requirements are to be met.

- (c) If access to “appropriate” and “available” health care is to be achieved, there needs to be a comprehensive human resources strategy alongside any health care system reform. This strategy needs to take into account the length of time it takes to train those human resources and thus needs to pragmatically engineer health care reform within that time frame so as to ensure practical access to health care services.
- (d) It is erroneous to suggest that the mere existence of the private health care sector is inequitable. If that were the case, almost every health care system where there is either private health care or limited private health care would be inequitable, including in those jurisdictions where the State seeks actively to partner with private health care in the delivery of health care services to its population. Most, if not all, first world countries as well as the BRIC countries and a number of African countries (such as Kenya, Uganda, Nigeria and Mozambique) that have established publically-funded universal access health care systems also make use of the private sector to varying levels to achieve a comprehensive level of health care for their citizens.
- (e) The private health care sector does not only service 16.2% of the South African population (as suggested in paragraph 4). Out-of-pocket expenditure and voluntary purchasing of private health care (as evidenced in the Statistic South Africa General Household Survey) suggests that the number of individuals serviced by the private health care sector is far more than those who are medically insured. Many non-insured individuals access portions of their health care needs in the private sector, including those who make out-of-pocket payments and a vast number of patients who receive free emergency medical treatment in that sector. Furthermore, the figure of 16.2%, as far as we are aware, does not take into account the number of individuals who access health care through the Department of Defence (military personnel and their families) as well as the total health-related expenditure as provided in Social Services, Education, Public Works and Local Government (not all of which are funded out of DOH’s budget allocation). All of these factors reduce the burden on the public sector and should be considered when assessing figures on the usage of the public and private sectors. We note in this regard that the draft HR Strategy released by the DOH a few days after the Green Paper suggests that the public/private health care split is approximately 65/35 (pg. 36 of the draft HR Strategy). Similarly, the CDE Report observes that “the true percentage of those who use the private sector wholly or in part is around 35 per cent” (at pg. 10). We also note that DOH’s pamphlet entitled “National Health Insurance: Healthcare for all South Africans” published in September 2011, states that 68% of South Africans “rely entirely on public health services” (at pg. 12). It is therefore generally accepted that the private sector services a great deal more patients than might be thought to be the case if one only has regard to the number of persons that are medically insured.

- 2.9. SAPPF does not support any suggestion that private health care should no longer exist or should be marginalised, nor the compulsory movement of health professionals into the public health care sector. It seems to us that an appropriate human resources strategy together with suitable PPPs and other contracting arrangements can achieve vastly improved health care outcomes for all South Africans.

- 2.10. We reiterate that it is neither accurate nor appropriate to argue that private health care is the cause for failings within the public health care sector. While we acknowledge that the standards of care are far superior in the private sector to that experienced in the public sector, it will not help to discourage investment in the private sector and to encourage more persons to make use of public sector facilities. This would only serve to further over-burden the public sector at a time when the real issue that requires urgent redress is the poor standard of care within that sector.
- 2.11. Paragraph 5 makes reference to the position of the WHO on universal coverage and “NHI”. It is important to note that there is no single, internationally recognised conception of NHI and SAPPF believes that it is critically important that whatever model is applied in South Africa must be adapted in a way that is mindful of the country’s specific needs and realities. We note in this regard that the WHO Report cited extensively in the Green Paper (the World Health Report (2008) (the WHO Report)), emphasises the need for “adapting reforms to country context” (pg. 100, Chapter 6).
- 2.12. Paragraph 5 also suggests that NHI would have the net effect of extending coverage to all South Africans, and reducing the negative effect of out-of-pocket expenditure. In this regard, however, it must be noted that:
- (a) No comparative international study on out-of-pocket expenditure has been undertaken for purposes of establishing whether South Africa is performing differently in this regard. We understand that South Africa’s levels of out-of-pocket expenditure (at approximately 1.44% of GDP) are normal by international standards.
  - (b) Most importantly, 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. The only obstacle to the achievement of substantive universal access is the improvement of swift access to quality care in the public sector.
  - (c) Our reading of the WHO Report is that it does not suggest that NHI is the sole means by which reform should to be undertaken. The Report rather suggests that countries should design a health reform model which is mindful of their particular needs and is based on a comprehensive policy.
- 2.13. Paragraph 6 states that in order to achieve equity and improved access, four key interventions are required to take place simultaneously:
- 1. The **complete transformation** of health care service provision and delivery;
  - 2. The **total overhaul** of the entire healthcare system;
  - 3. The **radical change** of administration and management; and
  - 4. The provision of a **comprehensive** package of care underpinned by a **re-engineered** PHC.
- 2.14. These are ambitious goals and this paragraph seems to suggest that virtually every aspect of health care service delivery requires transformation under NHI. Nevertheless, the Green Paper provides no benchmarks or measurements against which the envisaged reform would be tested, adapted, designed and monitored.

- 2.15. Importantly, the Green Paper does not provide sufficient detail as to the dramatic changes to the health care system that it proposes, nor how the proposed transformation of the health care system will achieve the desired outcomes.

### 3. Problem Statement

- 3.1. We agree with the content of paragraph 7. South Africa's Apartheid past has left deep inequalities in our society, which manifests in unequal access to various goods and services, including access to health care. The introduction of NHI is, however, not necessarily the best means to address these inequalities. We note, in this regard, that there are many unequal societies in the world (such as Brazil) which have successfully addressed access to health care in ways other than the introduction of NHI. The Green Paper does not indicate that these other methods of addressing access to health care have been considered.
- 3.2. Paragraph 9 states that "[p]ost 1994 attempts to transform the healthcare system and introduce healthcare financing reforms were *thwarted*" (emphasis added). To what this statement refers is unknown, and no detail is provided as to what proposals (if any) were "thwarted" and by whom. It is noted, however, that critical recommendations relating to health care financing and reform in the private medical scheme sector remain incomplete. In particular, we mention the Risk Equalisation Fund (REF), which, if implemented (it remains only reflected in draft legislation), could comprehensively improve financing within the private medical scheme sector. It is not known why this positive initiative has not been implemented.
- 3.3. Paragraphs 9 and 10 again appear to place the blame for the poor performance of the public sector on the two-tier system. SAPPF reiterates that this is an inaccurate and oversimplified position, which does not advance the important debate as to the fundamental problems with our health care system. It should be noted that private health care serves a complementary role in many countries where NHI-type health care reform has been implemented. This is acknowledged in the WHO Report, where Portugal is critically analysed in this regard (see pg. 3, Chapter 1, WHO Report). Internationally, many (if not all) health care systems have various tiers of health care financing, service delivery and access. We note that the International Labour Organisation (ILO) has observed that "[v]irtually all countries have built systems based on various financing mechanisms that combine two or more financing options" and that "[t]he financing of social health protection is therefore a mixture of taxation and contributions to public and mandated private health insurance. Through risk pooling, these funds provide for equity, solidarity and affordability of services" (Issues in Social Protection: Discussion paper 19 "Social Health Protection: An ILO strategy towards universal access to health care: A consultation", August 2007, pgs. 3 and 4).
- 3.4. The Green Paper refers, at paragraph 11, to the WHO Report as detailing "hospital centrism", "fragmentation" and "uncontrolled commercialism" as causes of poor health outcomes globally. We note that the WHO Report makes it clear that these three problems arise in both the public and private sectors. In addition, a reading of the WHO Report indicates that the problems facing health care globally are multi-faceted and take different forms. Importantly, the Report emphasises the role of PHC in addressing service delivery, and recognises the fact that many of the "root causes" of ill health and disease lie beyond the control of the health sector. The Report emphasises the need for a "health-in-all" approach to reform. Some other noteworthy aspects of the WHO Report are as follows:
- (a) The Report is primarily an assessment of the role of PHC and its importance in addressing critical failings within health care sectors (Chapter 3).

- (b) It recognises the need for innovation in health care reform, and the value of identifying opportunities and alliances (Chapter 5).
- (c) It identifies the need for an integrated approach to the design and implementation of health care policies, beyond mere health and including other important government departments such as education, trade and environment, as all could impact health outcomes positively.
- (d) The Report also emphasises the need for a patient-centered approach to health care delivery. It notes that many of the failings within health care systems across the globe are as a consequence of inappropriate and ineffective policies, fragmentation within and between sectors (public and private), inadequate understanding of the “human dimension”, and the absence of comprehensive and integrated responses.

“Insufficient recognition of the human dimension in health and of the need to tailor the health service’s response to the specificity of each community and individual situation represent major shortcomings in contemporary health care, resulting not only in inequity and poor social outcomes, but also diminishing the health outcome returns on the investment in health services.” (Pg. 48, Chapter 3 of the WHO Report)

- (e) “Fragmentation” is said to result from the “multiplication of programmes and projects” and seems to arise primarily in the public sector (pgs. 11 to 13).
- (f) “Commercialisation” refers to the commercialisation of health care in “unregulated health systems”. More specifically, “the unregulated fee-for-service sale of health care, regardless of whether or not it is supplied by public, private or NGO providers” (pg. 13 and pg. 20 of the WHO Report). This state of affairs does not arise in South Africa. It is clear that private (and public) health care in this country is neither “unregulated” nor “uncontrolled”. There are numerous laws in place which protect the interests of patients, and closely regulate both health establishments and health care practitioners (see, for example, the legislation referred to in paragraph 5.2 of Appendix A). For example, health establishments are licensed, subject to strict minimum standards and are inspected on an annual basis; and health providers are required to be registered with the Health Professions Council of South Africa (HPCSA) and are subject to the disciplinary rules of the HPCSA (including a prohibition on over-charging, which amounts to unprofessional conduct). Similarly, medical schemes are regulated with strict rules relating to, amongst others, financing, patient rights and the minimum standards.
- (g) One particularly critical observation of the WHO Report is that:

“A more effective public sector stewardship of the health sector is, thus, justified on the grounds of greater efficiency and equity. This crucial stewardship role is often misinterpreted as a mandate for centralized planning and complete administrative control of the health sector.” (Pg. 82)

Moreover, we note that the Green Paper offers little detail on how NHI as a funding model will address such issues of hospital-centrism, fragmentation and commercialism.

- 3.5. Paragraph 12 attempts to draw an analogy between the two-tiered system in South Africa and some of the statements attributed to the WHO Report. Unfortunately, this analogy is not critically explained or described. It is, with respect, unhelpful and over-simplistic to refer to South Africa’s health care system as “unsustainable, destructive, very costly and highly curative or hospi-centric”. No factual basis is given for these far-ranging assertions.

- 3.6. The Green Paper goes on to describe, in paragraph 13, the challenges of the quadruple burden of disease, and the shortage of key human resources as well as underperforming institutions characterised by poor management, underfunding and deteriorating infrastructure. We note this and believe that practical, primary health-driven programmes across sectors would be manifestly beneficial in addressing these pressing challenges.
- 3.7. We note that paragraphs 13 and 14 refer to the poor quality of services within the public health sector. This is, in our submission, the most pressing problem currently facing access to health care in this country and is in urgent need of redress. As CDE recently remarked: “the essential task of health care sector reform is the rehabilitation of public sector healthcare from its current dysfunctional state”, and “it will be a huge task to turn public sector healthcare around by addressing the widely acknowledged problems of staff morale, productivity and attitudes to service” (pgs. 10 and 11 of the CDE Report).
- 3.8. We note in this regard that the Constitutional Court, after examining extensive evidence on the treatment of road accident victims, unanimously made the following findings in the recent case of *Law Society of South Africa and Others v Minister of Transport and Another* 2011 (1) SA 200 (CC):
- (a) Public health institutions are in certain material respects “not able to provide adequate services crucial to the rehabilitation of accident victims who are permanently disabled” (at para 93).
  - (b) “A quadriplegic or paraplegic is constantly at risk in a State hospital as a result of the chronic lack of resources, paucity of staff and inexperience in dealing with spinal-cord injuries” (at para 94).
  - (c) There are “serious deficiencies within the State health care centers” and there are “vast disparities between the public and private sector” (para 94).
  - (d) The National Plan for the Efficient and Equitable Development of Tertiary and Regional Hospital Services of 2004 “frankly confesses to serious systemic challenges due to chronic underfunding and an ever increasing demand for services. It recognises that this under-resourcing of public health care establishments leads to poor quality of care, substantial geographic inequality of care, poor referral systems between regional and tertiary hospitals and a lack of patient transport” (at para 95).
  - (e) The Minister of Transport and the Road Accident Fund “did not meet head-on the complaint that quadriplegic and paraplegic road accident victims would not easily survive the health care services at public hospitals” (at para 97).
  - (f) The Road Accident Fund's use of the UPFS tariff as a measure of compensation for medical treatment for road accident victims gave rise to inadequate compensation and was irrational (at paras 92 and 99).
- 3.9. We are conscious of the fact that DOH has in recent years itself acknowledged the problems within the public sector and the need for radical reform of that sector. For example, in his statement launching the Green Paper, the Minister of Health noted that “we have a massive amount to achieve in uplifting the public health sector” and “it is true that the quality of care in public health institutions is often totally unacceptable and that radical measures are needed to put matters in order” (media statement by the Minister of Health, 11 August 2011, pg. 1). The draft HR Strategy, published by DOH a few days after the Green Paper also states, at pg. 9:

The evidence is that South Africa’s performance in terms of health outcomes when compared with peer countries is extremely poor, with much higher infant and maternal mortality. This reflects on poor productivity, poor design and poor management of

resources and not necessarily only the number of available professionals in the health sector. (Emphasis added)

- 3.10. Paragraph 15 refers to what the Green Paper considers to be the problems of the private health sector: *high service tariffs, provider-induced utilisation of services and the continued over-servicing of patients on a fee for service basis*. We are most concerned that the Green Paper makes numerous unsubstantiated assertions about high tariffs and over-servicing directed against the private sector, and displays an overwhelming negativity towards this sector as a whole. It fails to acknowledge the complementary and important role that private health care performs within South Africa, and inaccurately attributes endemic failings to private health care. We dispute the allegation of high service tariffs within the private sector, and note that the High Court has in fact suggested, in a judgment relating to the Reference Price List (RPL), that private health providers in many instances struggle to cover their costs (see paragraph 12.5 below).
- 3.11. Rather than engaging in unsubstantiated contentions, the Green Paper should, in our submission, seek to identify all the contextual problems with health care, verify those problems and their extent with rigorous research, and then make practical recommendations to address those verified problems within the proposed health care reform measures.
- 3.12. Paragraph 15 goes on to state that the private sector “will not be sustainable over the medium to long term”. Again, no explanation is provided for this dramatic assertion. The South African private health sector generally functions well and there is no basis, we submit, to label it as unsustainable.
- 3.13. We reiterate that the Green Paper persistently attempts to link the failings of the South African health care sector to the existence of the two-tiered system of health care. We submit that the problems which beset health care delivery in this country are far more complex and substantive than that. It is important in this regard that critical failings within the system are acknowledged in identifying the problems with health care delivery. The closure of nurse training academies, poor managerial performance, infrastructure maintenance and procurement problems, and the freezing of posts within the public sector, are all examples of policy decisions and administrative realities in which the private sector played no role.
- 3.14. Having noted our concerns with the manner in which the “problem statement” is described in the Green Paper, we note, at this juncture, that health care reform should, in the opinion of SAPPF, be:
  - (a) **Transparent** – all aspects of the proposal must be made known for a comprehensive and necessary understanding of the health care reform.
  - (b) **Consultative** – throughout the process all stakeholders should be engaged. This is at the identification of the problem, as well as the means by which it is to be addressed.
  - (c) **Researched** – unsubstantiated statements and unqualified proposals should be avoided. All recommendations should be supported by empirical evidence, based on actual figures, using universally accepted measurement tools.
  - (d) **Qualified** – each recommendation (where applicable) should be validated, piloted if necessary, and tested prior to implementation.
  - (e) **Contextual** – health care reform must be adapted to the South African population, mindful of its needs and cognizant of its unique health care design.
  - (f) **Flexible** – it must be acknowledged that there is manifest uncertainty within any health care reform, and a great deal of adaption and change throughout implementation may be necessary.

- (g) **Accountable** – this requires monitoring and accountability of persons both for policy formulation and implementation. It also contemplates that decision-makers should be willing to adapt their policy in light of input from the public.

#### **4. The Burden of Disease in South Africa**

- 4.1. Paragraph 17 states that the implementation of NHI should take into account the burden of disease that the country is experiencing. While we agree that the substantial challenge of the burden of disease must be borne in mind in any health care reform, the Green Paper unfortunately provides no detail as to how NHI will meet this challenge. We are accordingly not in a position to comment on this issue substantively. It must be noted, however, that any policy aimed at tackling the burden of disease should, as recommended in the WHO Report, be an integrated approach involving sectors outside of health such as education, trade, environment and social welfare.
- 4.2. Data on the disease profile of public sector patients is at present scarce and unreliable. It is important that comprehensive research, collecting reliable data on the burden of disease, should precede the design and implementation of any health reform measure aimed at combating that burden of disease (whether or not that health reform is coupled with a NHI mechanism). This research process should be ongoing as the burden of disease changes over time as countries develop.

#### **5. Quality of Healthcare**

- 5.1. Paragraphs 22 and 23 refer to the deterioration in the quality of public sector facilities and the resulting preference by the public for services in the private sector even where this has meant making out-of-pocket payments.
- 5.2. The deterioration of the quality of services and facilities in the public service is a major cause for concern and clearly substantial investment and effective management is needed to turn the sector around. The intention to appoint appropriately qualified and experienced hospital managers is therefore applauded but where these individuals are going to be found in the near future remains uncertain. We reiterate that there is a need for a comprehensive human resources plan to ensure that any health care reform delivers practical outcomes.
- 5.3. Critical to this process of improved service delivery in the public health sector are the training and qualifications necessary for public sector appointments, and the process of appointment itself. Other concerns include:
  - (a) The need to put in place measures to ensure management accountability.
  - (b) The powers afforded to managers to run health care facilities, including their powers to hire categories of staff, to procure equipment and materials and their jurisdiction over key areas of operation within these facilities.

Unfortunately, none of this detail is provided in the Green Paper.

#### **6. Healthcare Expenditure in South Africa**

- 6.1. Paragraph 24 notes that, despite South Africa spending 8.5% of GDP on health (more than what the Green Paper describes as the WHO recommendation of 5% of GDP), outcomes remain poor. We have two observations in relation to this statement. First, the WHO recommendation of 5%

refers to a minimum rather than a recommendation. Second, paragraph 26 states that 8.3% (rather than 8.5%) of GDP is spent on health; it appears that the 0.2% difference is made up of funding through foreign aid and non-governmental organisations (see the CDE Report, pg. 8).

- 6.2. We attach in this regard, as Annexure A, a table setting out the actual and forecasted sources of South African health care funding for the period from 2006/07 to 2012/13, reflecting the expenditure in both the public and private sectors.
- 6.3. The Green Paper goes on to state, at paragraph 26, that this 8.3% of GDP is split 4.1% in the private sector and 4.2% in the public sector, with the former covering 16.2% of the population and the latter covering 84% of the population. We reiterate that these figures are based on an inaccurate assessment of the number of patients who receive treatment in the private sector. As explained above, the percentage of persons serviced by the private sector is significantly higher than 16.2% (see paragraph 2.7(e) above).
- 6.4. The Green Paper conflates private expenditure on personal health care and public financing of public health care as though they are one and the same thing. Clearly they are not. One cannot speak of the inequity of “financing“ of health care when comparing what individuals choose to spend on their own health care with the portion of the fiscus that the State decides to spend in providing free health care to those in need. A more appropriate comparison is the financial cost to Government of public and private health care. Conceptualised in this way, it is clear that the cost to government per person in the public health system (i.e. the total cost of treatment) is more than the cost per person in the private sector (which consists only of the tax deduction in respect of medical aid contributions) (see paragraph 3.4 of Appendix A).
- 6.5. Paragraph 27 refers to the escalation of private hospital (121%) and specialist (120%) costs over the past decade, asserting that this is due to the “charging of exorbitant fees completely out of proportion to the services provided“. The persistent claim that South African private health care is excessively expensive is, we submit, incorrect.
  - 6.5.1. The reference given for these figures in paragraph 27 is a 2008 report of the Council for Medical Schemes (CMS) (the 2008 CMS Report). It is thus unclear what decade is referred to in this paragraph. Is it the decade prior to the Green Paper (as reflected in the phrase “[o]ver the past decade“ or ten years prior to 2008 (the year of the CMS Report)? It is also unclear whether or not these figures are adjusted for inflation and whether they are calculated on a per beneficiary basis or reflect total increases in health care expenditure. We have used the latest CMS Report for 2010/11, published in September 2011, and have calculated the relevant cost increases on a per beneficiary basis for the preceding 10-year period. This reveals a picture which is very different to that reflected in paragraph 27. After adjusting for CPI/X, private hospital costs have increased by 55.3% and specialist costs by 45.7% over that 10-year period. If one uses medical inflation of CPI/X plus 3%, hospital costs have increased in real terms by 17.7% and specialists by 10.5%. If one examines the position over the last five years, the position is even more stable: after adjusting for CPI/X, private hospital costs have increased by 15.1% and specialist costs by 19.3%; and if one uses medical inflation over that five-year period, private hospital and specialist costs have increased by 1.3% and 3.9%, respectively.
  - 6.5.2. We submit that an adjustment for medical inflation is an appropriate basis for assessing real increases in health care costs. This is because it is generally acknowledged that health care is exposed to costs that exceed normal inflation (CPI). An examination of health care inflation in publicly-funded health care systems internationally shows similar trends to that experienced in South Africa. For example, medical inflation in Canada has been 3 to 3.5% above CPI over the

past decade, in New Zealand CPI ran at 2.7% from 2000 to 2010 with medical inflation at 9 to 10% (i.e. more than three times CPI). Throughout Europe medical inflation exceeded CPI by 6.5% over this period.

- 6.5.3. Moreover, there is ample evidence that health care services of South African specialists are not over-priced. The reality is that many specialists struggle to make a reasonable return over and above covering the costs of practice, particularly given the downward pressure exerted on specialists by medical schemes' rates of reimbursement. Several cost studies compiled as part of the now defunct RPL process indicated that the levels of medical scheme reimbursement which were based on the RPL resulted in significantly lower payments than would have been the case if doctors were entitled to recover their efficient costs and make a reasonable return (see also the statement of the High Court at paragraph 12.5.2 below).
- 6.5.4. To again draw on international comparators, the Green Paper states that private health care spend in South Africa is R11 150 per person per year (see paragraph 31), while the United Kingdom spends over R20 000 per person per year and New Zealand spends R19 286 per person per year (see also paragraph 6 of Appendix A read with Annexure B below).
- 6.6. South African health care funding is derived from three major sources, which, as the Green Paper points out, is consistent with expenditure trends as reported by the World Bank. These sources are: public sector allocations derived from general revenue (not limited to the health allocation, but also health expenditure in public works, social development and welfare, the military, and other departments), private voluntary contributions in the private sector to medical schemes and out-of-pocket payments. The 4.1% of GDP that is contributed by the private sector is private money and is therefore a saving to Government, and is generally paid by the same individuals who, *in addition to their voluntary medical scheme expenditure*, contribute through their personal income tax approximately 78% of the taxes used to fund public health care services (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)).
- 6.7. Sight should not be lost of the fact that the funding of the South African health system is currently highly redistributive and characterised by a high level of cross-subsidisation. This follows from the approach of funding public health through tax revenues and making public health services freely available at the point of use (for those below a specified income threshold). As CDE recently stated, the source of public health funding is taxation "a substantial portion of which is progressive income tax through which the better-off, who by and large do not use public sector health facilities, significantly subsidise those who do use them. As a result, South African healthcare financing is highly redistributive" (at pgs 9 to 10 of the CDE Report).
- 6.8. One of the difficulties with seeking to rely on the 2008 CMS Report for the purpose of assessing the increase in specialist costs (as the Green Paper does) is that the Report inaccurately conflates all fees paid to specialists, which are lumped together and represented as a total spend attributed to specialists. The reality is that this global figure is not limited to professional service fees *per se*. It includes radiology, pathology and oncology as well as salaries paid to non-professional staff and both equipment and consumables (which make up the greater part of the fees paid to specialists by far). To get a fairer idea of what doctors are earning, one should rather look at historical rates and increase them by inflation each year to the present. If we do this from 1968 to the present, we find that the 1968 "medical aid tariff" (adjusted for inflation)

is more than twice the 2008 medical scheme rate for consultations and three times the rate for procedures (see Appendix A, paras 6.2 and 6.3).

- 6.9. The Green Paper also criticises what it refers to as the doubling of medical scheme contribution rates over the past seven years, on the basis that this increase has not been accompanied by a proportionate increase in access to services. This contention is unfounded. In fact, increases in medical scheme contributions over the last decade have only increased (in real terms) by 27.3%, while the increase over the last five years has been 5.1% (these figures are based on a CPI/X adjustment rather than on medical inflation). As the CMS noted in its Annual Report 2010, pg. 37, increases in medical scheme contributions over the preceding nine years had “been similar to inflation”. We are concerned that a factual inaccuracy of this nature should find its way into the Green Paper.

## **7. Distribution of financial and human resources**

- 7.1. Paragraphs 29 to 31 make the claim that human resources are skewed in favour of the private sector and that the amount spent in the private sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity. No figures are provided in support of this contention. Looking at health care professionals as a whole, our understanding is that 73% of these professionals are in the public sector. According to the Econex Health Reform Note 7 of October 2010, the distribution of active doctors in 2010 was as follows: general practitioners (GPs): 61.9% (State) and 38.1% (private); and specialists: 43.8% (State) and 56.2% (private). Given that it has been Government policy since 1994 to deprioritise tertiary care in favour of primary care, the lower numbers of specialists in the public sector cannot be blamed on the private sector. Indeed, were it not for the existence of the private sector many more specialists may have been lost to South Africa through emigration.
- 7.2. We therefore dispute the contention in the Green Paper that human resources are currently heavily skewed in favour of the private sector. The spread of health professionals (other than specialists) across the public and private sectors is not out of sync with the sizes of the populations that make use of these services (see paragraph 2.8(e) above for a discussion of the utilisation levels across the public and private sectors).
- 7.3. Whilst reference is made in paragraph 30 to the draft HR Strategy currently being considered by DOH, no detail is given as to how this Plan is intended to integrate with NHI, and whether the timing required to implement the necessary human resource reform is consistent with the proposed 14-year timeframe for the implementation of NHI.

## **8. Medical Schemes Industry**

- 8.1. Paragraph 32 suggests that the medical schemes industry is under pressure and that schemes are experiencing problems of sustainability, with the number of schemes having reduced from over 180 in 2001 to 102 in 2008. This is said to be mainly due to “*over pricing of healthcare*” which has forced schemes to either raise premiums or reduce benefits (with the result that benefits are often depleted by mid-year) (paragraph 33). The Green Paper acknowledges that the position has been exacerbated by increases in non-health related costs of medical schemes.
- 8.2. The suggestion in the Green Paper that the medical scheme industry is under pressure of sustainability due to over-pricing of health care is not supported by the available evidence. We submit, on the contrary, that there is no evidence of unsustainability of the medical schemes industry. It seems to us that the original number of medical schemes at 180 in 2001 reflected

unnecessary fragmentation and an unsustainable number when compared to the total number of persons medically insured. Consolidation of those medical schemes, through member-approved mergers, has improved economies of scale and decreased the net costs to those merged schemes (and generally brought about greater stability). Our understanding is that Government has, in fact, encouraged this consolidation.

- 8.3. There is no empirical evidence that the private medical funding sector is in financial trouble. Perusal of the latest 2010/2011 Registrar of Medical Schemes' Annual Report shows that net surpluses have increased from R972 million in 2009 to R2.85 billion in 2010 with an average solvency ratio of 31.6%, well above the required 25%.
- 8.4. It is important to stress in this regard that the financial difficulties of a limited number of medical schemes may be due to a variety of factors other than so-called over-pricing of health care, such as mismanagement and high administration fees. We also note that the Green Paper does not acknowledge the impact that State policy has had on premium increases. In this regard, we mention the effect of increasing the solvency levels of medical schemes to 25% and the requirement that medical schemes place significant sums of their resources into such accounts to meet that requirement.
- 8.5. Moreover, it should be noted that, despite a decrease in the number of medical schemes, the number of medically insured persons has grown steadily over the last decade and levels of scheme solvency have improved. The decline in the number of schemes therefore does not reflect a decline in the medical schemes market. There is thus no basis whatsoever to contend that medical schemes have been placed into difficulty through over-pricing for health services. We return to this issue at paragraph 8 of Appendix A.
- 8.6. The financial and sustainability problems of medical schemes are referred to in the Green Paper as being the result of "*uncontrolled commercialism*" as described by the WHO. We dispute this contention. As we point out above, the South African health care market is regulated and is not characterised by uncontrolled commercialism.

## **9. Out of pocket payments and co-payments**

- 9.1. We note the contents of paragraphs 35 to 37.
- 9.2. For those persons who are medically insured, the "catastrophic effects" of health expenditure should be addressed through the PMB regime (as medical schemes are required to reimburse for the costs of PMB conditions in full). The difficulties occasioned to those who are not on medical aid (and lack the means to afford private health care) demonstrate the pressing need to address access to quality care in the public health sector. For such persons, the "catastrophic effects" of health expenditure should be avoided through reliance on a properly functioning public health system.

## **10. History of proposals on healthcare financing reform in South Africa**

- 10.1. Social Health Insurance (SHI) was never properly developed in this country, with the key elements of compulsory enrolment of all formally employed and the establishment of the REF not being introduced. Had these two key reforms been introduced, the positive impact on the growth of the private sector and the ability of smaller schemes to manage their financial risks would have reduced the burden on the public sector. This would have enabled scarce public

resources to be spent on a smaller State-dependent sector with a consequent improvement in health outcomes.

- 10.2 SAPPF therefore supports the implementation of compulsory medical scheme enrolment by all formally employed persons and the establishment of the REF as originally envisaged by the proposals on SHI (together with the improvement of the public health service), as a more affordable, but nevertheless progressive, step towards the ultimate achievement of universal access than the NHI proposal contained in the Green Paper.

## **11. National Health Insurance**

- 11.1. Paragraph 50 explains that the rationale for introducing NHI is to eliminate the current tiered system. It goes on to state that NHI will improve access to quality health care services and “provide financial risk protection against health-related catastrophic expenditures for the whole population” and thus reduce the risk of families being impoverished by health care costs. We are concerned that the Green Paper does not demonstrate how NHI will achieve this outcome and why it is the best means of doing so.

11.1.1. Insofar as the private health care sector is concerned, we submit that the implementation of the REF, coupled with the PMB regime, would address the issue of “financial risk protection against health-related catastrophic expenditures” for those persons with medical insurance. The Green Paper should therefore clarify the role of ongoing reform within the private sector as an important aspect of health care reform in general.

11.1.2. In relation to the public health sector, there should be no need to refer to “financial risk protection” as the public sector should provide quality services to all persons, including indigent persons who cannot afford to make any payment for health care, let alone cost-related payments for significant procedures and extended hospital stays.

11.2. We note that it is by no means clear that NHI will reduce the cost of health care for families and households, particularly given the huge costs that the establishment and implementation of NHI will entail. Moreover, if many South Africans elect to continue with their own private medical insurance in addition to making contributions to NHI, the net result for those persons will be a sizeable increase in health expenditure. A failure to place sufficient emphasis on the costs of NHI is to ignore the possible impact that the imposition of NHI will have on the economy as a whole.

11.3. The imposition of NHI will have far-reaching consequences for persons who are currently privately insured. It appears that they will be required to fund NHI through the payment of similar amounts to what they currently spend on private medical aid.

11.3.1. Many of those persons will not be able to afford to continue to make payments for private medical aid on top of their compulsory payments to NHI. Those persons will, in effect, continue to make equivalent payments but they will no longer have ready access to services that they were previously able to access. A large group of people will thus be worse off under NHI as they will no longer be able to access the quality of care that they currently enjoy. It must be noted that these current medical scheme members (and their dependants) will then become dependent on the public sector, which, in turn, will have to meet its existing demands as well as an added burden previously shouldered by the private sector. We are concerned that this issue is not considered in the Green Paper, and believe that it is critical in any NHI costing analysis.

- 11.3.2. For those (perhaps small group of) persons who can continue to make simultaneous contributions to private medical schemes, those persons will face a significant increase in health care costs – making two sets of medical aid contributions over and above the payment of ordinary income and other taxes. This, of course, perpetuates the current situation for those persons, but at even higher costs.
- 11.4. The implication for medical schemes is also potentially dire, as they will be faced with declining membership (as members battle to meet their additional obligations to make NHI contributions), which could in turn lead to increasing prices.
- 11.5. Declining medical scheme membership will, in turn, negatively impact on health care providers who are unable or unwilling to contract with the NHI, potentially resulting in these highly skilled persons exiting the profession or emigrating.
- 11.6. For the reasons canvassed in these submissions, we reiterate that the implementation of NHI may impact adversely on the right of access to health care currently enjoyed by those persons who receive treatment in the private sphere. It must be noted that the constitutional right of access to health care, as contained in section 27 of the Constitution, requires the progressive realisation of this right by reasonable measures within the State's resources. Any policy which has the net effect of reducing or diminishing levels of access may therefore offend this constitutional right.
- 11.7. Paragraph 51 mentions a “defined comprehensive package of healthcare services”, delivered by accredited and contracted service providers. As explained below, the Green Paper provides insufficient detail on these important concepts.

## **12. Principles of National Health Insurance in South Africa**

- 12.1. We agree that any health care reform initiative should be guided by the principles identified in paragraph 52. We, however, submit that the Green Paper begs the question as to whether the proposed NHI is the best means of furthering the enumerated principles.
- 12.2. The right to access and social solidarity are two important principles that are said to underpin NHI; they are also the basis upon which the National Health Act, 2003 currently operates. This Act, for example, specifies that its objects are to “regulate national health and to provide uniformity in respect of health services across the nation by ... establishing a national system which (i) encompasses public and private providers of health services; and (ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford” (section 2(a)). We reiterate that a REF would further both these principles.
- 12.3. Effectiveness, it is claimed, will be improved through the application of evidence-based interventions, strengthened management systems and better performance of the health care system. While we agree that these developments will improve the all-important effectiveness of health care delivery, we point out that none of these developments are dependent on NHI for their introduction. The Green Paper fails to explain why NHI, as a funding model, is the best means to promote these developments. It seems to us that they are better pursued through targeted interventions aimed at improving service delivery in the public (and, to the extent necessary, the private) sector.

- 12.4. Paragraph 52(f) states that services will be procured “at *reasonable costs* that recognise health as not just an ordinary commodity of trade but as a public good”. The Green Paper provides no detail as to how this principle is to be achieved. It needs to be explicit about how the reasonable cost of services will be determined and should suggest a mechanism for such determination. Without this detail, it is impossible for SAPPF to comment meaningfully on the pricing aspects of the Green Paper.
- 12.5. The Green 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.
- 12.5.1. 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 should be if a proper 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.
- 12.5.2. 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” (*Hospital Association of South Africa and Others v Minister of Health and Others*, unreported judgment of the North Gauteng High Court handed down on 25 July 2010 under case no. 37377/09 at para 118).
- 12.6. 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 would not only undermine the right of access to health care but would also, we submit, amount to an unconstitutional infringement of the rights to property and freedom of trade, occupation and profession.

### **13. Objectives of National Health Insurance**

- 13.1. Paragraph 55 sets out the objectives of NHI. A reading of the Green Paper, however, indicates that it fails to explain convincingly how the proposed NHI regime is likely to achieve these objectives.
- 13.2. Sub-paragraphs (b) and (c) speak of a single fund procuring services on behalf of the entire population and “efficiently mobiliz[ing] and control[ling] key financial resources”. 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 Green Paper simply asserts the proposition that NHI will be more effective.
- 13.3. The envisaged NHI Fund will need to be as efficient as the most sophisticated private administrator operating at both a national and provincial level (and adapting to the different health care needs and burdens across the country), and yet will be about twenty times the size

of any existing administrator. While collecting monies for the Fund is a significant administrative burden in its own right, it is a relatively uncomplicated task; ensuring accurate and timely payment for diverse health care services provided across the country, and managing a single fund for this purpose, is a different matter entirely. It should not be assumed that simply because an institution forms part of the public service, such an institution will operate effectively in the public interest. The systemic failings in service delivery in the public health system are a cause for concern in this regard. The public sector's ability efficiently to manage a complex system of disbursements is, in particular, called into question by the fact that various provincial departments of health currently owe approximately R1.8 billion to National Health Laboratory Services. A report by the Auditor-General also paints a worrying picture of the finances and administration of the Gauteng Department of Health. According to the report, that Department faced R875 million in lawsuits; wasted R217 million in "fruitless expenditure"; failed to provide sufficient audit evidence for tangible assets valued at R3.1 billion; and wasted R1.5 billion on the premature cancellation of contracts with service providers. With the exception of the Western Cape, all of the provincial departments of health received qualified audit reports from the office of the Auditor-General.

#### **14. Socioeconomic benefits of National Health Insurance**

- 14.1 Deepening universal coverage will undoubtedly bring socio-economic benefits to the country and we support the quest for improving universal coverage. Nevertheless, we reiterate that the Green Paper does not make out the case that NHI will achieve this goal, or that NHI is the best way to pursue it.
- 14.2. The Green Paper goes into some detail as to the positive international experience following the introduction of universal coverage. It is, however, important to note that these "success" stories have generally occurred in countries with vastly different socio-economic challenges to those faced by South Africa and have also been subject to contextualised internal reform. Norway, for example, implemented vastly different reforms to Brazil, and yet both countries have measured significant health care improvements. The question, therefore, is what model is South Africa considering, and does it take into account the South African context?
- 14.3. There is an overwhelming argument in favour of improving the overall health of any nation. Universal access to health care is a laudable and worthy objective and should be supported by all. However, there is little evidence to show that the public financing of health services is the most efficient way to achieve this noble objective. In this regard, two of the major constraints in South Africa are the high rate of unemployment and the very small number of tax-paying individuals who are already taxed at higher levels than comparative countries and who may now be expected to be the primary source of finances for NHI. These challenges should receive greater priority and must be fully researched prior to implementation of any NHI model.

#### **15. Economic Impact Modeling**

- 15.1. Paragraph 61 makes reference to macro-economic modeling and the potential impact of NHI, which could be either positive or negative. Much of the financing model and costs of NHI remain unknown at this stage, and as such it is not possible to do appropriate modeling. The imposition of NHI would obviously involve significant financial and other resources. It would thus entail a significant cost, particularly in a country such as South Africa with numerous pressing demands (such as education, housing and water) on limited resources. It would, with respect, be reckless and wasteful to embark on such an ambitious and costly venture without the assurance that the implications will be overwhelmingly positive. Any decision to implement

NHI should therefore be preceded by a policy document which convincingly demonstrates that the NHI model chosen will have a positive outcome. We submit that the Green Paper does not do so, and it is thus disconcerting to read, in paragraph 61, that macro-economic modeling “suggests that the implementation of [NHI] could have positive or negative implications, depending on the model utilized and its outcomes”. The vital detail as to what “models” of NHI will carry positive or negative implications is absent and it is thus impossible to interrogate this aspect of the Green Paper. It is crucial in this regard that the assumptions on which the model is based are robustly tested, that full economic modeling is undertaken and that the results thereof are disclosed for public comment.

- 15.2. The last sentence of paragraph 61 is particularly significant. It states that: “for National Health Insurance to have this positive macro-economic implication it needs to address the current institutional and staff constraints, improve significantly South Africa’s health indicators, achieve the productivity gains and remain affordable”. Unfortunately, the Green Paper does not explain the manner in which DOH seeks to address these constraints and challenges though NHI. It also does not describe in any detail the institutional and staff constraints or what is meant by the “productivity gains”.

## **16. The three dimensions of universal coverage**

- 16.1. The intention to focus primarily on prevention of disease and the promotion of health is supported as the most appropriate use of State resources.
- 16.2. Unfortunately, this section of the Green 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.
- 16.3. 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.

## **17 Population Coverage under National Health Insurance**

- 17.1. Paragraph 64 states that NHI will cover “all South Africans and 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 the segment of this group that will no longer maintain private medical insurance, and will be responsible for their contribution to the national load of disease which will be treated in the public sector.
- 17.2. The Green Paper provides some detail as to how the information that such a system requires will be collated, stored and shared amongst both public and private entities (both at a national and provincial level). This will require a significant IT infrastructure and investment, with suitably qualified persons to collate and input data. This involves an investment in human resources over and above the required clinical health care professionals.

## **18. The re-engineered primary health care system**

- 18.1. In general, the concept of strengthening the PHC system, with its focus on prevention of disease and promotion of health, is supported. The appropriateness of such an approach was outlined by the WHO at the international conference on PHC held in Alma Ata in 1978.
- 18.2. Nevertheless, the Green Paper does not clearly specify what exactly is meant by “primary health care services”. It is important to ensure that the Paper is explicit as to what is meant by PHC services as this is one of the essential components of the NHI basic package of care (see paragraph 68).
- 18.3. Paragraph 69 states that “[a]ll members of the population will be entitled to a defined comprehensive package of health services at all levels of care...”. The problem is that the Green Paper does not explain the make-up of the package. It is not possible to comment meaningfully on the proposals in the Green Paper without a detailed explanation as to the composition of the envisaged package of health services. In circumstances in which contributions to NHI are mandatory, the determination of the package of care will in the majority of instances determine whether a particular health service or medication is available to a patient (as few people would be in a position to afford to pay for services that fall outside the package of care). This impact is even more apparent in relation to those persons who cannot afford to make contributions to NHI. The exclusion of any health care services and medicines from the package of care will therefore have a dramatic impact on access to health care. Such exclusion will, in effect, amount to retrogressive measures limiting the constitutional right of access to health care. Any such exclusion will thus only survive constitutional scrutiny if it is shown to be reasonable and justifiable (in accordance with the requirements of the limitations clause in section 36(1) of the Constitution).
- 18.4. We support the intention to strengthen specialist services at the district level to manage the burden of disease in currently underserved areas (at paragraphs 71 to 73). 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 be alive to this practical reality.
- 18.5. Paragraph 73 states that the medical schools “should be able to provide these teams, even if it is on a rotational basis”. This is, in our submission, unrealistic given that there is a need for appropriate supervision of medical graduates while they are training and developing their skills. Medical students and recent graduates would also not be equipped to perform an oversight or management role at the district level; this role would require the involvement of more experienced practitioners.
- 18.6. We note that the private health sector is relatively well resourced, but design constraints within that sector limit its capacity to assist in alleviating resource constraints within the public sector. Currently, most doctors work alone in solo practices, which structure limits their ability to participate part-time in initiatives aimed at improving the public health sector. In other words, the design constraints of current private practice restrict the role that private specialists are able to play in health reform initiatives. The introduction of large single-discipline or multi-disciplinary group practices would create the flexibility to enable better utilisation of human resources. This restructuring could free-up private specialists to participate on a rotational basis in beneficial initiatives aimed at delivering health care to those outside the private sector. Regulatory reform to enable the establishment of single-specialty or multi-disciplinary group practices will thus be an important prerequisite to maximising the participation by the private sector in health reform initiatives.

18.7. Strengthening school health services is also supported. We suggest in this regard that deafness screening services should be added to the proposed list of services set out in paragraph 76. Private resources could be used to complement these initiatives if current design constraints within the system are addressed.

## **19. Healthcare benefits under National Healthcare Insurance**

19.1. Paragraph 79 refers to the provision of a “comprehensive benefit package of care under NHI” but, as stated above, no detail is provided as to what is to be included and what is to be excluded from that package. We are therefore not able to comment on this important issue in a meaningful manner.

19.2. The hierarchical design of health care services for PHC, district hospital services, regional hospital services and tertiary hospital services, as envisaged in the Green Paper, is supported. Ways of incorporating private hospitals into a national grid should be explored and use of private GPs as part of the PHC network must be encouraged.

19.3. In order for the hierarchical design to operate efficiently, there would need to be a comprehensive and detailed referral system in place to ensure that patients utilise benefits at the appropriate level. The design and nature of such a referral system is obviously dependent on the ambit of the package of care (in respect of which, the Green Paper does not provide any detail).

19.4. Paragraph 86 touches on the important issue of the ways in which private providers could participate in providing PHC services, and notes that this will entail “the specification of the range of services that will be provided”. The difficulty is that the Green Paper does not go on to specify the relevant range of services. As with the package of care, this omission means that it not possible for us to comment meaningfully on this issue.

19.5. Paragraph 87 refers to a “referral system” but also provides no detail in this regard. The costs of transferring patients from one level of care to another should be acknowledged and assessed, as this will affect the cost of the implementation of NHI. One of the current problems in the health care sector is the fact that patients are not aware of the levels of care, and often present at tertiary institutions for PHC services. The same happens at other levels within the system and, whilst an effective referral system may help reduce these problems, the Green Paper does not explain how the utilisation of the appropriate levels of care will be monitored and assessed so as to enhance efficiency and effectiveness.

19.6. We note that paragraph 87 refers to an “evidence-based comprehensive package of health services”. Again, this concept is not fleshed out and it is thus not possible to comment meaningfully on this aspect of the Green Paper.

19.7. We are concerned that the categories of hospitals and the explanation of the services offered by each category do not take account of the private sector hospital model. The Green Paper does not explain how these hospitals are to be incorporated within the broader hospital model contemplated under NHI. It does not shed light on how private hospitals will be accommodated within this context, and what levels of care will be provided by these private health establishments.

19.8. It should be noted that the health care benefits of the hierarchical system discussed in the Green Paper are not dependent on the introduction of the NHI model that the Paper envisages.

The question of the optimal approach to health care financing is very different to the question as to how health care service delivery should be structured.

- 19.9. We note that paragraph 85 states, correctly, that a sizeable proportion of South Africa's population use private providers for their health care needs, and adds, incorrectly, that "more often than not it involves substantial out of pocket payment". The Green Paper provides no basis for the latter assertion. In practice, out-of-pocket payments (as distinct from medical scheme reimbursement) account for a low portion of payments. This is particularly the case in respect of PMBs, in respect of which medical schemes are required to reimburse in full without the imposition of a co-payment.

## **20. Accreditation of providers of health care services**

- 20.1. The Green Paper provides scant detail as to the manner in which health service providers will be accredited for purposes of participation in NHI. Paragraph 97, however, indicates that a service provider will only be accredited if it complies with certain norms and standards. It therefore indicates that accreditation is a type of quality assurance function (see also paragraph 99).
- 20.2. SAPPF does not support the accreditation of individual doctors. Doctors hold professional qualifications and are registered with a statutory body (the HPCSA). The HPCSA exercises regulatory control over doctors and ensures that standards are not compromised. It is therefore unnecessary, and an imprudent use of resources, to require individual doctors to obtain accreditation in order to participate in NHI. To the extent that it is intended that doctors that participate in NHI must comply with specific requirements, this can be regulated through the instrument of contracting with doctors.
- 20.3. While we generally support the concept of accreditation (in the sense of ensuring compliance with norms and standards) for health establishments, we submit that the accreditation of such establishments should be through an independent process, which is audited and accountable. The compiling of national norms and standards for accreditation and the administration of the accreditation system must be independent of DOH, so as to ensure a consistent application of standards across the public and private sectors and to avoid the conflicts of interest that will otherwise arise where DOH in effect competes with private health establishments. If this is not the case, there is a risk that the accreditation body will prefer (or be perceived to prefer) the public sector over the private sector. In such an instance, accreditation decisions may be open to legal challenge on administrative law grounds.
- 20.4. Unfortunately, the Green Paper does not address the independence and accountability of the body that is intended to perform the accreditation function, and as such our ability to comment on this aspect is significantly diminished. We simply note that mechanisms to ensure independence should be built into the relevant legislation, including provisions relating to the appointment, tenure and removal of the governing body of the accreditation agency as well as provisions governing conflicts of interest.
- 20.5. Our other general comments on the accreditation of service providers are as follows:
- (a) Accreditation must be subject to uniform and objective standards which are clear and implemented on a consistent basis. Accreditation should not depend on the exercise of the broad discretion of a decision-maker.

- (b) In determining these standards, it is important to take into account the fact that the public and private health care sectors have fundamentally different business models, which must be addressed in uniform accreditation standards.
- (c) The opportunity for graft and corruption to thwart the noble intention of this accreditation process should be acknowledged and safeguards introduced to combat this threat.
- (d) The Green Paper does not explain what the effect will be of a public health establishment failing to gain accreditation. Without appropriate action taken against facilities in such instances, the process of accreditation would be futile and health standards would be compromised.
- (e) The Green Paper fails to address the process for the withdrawal of accreditation and re-accreditation subsequent to such a withdrawal.

## **21. The Office of Health Standards Compliance (OHSC)**

- 21.1. We submit that the operation, structure and reporting of the OHSC must be independent and accountable. The location of such an office within, or reporting to, DOH or the Minister of Health would, in our submission, give rise to actual or perceived conflicts of interest (see paragraphs 20.3 and 20.4 above).
- 21.2. Paragraph 99 refers, in broad terms, to criteria for accreditation, namely, safety, facilitation of access to care, “service elements”, management systems, performance standards and coverage. These criteria are exceptionally vague and it is thus not possible to comment meaningfully on the accreditation criteria.

## **22. Accreditation Standards**

- 22.1. Paragraph 100, despite its heading, contains no further details as to the envisaged accreditation standards. It is unfortunate that the Green Paper is so thin on this important issue.
- 22.2. This paragraph states that the provision of PHC is central to accreditation. While we acknowledge the fundamental value of PHC, it is inappropriate to place such emphasis on this type of care for purposes of accreditation. For example, the provision of PHC services should not play a role in the accreditation of private hospitals, which do not provide PHC but rather complement the PHC services provided in their area.
- 22.3. Paragraph 100 goes on to state that providers must adhere to “referral procedures as defined by the [NHI] and the referral system will be clearly defined ...”. The difficulty for present purposes is that, as we pointed above, the Green Paper does not explain the referral system. It is important that health care service providers, as persons that currently operate within the health care system, have input into an appropriate referral system, which is integral to the success of any health care reform measure.

## **23. Payment of providers under National Health Insurance**

- 23.1. Paragraph 102 states that, at the primary care level, accredited providers will be reimbursed “using a risk-adjusted capitation system linked to a performance-based mechanism”. Insufficient detail is provided to enable us to comment meaningfully on this proposed reimbursement model. The comments that follow are therefore general in nature.

- 23.2. A “risk-adjusted capitation system linked to a performance-based mechanism” is not a recognised model for health care reimbursement and it not clear what is meant by such a mechanism or how it would be feasibly applied at the level of an individual practitioner.
- 23.3. The use of capitation as a reimbursement model for GPs is problematic. The idea with capitation is that it is in the doctor’s best interest to keep his or her patients healthy. This is a seductive theory but one that is fraught with difficulty. In particular, there is a risk that some doctors will seek to maximize their financial position under a capitation model through under-servicing. This would be particularly problematic in an environment in which patients are unsophisticated and not easily able to stand up for their rights. As the Green Paper itself notes: “under-servicing ... is a common characteristic of many capitation-based systems” (at paragraph 107(c)).
- 23.4. It is also 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 designed.
- 23.5. We note that paragraph 104 records that mechanisms to achieve cost-efficiency will be investigated, including “international benchmarking”. No detail is provided as to what form such a benchmarking exercise may take. We caution that international benchmarking is a complex exercise which should only be undertaken after extensive research and with great sensitivity towards the differences between South Africa and other countries. In relation to specialists’ pricing, we submit that the cost and complexity of a benchmarking exercise is not justified where there is no evidence that specialists’ prices are too high; in fact, as pointed out above, there is evidence that this is certainly not the case.
- 23.6. Paragraph 105 provides that contracted private emergency services will be reimbursed using “a case-based approach”. It is not clear what is meant by a “case-based” approach and insufficient detail is provided to enable us to comment on this proposal. In addition, this proposal does not take into account the fact that specialists are not employed by private hospitals, but work independently of them. Case-based remuneration models that combine the payments for both hospitals and specialists into one are thus not currently feasible. Furthermore, this statement appears to suggest that non-contracted service providers will not be reimbursed for emergency services. If this is the intention, such differentiation between contracted and non-contracted service providers would, in our opinion, be unfair and unconstitutional, particularly given that section 5 of the National Health Act compels all health care providers and health establishments (whether public and private) to provide emergency services. It is equitable that all service providers should be appropriately reimbursed for emergency medical treatment that they are obliged to provide.
- 23.7. It is, we submit, also insufficient for paragraph 107 merely to state that there will be a risk-adjusted capitation formula. Detail on this important proposal must be provided to the public in order to facilitate adequate and meaningful commentary on this aspect. Currently, most medical disciplines have not adopted stringent diagnosis and treatment protocols that could be used as management tools in a capitation environment. Paragraph 107(c) envisages that

treatment protocols must be adhered to “for all conditions covered under the defined package of care”. It is important to note that the development and approval of treatment protocols will be a lengthy process, with experience suggesting that the average development time for a typical protocol from conception to final approval is about six years. The Green Paper does not engage with this complexity, nor does it explain who will be responsible for the production of suitable protocols. We submit that it is vital that the relevant service providers (and their professional associations) are closely involved in the development of treatment protocols as this exercise in essence involves the application of clinical judgement.

- 23.8. The calculation of risk-adjusted capitation budgets taking into account various variables (as suggested in paragraph 107(d)) is problematic. It is not understood how this can be applied practically in circumstances in which patients with varying risk characteristics constantly move from one area to another.

## **24. Healthcare Coding Systems and Reimbursement**

- 24.1. We agree that the coding system is an important component of health informatics and reimbursement. Any system for reimbursement, including NHI, simply cannot operate without a comprehensive and appropriate coding system.
- 24.2. It should be noted that the development of a coding system is a complex and time-consuming exercise in which some of SAPPF’s members have had extensive experience over the years. It is an exercise which, first and foremost, involves the application of clinical judgement as to the relative value and complexity of the various medical procedures.
- 24.3. In any coding or funding system for NHI, it is vital that the real costs of providing health care services are acknowledged and incorporated. In addition, it is important that the system keeps pace with cost increases. Certain costs, such as the cost of malpractice insurance cover, continue to increase at well above CPI and mechanisms to make appropriate annual adjustments will need to be found. It is also important to acknowledge that code maintenance is an ongoing process, and it is necessary to keep pace with new technological developments in health care to ensure that patients’ interests are not compromised.
- 24.4. As discussed at paragraph 23.4 above, if a capitation system is implemented for certain types of health care services, every item of service to be provided under such a system must be individually priced so as to ensure that the provider is adequately remunerated for the service. This will require the development and use of a particularly extensive and comprehensive coding system, which will have to be much more detailed than the system currently used in the public service.
- 24.5. Paragraph 109 states that the reimbursement system for inpatient services will be according to “disease related groups” and that a “case mix” or “grouper system” will be adapted for the South African environment. Our comments on this paragraph are as follows:
- (a) Insufficient detail is provided as to the manner in which such a system of reimbursement is to operate.
  - (b) The Green Paper does not acknowledge that most 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 hospital and no joint billing for services is currently possible. 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.

## **25. Unit of Contracting Providers of Healthcare Services.**

- 25.1. A District Health Authority (DHA) is envisaged to perform the function of contracting with accredited service providers (which would presumably include both health care establishments and doctors). The Green Paper contains insufficient detail as to the establishment, composition, structure and functioning of the DHA. It also does not explain how oversight will be exercised over this body so as to ensure accountability.
- 25.2. In addition to its function of contracting with and managing the contracts with accredited providers, the DHA is expected to monitor performance of contracted providers (paragraph 112). This is an enormous task as quality assessment and outcomes will need to be monitored. No details are provided as to how the relevant information will be obtained. One thing is certain: this function will require a huge amount of data collection and analysis.
- 25.3. Paragraph 112 states that accredited providers will be contracted and reimbursed “on the basis of the payment levels determined by the [NHI]”. This confers extensive power on “NHI”, particularly if one has regard to the facts that, first, many private service providers will have no option but to seek accreditation under NHI (as their private patient-base is likely to shrink under the strain of making compulsory NHI payments) and, second, an accredited provider will presumably not be entitled to charge a co-payment. The power unilaterally to determine payment levels under NHI is therefore, in substance, a price regulation power. It is crucial that clarity is given as to the manner in which this price regulation will take place. We reiterate that any pricing regime must ensure that service providers are able to cover their costs and to make a reasonable return. As Ebersohn AJ stated in the *Hospital Association of South Africa* case, discussing the proper approach to the determination of the RPL, “[i]t was therefore incumbent upon the Director-General to produce an effective RPL which sets rates at an appropriate, reasonable level that was grounded in the reality of the costs of operating private medical practices” (at para 120).
- 25.4. This paragraph of the Green Paper goes on to provide that accreditation of private health care providers will take into consideration the “need” for particular providers within an area, the type of health services “required” and “available resources” within the district. This wording suggests that service providers who meet the appropriate standards will not necessarily be accredited in the areas in which they currently practice, and that new providers, having completed their community service, will not be able freely to choose the areas in which they practice, depending on the needs of the relevant areas. To the extent that this paragraph suggests the “forced redeployment” of providers from areas of over-supply to areas in greater need, it is not supported. Such an approach, in our submission, amounts to an infringement of the constitutional rights to freedom of movement and freedom of trade, occupation and profession. It may also amount to an infringement of the constitutional right to property in circumstances in which a practitioner is obliged to relocate and to abandon his or her current practice in which he or she has made a substantial investment over the years.
- 25.5. Paragraph 113 suggests that the NHI purchaser and provider function will be split. While we do not object to such a split, we point out that putting in place a separate purchaser will be a significant task, which will be both time-consuming and expensive.

## **26. Principal funding mechanisms of National Health Insurance**

- 26.1. Paragraph 114 states that funds for NHI can be obtained from a combination of sources (e.g. the fiscus, employers and individuals). It adds that “[t]he precise combination of these sources is the subject of continuing technical work and will be further clarified in the next 6 months in parallel to the public consultation process”.
- 26.2. The funding mechanism for NHI is obviously of crucial importance, and we welcome a commitment to engage in extensive technical work on this issue. Given the importance of this issue, it is crucial that the proposed funding mechanism is subject to extensive public consultation in due course. We are obviously at this stage not in a position to comment on this aspect of the Green Paper.
- 26.3. We note that paragraph 115 provides that the revenue base for NHI must generate sufficient funds to supplement the general tax allocation to NHI. The current position is that South Africa only has 5.9 million registered taxpayers. A number of these registered taxpayers are currently unemployed and the number of actual taxpayers is thus probably substantially less than 5.9 million. This limited number of persons pay about 34.3% of total tax revenue collected (the top 10% of earners pay 55% of this). About 22.5% is contributed from companies and 24.7% from VAT (Heather Mcleod, National Health Insurance Policy Brief 20 of 8 August 2011). There is thus limited room for more collections.
- 26.4. Added to the problem of the narrow tax base, is the high level of unemployment. The prevailing economic climate has resulted in a serious contraction in the labour market in recent years (in the order of 13%). As of March 2011, only 40.8% of working age people were employed, while 15 million people received social grants. Furthermore, South Africa has a very low GDP per capita (about US\$350, compared, for instance, to that of the United Kingdom which is about US\$2 500), which seriously limits the country’s ability to fund overly ambitious health care reforms.
- 26.5. Against this economic backdrop, we have real concerns relating to the affordability of NHI as envisaged in the Green Paper, and this issue requires careful consideration. We note in this regard that it has been estimated that the implementation of NHI will result in an increase in personal income tax of 35% (if the full NHI funding is derived from personal income tax) or a 20% increase in both VAT and personal income tax (if the cost is spread across these two taxes).
- 26.6. It is important to note that the cost of increased taxation (or a mandatory NHI contribution) 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.
- 26.7. It makes logical sense to attempt to address these economic constraints through increasing employment opportunities. As with other industries, the private health sector has an important role to play in this regard but, in SAPPF’s view, the Green Paper proposals will seriously jeopardise the private sector’s ability to perform this valuable role, as these proposals would place the private sector under threat and probably lead to a contraction of that sector.

## **27. The role of co-payments under National Health Insurance**

- 27.1. We note that it is implausible that NHI will eliminate co-payments. As far as we are aware, no country in the world has been able to eliminate these payments entirely.

- 27.2. The Green Paper, at paragraph 116, indicates that co-payments “will not be encouraged” under NHI and notes that there are instances in which NHI “may be forced to impose co-payments” and goes on to state that these “may” include “amongst others” the circumstances listed in sub-paragraphs (a) to (e). The proposal in relation to co-payments, including the anticipated level of such payments, is therefore most unclear and we are not in a position to comment on this issue in a meaningful manner.
- 27.3. Nevertheless, we have the following comments on the circumstances listed in (a) to (e) of paragraph 116:
- (a) Sub-paragraphs (a) and (b) refer to services rendered not in accordance with NHI treatment protocols and guidelines, health care benefits not covered by the NHI benefit package and non-adherence to a defined referral system. As noted above, no clarity is provided as to these treatment protocols and guidelines as well as the benefit package and the referral system.
  - (b) Sub-paragraph (d) indicates that a co-payment may be imposed where services are rendered by a provider that is not accredited and contracted by NHI. This suggests that NHI will make payment in such instances but will impose a co-payment on the patient. If the co-payment is set at an appropriate level, this appears to be a sensible approach (save for in respect of emergency medical treatment, where no co-payment should be imposed); it would be unfair to expect a patient who chooses to use a non-contracted service provider to shoulder the full cost in circumstances in which that patient has made contributions to NHI. Put differently, the NHI “subsidy” should be available to all persons whether or not they choose to access accredited providers.
  - (c) It is difficult to reconcile the statement in sub-paragraph (e) that a co-payment may be imposed in respect of non-insured persons (such as a tourist) with paragraph 64 that indicates that such persons fall outside NHI. Clarity is required on this issue.
- 27.4. It is also important to clarify whether it is intended that NHI will pay the service provider directly or whether payment will be made to the patient (both in general and in circumstances where a co-payment may be imposed). Given the difficulties, and resultant costs, that service providers currently experience in attempting to recover payment for services rendered, the NHI model should provide for service providers to be reimbursed directly by the NHI Fund. In addition to reducing the costs of health care (by reducing the service providers’ costs), such a system will be easier, and cheaper, for the NHI Fund to administer. This should be the case irrespective of whether the service provider is contracted to NHI.

## **28. How much will National Health Insurance cost**

- 28.1. This section of the Green Paper sets out “preliminary estimates of the resource requirements for [NHI]” and explains that further work will be done to refine cost estimates (paragraph 118). The cost of NHI and the affordability thereof are obviously crucial to the viability of the proposal and require careful consideration and stakeholder engagement once a clearer picture emerges of the proposal.
- 28.2. Given the paucity of information on the NHI model proposed by the Green Paper, it is not understood how the drafters are in a position to estimate the cost of that model. It is impossible to cost a model without details as to, for example, the benefit package to which persons will be entitled under NHI, the scope of the persons that are likely to use those benefits, the burden of disease of those persons and the manner in which NHI will be governed.

- 28.3. Paragraph 120 states that the costing model uses a “public sector framework”, which implies a defined comprehensive package of services that is defined in terms of individuals having access to primary care facilities and to specialist and hospital care on referral. The model is said to be based on “public sector unit costs” but at improved resourcing levels. This portion of the Green Paper, including what is meant by “public sector unit costs”, is particularly unclear. It is therefore not possible to comment on this important aspect in a meaningful way.
- 28.4. Paragraph 121 states that the model “makes allowance for large increases in utilisation when financial barriers to service use are removed under [NHI] (of over 70% in outpatient care and about 80% in inpatient care for those that are currently ‘uninsured’ relative to their current utilisation levels)”. This statement is not understood, in circumstances in which uninsured persons are generally entitled to free treatment in the public sector (which is very different to the position that applied in Thailand (which is the basis for the assumption in this paragraph of the Green Paper), where basic insurance coverage was introduced for persons who previously enjoyed no coverage). Nevertheless, it is important to note that the NHI model, if successful, would not only increase utilisation by those without medical insurance, it would also increase utilisation by those currently insured population who will no longer be able to afford to continue to make private medical scheme contributions. This will place an even larger burden on the public service. The range of requisite services may also differ from the current situation as the burden of disease, age profile and other variables differ greatly between the currently insured and uninsured populations.
- 28.5. Paragraph 122 states that “[t]his model indicates that resource requirements under this model increases [in real terms] from R125bn in 2012 to R214bn in 2020 and R255bn in 2025 if implemented gradually over a 14-year period”. Paragraph 123 goes on to state that these figures “should be placed within the context of current spending levels. The 2010/11 health MTEF budget is R101bn and increases to R110bn in 2012/13 (2010 prices). This does not include spending by other departments (such as health spending by Defence and Correctional Services)”. This paragraph then notes that R90 billion was spent on medical scheme contributions in 2009 and is estimated to total R92 billion in 2010. This is stated to “represent a total of R227 billion being spent on health services in South Africa in 2010”.
- 28.6. The Green Paper does not indicate how the figure of R101 billion is comprised at 2010/11 values. Our calculations, as reflected in Annexure A, indicate that this figure comprises spending by DOH at R5.3 billion, provincial health departments at R93.5 billion, Safety and Security at R577 million and Local Government at R1.8 billion. Referring to the 2011/12 forecasts in Annexure A indicates that the provincial departments amount to R101.4 billion and the total to R109.7 billion (which matches the figure of R110 billion referred to in paragraph 123). Whilst this amount excludes spending by Defence and Correctional Services, it includes Local Government at R 1.865 billion, which is funded from own revenue and is not stated in 2010 real terms. In the absence of clarifying the two base years used, it is not clear how the total of R227 billion is arrived at. Following the approach set out in paragraph 123, the total for 2010 should be R101 billion plus R92 billion for medical scheme contributions. This amounts to R202 billion, with an unexplained difference of R25 billion. The total of R227 billion is by chance the total health care expenditure for 2009/10 as reflected in Annexure A (reflecting all components of health care expenditure, including, amongst others, out-of-pocket expenses of R36.4 billion and Defence and Correctional Services at a total of R2.5 billion). Paragraph 123 adds a further R9 billion in expenditure (from the 2010/11 to the 2012/13 figure) but does not indicate what it is to be used for or how it will be funded. It is therefore impossible to comment meaningfully on the budgetary amounts reflected in paragraph 123.

- 28.7. It is also not possible to comment critically on the calculations in paragraph 122, in the absence of clarity as to how various amounts and assumptions are arrived at in this paragraph. For example:
- (a) It states that “this model increases from R125 billion in 2012... “. There is no indication how this R125 billion reconciles to the R110 billion referred to in paragraph 123. If one has regard to Table 1 on page 39, the “total direct healthcare costs” are stated to be R117 billion for 2012. There therefore appears to be at least a R8 billion gap between the Green Paper’s estimate for 2012 and the MTEF budget.
  - (b) It continues to note an increase in expenditure to R214 billion by 2020 (in 2010 terms). The extent of this increase appears to assume that all medical scheme premiums will be diverted to NHI (we note in this regard that the 2010/11 expenditure for medical schemes was approximately R89 billion (i.e. the difference between R125 billion and R214 billion) – see Annexure A).
  - (c) Paragraph 122 then states that the 2025 expenditure will amount to R255 billion (in 2010 terms) but this paragraph and Table 1 fail to explain how the amount moves from R214 billion to R255 billion over this period.
- 28.8. Paragraphs 122 and 123 do not take account of the following forms of health care expenditure: out-of-pocket expenses, Correctional Services, Defence Force, the Road Accident Fund, Workmen’s Compensation, medical insurance, employer expenses, donors and NGOs. The Green Paper does not explain how these expenditures will be dealt with in the NHI budget. Annexure A reflects that these amounts make up R55.9 billion in the 2010/11 estimate.
- 28.9. Table 1 of the Green Paper summarises the NHI preliminary cost estimates from 2011 to 2025. The totals are split between non-AIDS-related services, AIDS-related services, so-called additional services, operational costs and NHI implementation costs. The Table starts with 2012 costs and escalates to 2025 costs. No details are provided as to how the amounts reflected in the Table 1 are made up. In addition, the Table provides neither any principles nor any assumptions that have been applied. Some examples of unexplained numbers are:
- (a) Table 1 starts off with total direct health care costs of R117 billion in 2012 and administration costs of R586 million (with a total of R117.796 billion). This total does not reconcile to any number nor is it reconciled to any data in the public domain.
  - (b) The tables are inflated by varying percentages between 3.8% and 8.5% without explanations in any given year.
  - (c) Total NHI operational costs start off at 0.5% and end as 2.9% of the total costs (i.e. R7.45 billion in 2025 (in 2010 terms)). This amount compares to medical scheme administration costs of approximately R7.8 billion in 2010 for administering 8.3 million lives and gives no indication what the current DOH administration costs are. It therefore appears that the total NHI operational costs have been grossly underestimated. We are concerned that the drafters of the Green Paper may have materially under-estimated the costs involved in administering a medical funding mechanism of the magnitude of the envisaged NHI.
  - (d) NHI implementation costs are included in the Table. These costs vary from R7.5 billion in 2012 to a high of R9.2 billion in 2024 (in 2010 terms). While we cannot comment on this aspect without any details, we point out that the current infrastructural backlog to improve public sector health infrastructure is estimated at R90 billion. When added to

other costs that will arise from the implementation of NHI, it appears that the implementation costs in Table 1 may be under-estimated.

- (e) No details are provided as to the costs of implementing the human resources strategy for public health. This cost is likely to be huge.
- 28.10. It is accordingly impossible to interrogate the estimated costs reflected in Table 1, and we therefore cannot comment on the figures in the Table, including the calculated 2025 cost of R255 billion, in an informed manner.
- 28.11. The question remains: how much health care can South Africa afford for all? The Green Paper does not offer a convincing answer. Currently, the State spends approximately R102.1 billion out of a total budget of R900.9 billion on health care, which is about 11% of the total budget. Given a population of approximately 50 million, the State is spending about R2 500 per person (the Green Paper puts it at R2 766, which is about US\$350). In comparison, the United Kingdom spends about US\$2 500 and New Zealand US\$2 384 per person. South Africa clearly cannot deliver a comprehensive health care plan of any quality for US\$350 per person.
- 28.12. Paragraph 125 states that the increased spending on NHI “will be partially offset by the likely decline in spending on medical schemes”. This paragraph provides no indication as to what is meant by “partially offset”. Moreover, we note that no analysis appears to have been done as to the extent to which private medical scheme contributions are likely to decrease under NHI. Without carefully modeling this critical variable, we submit that it is impossible to predict the total increase in health expenditure that NHI will occasion.
- 28.13. This paragraph of the Green Paper goes on to assert that the ultimate level of spending on “a universal health system relative to GDP” will be 6.2%, which is less than current spending by Government and via medical schemes (of 8.5% of GDP). The Green Paper, however, provides no indication as to how this reduction would arise. There is, we submit, no reason to predict that overall health care expenditure will come down under NHI. In fact, the opposite seems more likely, particularly given the huge administration costs that NHI will entail.
- 28.14. The Green Paper suggests, at paragraph 126, that increased spending on NHI will be partially offset by the likely decline in spending on medical schemes. The stated intention is that NHI benefits “will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply to draw on their [NHI] entitlements”. While this is a good intention, it may be a long while before such a choice is realised. Moreover, the realisation of this goal would require a significant increase in spending on health care.
- 28.15. Paragraph 127 asserts that preliminary costing estimates indicate that NHI is affordable for South Africa. Multiple sources, on the contrary, suggest that NHI is in fact not affordable to South Africa. The massive discrepancies between the projected costs in the Green Paper and the calculations performed by various expert commentators give serious cause for concern and these discrepancies will need to be dealt with. For example, health economists Sevaas van den Berg and Heather Mcleod estimate that NHI will require R156 billion per annum if based on current PMBs, R251 billion for a basic benefit package and R334 billion for a comprehensive package (we note that the Green Paper envisages a comprehensive package of care but calculates a far lower cost). Nicola Theron of Econex stated, at the 2010 Hospitals Association of South Africa conference, that one of the scenarios in Econex’s research suggested that additional tax revenue of R244 billion would be required for NHI.

28.16. We note that paragraph 127 reiterates the claim that the present system is characterised by “fragmentation, associated with the high costs, curative and hospi-centric approach and excessive and unjustifiable charges, especially within the private health sector...” and that this is “unsustainable” (see also paragraph 129). As noted above, the Green Paper offers no factual basis for these wide-ranging assertions in respect of the private sector. For the reasons set out above, we submit that these assertions are unfounded.

## **29. The establishment of the National Health Fund**

29.1. Paragraph 131 refers to the “reconfiguration of the institutions and organisations involved in the funding, pooling, purchasing and provision of health care services” in South Africa. It is unclear what this “reconfiguration” entails. To the extent that this may involve a change in the functional competencies of national and provincial government, we point out that such a change may require a constitutional amendment, given that health care services are a concurrent competence of national and provincial government.

29.2. The Green Paper states, at paragraph 132, that the NHI Fund will be a government-owned entity that is publicly administered. It goes on to provide that the NHI Fund will be a single-payer entity with sub-national offices. Our comments on this proposal are as follows:

- (a) A single fund model presents huge administrative challenges; the single-payer model in effect creates a massive public medical scheme which may prove very unwieldy to administer.
- (b) The Green Paper offers no indication that a range of options have been considered and that the single fund model has been found, on the basis of empirical research, to be the most appropriate model for South Africa. There is, in particular, no indication that international models have been researched and validated in a South African context, or that the various potential models have been costed.
- (c) One alternative that comes to mind is the possibility of multiple funds administered at a provincial level, which is similar to the German model, another is a multi-payer system. We note, in this regard, that paragraph 132 concludes by faintly acknowledging that a multi-payer system “will also be explored as an alternative to the preferred single-funder, single-purchaser publicly administered fund”.
- (d) No rationale is provided in the Green Paper for the preference for a single fund.

29.3. The Green Paper provides that the NHI Fund will report to the Minister of Health (paragraph 133). SAPPF contends that the NHI Fund should be independent of DOH and should thus not report to the Minister of Health. This is because of the conflict of interest that arises where DOH acts both as one of the service providers and as the payer. DOH is a participant and beneficiary of the NHI, as well as the body through which its competition (the private health care sector) is regulated. It should not also have oversight responsibility in respect of NHI.

29.4. Foreign examples of NHI funds (in their respective forms) are often subject to separate enabling legislation, and internal constitutions, which establish the means by which the fund operates, as well as the principles by which it is governed. Concern is noted that the Green Paper makes no attempt to capture critical principles that should govern the NHI Fund, and leaves the question of financial, clinical and legal mandate open.

29.5. Paragraph 134 lists a wide range of functions that DOH will perform under a NHI regime. In addition to the conflicts of interest concern expressed above, we are concerned that this proliferation of roles and responsibilities will place further strain on DOH which, in our view,

struggles to carry out its current mandate. The allocation of further multiple roles to DOH may prove to be over-ambitious given the current realities facing public health care service delivery in this country.

- 29.6. A crucial unknown is whether the staffing, appointment and allocation of resources for the operation of NHI will be a responsibility of DOH. It would radically undermine the independence of the NHI Fund if DOH is able to appoint employees (including the Chief Executive Officer (CEO)) of the Fund or if DOH holds the purse strings of the NHI Fund.
- 29.7. Paragraph 135 provides that the NHI Fund will be managed by a CEO who will report directly to the Minister of Health. For the reasons set out above, this is unacceptable. The Green Paper envisages a situation in which not only will the NHI Fund, as a statutory entity, report to the Minister of Health but so will its senior executive member of staff. This is a significant conflation of powers, responsibilities and functions. It will undermine the independence of the Fund and give rise to actual or perceived conflicts of interest.
- 29.8. The monitoring and accountability of the NHI Fund are not addressed in the Green Paper. Without effective monitoring and accountability, the Fund (and the country's limited health care resources) will be open to the threat of mismanagement and corruption.
- 29.9. Paragraph 135 adds that the CEO will be supported by an executive management team and specific technical committees, including technical advisory, audit, pricing, remuneration, benefits advisory committees and so forth. No detail is provided as to how the individuals who will compose these committees are to be identified and appointed.
- 29.10. We welcome the suggestion, at paragraph 136, that the NHI Fund will be advised by a technical advisory committee made up of experts in various fields, including health economics, and providers of medical and nursing services.

### **30. The Role of Medical Schemes**

- 30.1. Paragraph 137 states that, while membership of NHI will be mandatory for all South Africans, members of the public may choose to continue their membership of voluntary private medical schemes. There will, however, be no tax subsidies for those who choose to continue with medical scheme cover.
- 30.2. Many countries, including both advanced and developing nations, that have introduced mandatory health insurance have allowed voluntary health insurance to co-exist in parallel. These systems can be complementary, supplementary or duplicative. In South Africa, for example, the current private system duplicates and in some instances supplements those services that are available in the public service. However, the introduction of a mandatory tax that is equivalent to the average medical scheme premium, may make continued contribution towards voluntary insurance unaffordable for many medical scheme members, who may then be forced to use State facilities at a point in time when those facilities do not provide access to adequate quality health care. This diversion of private resources into a public fund may offend the constitutional requirement that there must be *progressive realisation of the right of access to health care* and improvement in access for all South Africans. For those persons who are currently beneficiaries of medical schemes, their current access is likely to be diminished by the proposals contained in the Green Paper.

- 30.3. While the Green Paper refers to the continuance of private medical insurance, not much detail is provided as to how it is envisaged that the private sector will exist alongside NHI. Critical questions as to the role and function of private medical insurance remain, including whether medical schemes will be allowed to offer the same coverage (and more) provided by the NHI, or whether that coverage be limited to top-up insurance (paragraph 138 simply notes that the “exact form of services that medical schemes will offer may evolve to include top-up insurance”). Moreover, the Green Paper does not explain the envisaged role of the CMS, as a regulator of medical schemes, and the application of the MSA, under NHI. This lack of detail is unfortunate as it compromises our ability to comment on the proposals contained in the Green Paper in an informed manner.
- 30.4. The Green Paper does not address what will happen to member funds of approximately R32 billion currently within the medical scheme market, especially the funds of those members that no longer maintain their private medical insurance and become dependent on NHI?
- 30.5. There is also no clarity on the future of the Government Employees Medical Scheme (GEMS), the South African Police Services Medical Scheme (POLMED) and the schemes of state-owned entities. These are large medical schemes that generally operate effectively but it is difficult to reconcile their continued existence with the concept of NHI.
- 30.6. SAPPF believes that the most efficient way to achieve meaningful, quality universal coverage is through the strengthening of both the public and private sectors and that the rules governing the application of VAT to health services and the issue of tax subsidies should be treated in such a way as not to undermine or inflict harm to either sector.

### **31. Registration of the population**

- 31.1. Paragraph 140 states that the NHI Fund will only deal with “registered citizens”. We note that this contradicts paragraph 64, which, as discussed above, indicates that NHI will cover all South Africans and legal permanent residents. It appears to us that it would be unconstitutional for the benefits of NHI to only be granted to citizens, to the exclusion of permanent residents (see *Khosa and Others v Minister of Social Development and Others* 2004 (6) SA 505 (CC)).
- 31.2. The registration process is not sufficiently addressed in the Green Paper. This would be a complex process. For example, issuing a registration card to each and every eligible person across the country would be a mammoth task that would require an extensive IT system.

### **32. Information systems for National Health Insurance**

- 32.1. Nowhere in the world is there a truly paper-free electronic health reporting and administrative system, although there are sophisticated systems in operation in a number of developed countries. Development of a seamless information system will take time and considerable resources and will in the short- to medium-term have to be supported by a paper-based system.
- 32.2. As pointed out at paragraph 17.2 above, the information system that will be critical to the operation of NHI will be extremely expensive and will take a large amount of time to implement.

### **33. Migration from the Current Health System into the National Health Insurance Environment**

- 33.1. The proposed migration will be critical to the successful transition from the current system to NHI. The statement, at paragraph 143, that the transitional process “will require a well-articulated implementation plan” is therefore sensible.
- 33.2. A key risk is that mandatory NHI contributions will divert medical scheme funding for individuals that are not able to afford both to make these mandatory contributions and to fund private medical cover, particularly in the period before the services available through NHI have reached a comparable level of care to that currently enjoyed in the private sector. Currently, medical scheme members enjoy unrivalled access to health care services with short waiting times and queues and a comprehensive range of services. If forced to use public services under NHI, these persons can expect a much inferior service with long waiting lists, the prospect that many services may not be available (e.g. hip replacements or expensive medications) and a reduction in choice of practitioner. Such a development would undermine the constitutional right of access to health care.
- 33.3. Furthermore, doctors who have not been accredited for NHI, including those who choose not to seek accreditation, may find that their practices are starved of patients whose schemes have closed due to the pressure on their membership of simultaneous NHI payments.
- 33.4. It is important to acknowledge the challenge of building the required human resource capacity for the effective delivery of health care as envisaged in the Green Paper, and that this will take some time. In this regard, it would be worthwhile to consider attempting to persuade doctors and other providers currently living abroad to return to South Africa so as to assist in alleviating the demands on existing human resources. There is also a need to bolster training within medical schools to enhance the numbers of quality medical graduates. This is acknowledged at paragraph 147.
- 33.5. The need to pilot the model, as suggested in paragraph 148, is accepted. The question remains, however, as to what the pilot projects will entail in terms of services, delivery and goals? In particular, careful thought should be given as to the manner in which pilot projects will be measured. International best practice indicates that the proposed pilot projects will only be meaningful if all relevant indicators are: established and measured before commencement of the projects, monitored throughout the projects, and measured at the end of the projects. This process will require careful consideration and planning.
- 33.6. The desirability of pilot projects also demonstrates that there is a need for flexibility in the timing of the proposed introduction of NHI; the process must be able to adjust to insights gained and lessons learned through the pilot projects.

## **Conclusion**

It is critical not to conflate the laudable aim of universal access to appropriate and affordable health care with NHI. They are not the same and are not inter-dependent. SAPPF is fully committed to working with all stakeholders to broaden access to health services as a vital and progressive step towards the ultimate goal of improved universal access (both through enhancing the private sector and in undertaking the most pressing task of rehabilitating the public sector).

SAPPF does not support the introduction of a completely new and untried funding mechanism which will entail huge expense and will threaten the continued viability of private health care in this country. Given the views expressed in this document, the proposals for the establishment of a single purchaser/payer NHI funding model cannot at this time be supported by SAPPF. It is, however, hoped that serious consideration will be given to the comments and recommendations made in these submissions (including those set out in Appendix A).

In light of the comments set out above, we request the publication of a revised draft of the Green Paper with suitable detail so as to enable SAPPF and other interested parties to comment in an informed and meaningful manner prior to the finalisation of the Paper.

## **Appendix A: The private health care sector: comments and recommendations**

### **Comments on private health care**

SAPPF's members are specialists operating within the private health care sector. We are therefore particularly well-placed to respond to those aspects of the Green Paper that relate to the private sector. Having set out our detailed commentary on the Green Paper, we therefore now comment specifically on the Green Paper's treatment of the private sector and set out some recommendations as to the manner in which that sector can contribute to the overall reform of health care in this country.

In this section of our submission, we refer to the preceding portion as "our detailed commentary".

#### **1. Introduction**

The Green Paper criticises the private health care sector, generally casts the sector in a negative light, and adopts an ambivalent approach to the future role of the private sector under NHI. In this Appendix, we firstly challenge the perception that the private sector is to blame for the woes of the public sector and, secondly, we submit that a reformed and restructured private sector is an essential player in the quest for quality universal access. In short, the private health care sector is a valuable asset that must be protected.

#### **2. Health care financing is already highly redistributive**

- 2.1. The Green Paper takes issue with the two-tiered structure of the South African health care system, arguing that the available resources are heavily skewed in favour of the minority of South Africans who can afford private care. The Paper therefore suggests that the current system is inequitable and discriminates unfairly against the poor.
- 2.2. Theron, van Eeden and Childs, however, make the point that health care financing in South Africa is already extremely progressive, with the richest quintile contributing 82.3% of total health financing whilst receiving 36% of the benefits. This is because of the system of progressive income tax and the fact that the persons who contribute the most to the source of public sector funding (i.e. tax revenue) generally do not use the services which they fund (see further paragraph 6.6 of our detailed commentary).

#### **3. The fundamental difference between public and private expenditure**

- 3.1. As pointed out in our detailed commentary, the Green Paper conflates private expenditure on personal health care and public financing of public health care as though they are one and the same thing. Clearly they are not (see paragraph 6.3 of our detailed commentary).
- 3.2. The greater amount of money spent per beneficiary in the private sector as compared to persons who make exclusive use of the public sector is a reflection of the fact that wealthier persons generally spend more. It is therefore inaccurate to say that more is spent on private sector patients. The difference is due to the comparatively more wealthy spending more of their own (after tax) discretionary spend on health care.
- 3.3. When making comparisons of this nature, it is thus important to compare like with like and it is more appropriate to compare what the State spends on public sector patients with the tax

allowance the Government offers medical scheme members as an inducement not to use public services.

- 3.4. Expenditure per beneficiary for the different sectors in 2009, according to the *ANC Today*, was R11 300 for medical scheme members and R1 900 for those making exclusive use of the public service. This is, however, a misleading analysis. What needs to be compared is the public sector spending (per person) on users of public sector facilities with the per-person subsidy allowed to taxpayers to purchase private medical insurance. If one compares the public sector figure of R1 900 with what the State forgoes (“spends”) by way of the tax subsidy offered to medical scheme members (R1 730 in 2009), one gets a much fairer comparison of the cost to the State of treatment across the sectors.

#### **4. Human resource discrepancies and excess capacity are overstated**

There is a perception that there are more human resources in the private sector and excess capacity that could be used to lighten the load in the public sector. As discussed in our detailed commentary, this is incorrect. The evidence suggests that the human resource discrepancy between the public and private sector is not as dramatic as the Green Paper suggests and that there is a shortage of human resources in both the public and private sectors.

#### **5. Private health care is a highly regulated environment**

- 5.1. The Green Paper fails to acknowledge the facts that the private health care sector is highly regulated and that certain cost increases result from Government policy. Two examples illustrate the latter point: the introduction of a 25% solvency ratio requirement for medical schemes (regulation 29 of the Regulations published under the MSA) and the payment of a comprehensive list of PMBs at full cost (regulation 8). While we support the solvency requirements for medical schemes as well as the notion of PMBs, these measures impose costs on medical schemes.
- 5.2. The private sector is subject to a range of legislation, including the National Health Act 61 of 2003, the Health Professions Act 56 of 1974, the Allied Health Professions Act 63 of 1982, the Health Act 63 of 1977, the MSA, the Medicines and Related Substances Act 101 of 1965, the Pharmacy Act 53 of 1974 and various regulations promulgated under these Acts.
- 5.3. Should Government have chosen to control private sector spending, it could have done so by utilising the various pieces of legislation available to it. In this regard, SAPPF has repeatedly emphasised that it is not opposed to pricing guidelines (such as the RPL) provided that the guidelines are determined in an appropriate manner so as to ensure that health care service providers are able to cover their costs and to make a reasonable return. As the judgment of the High Court in *Hospital Association of South Africa v Minister of Health* held, the process for publishing the RPL was deeply flawed. Moreover, amendments to both the MSA and the National Health Act, aimed at health reform, have been on hold since 2008.
- 5.4. We submit that DOH has the mechanisms at its disposal to effect appropriate health reform. There is therefore no need to radically overhaul the system of health care funding through the introduction of NHI.

## **6. The private sector is not over-priced**

- 6.1. By international standards, South African private health care is affordably priced and service provider fees are not inappropriately high (see paragraphs 3.10, 6.4.3 and 12.5 of our detailed commentary). We refer, in this regard, to the graph attached hereto as Annexure B, which indicates that expenditure on private health care in this country (in 2005) compared favourably in relation to other countries surveyed (particularly given the high quality of care provided in our private sector).
- 6.2. Medical scheme disbursements to providers have declined in real terms by roughly three fold over the past 40 years. We note in this regard that the Representative Association of Medical Schemes (RAMS) tariff in 1968 employed a unit value of 48 cents, which, if adjusted for inflation (i.e. CPI/X), translates to R20.72 in 2009 terms (our calculations are reflected in the table attached as Annexure C). This indicates that, compared to their colleagues of forty years ago, current health care professionals are poorly remunerated. Had rates of medical scheme reimbursement kept pace with inflation, the 2009 medical aid reimbursement rate would have been R20.72 per unit, as opposed to the R11.35 for consultations and R7.03 for procedures (as reflected in the 2009 RPL). This figure of R20.72 would, of course, be higher if VAT and medical inflation were taken into account.
- 6.3. These results correlate well with the cost studies prepared as part of the RPL process, which indicated that the rates of reimbursement reflected in the RPL were far too low (see also the judgment of Ebersohn AJ in *Hospital Association of South Africa v Minister of Health*, quoted at paragraph 12.5.2 of our detailed commentary).
- 6.4. A further factor that must be considered is the recent massive escalation in malpractice insurance premiums, which far outstrips both CPI and medical inflation. As one example, the premium for obstetricians is now R185 750 per annum – an increase of almost 50% in one year – and it is expected to rise to more than R220 000 in 2012.
- 6.5. The contention in the Green Paper that the escalation of private sector costs is due to the “charging of exorbitant fees completely out of proportion to the services provided” is therefore wholly inaccurate. We are disappointed that such an allegation is made without any evidence to back it up.

## **7. The private sector is not responsible for the poor performance of the public sector**

- 7.1. As explained in our detailed commentary, SAPPF strongly disputes the implication that the well-functioning private health care sector is responsible for the poor performance of the public sector. The dire problems with the public health sector are independent of the existence of the private sector.
- 7.2. Although Government has in recent years to some extent accepted the role of failed Government policies and mismanagement in leading to the poor performance of the public health care service, it is inaccurate and misleading for the Green Paper to seek to blame the private sector for the current crisis. It must be accepted that policies such as the freezing of public sector posts, the closing of nursing colleges, the deployment of unqualified persons into management positions within the public service, the diversion of tertiary hospital funding to PHC, the failure to spend hospital budgets appropriately, inattention to the maintenance of facilities, flawed procurement policies and processes, together with provincial deficits running into billions of Rands (found in the Consolidated Report of the Integrated Support Team (IST))

are some of the real causes of the deterioration of the public health service over the past two decades.

- 7.3. Aside from the points made in this regard in our detailed commentary, we note that the private sector served, and continues to serve, a very important personnel-retention function during this period of crisis in public health. Had the option of private practice not been available to them, many practitioners that entered private practice because they were unable to find suitable positions within the public service may otherwise have exited health care or left the country, to the detriment of the general health care system. It is, with respect, critical that the Government takes ownership of these past mistakes and introduces steps to reverse the ill-effects that resulted therefrom, as an essential prerequisite to future progress. We therefore welcome the fact that DOH has indicated that the improvement of the public health sector is a precondition for any reform.

## **8. The medical schemes industry is not unsustainable**

- 8.1. The Green Paper suggests that the medical schemes industry is under pressure and that schemes are experiencing problems of sustainability mainly due to “over pricing of health care” (paragraph 32). As explained in our detailed commentary, this assertion is not supported by any facts. On the contrary, the indications are that the private medical scheme industry is sustainable.
- 8.2. Regulation 29 of the Regulations published under the MSA requires medical schemes to maintain a minimum solvency level of 25%. These accumulated funds are generally referred to as reserves and represent a percentage of the gross premium contribution. These reserves indicate the financial soundness of a medical scheme and are available to cover unforeseen expenditures and a change in claiming patterns of members. The CMS monitors solvency of schemes on a quarterly basis and requires strict corrective actions should a scheme fail to meet its requirements.
- 8.3. The average solvency ratio for the industry was 31.6 % as of 31 December 2010, compared to the statutory requirement of 25%. Open scheme solvency was at 27.4 % (unchanged from 2009) and restricted schemes were at 38.4% (a reduction from 42.5% in 2009). The reduction in average solvency levels in the restricted schemes environment flows from the growth of GEMS membership over the period (coupled with GEMS’s low solvency levels – see paragraph 8.4 below). Insofar as the open schemes market is concerned, this market competes strongly on price and there is no need for a scheme to maintain solvency levels above 25% (e.g. the solvency level of Discovery Health, the largest open medical scheme, does not vary materially above or below the 25% level). Where schemes have a material movement in solvency in a given year, this is usually attributable to: (a) changes in membership numbers; (b) incorrect pricing on premiums; (c) poor administration; or (d) exceptional claims patterns in smaller schemes.
- 8.4. The position is reflected in the following summary of the financial position of some of the major medical schemes as at 31 December 2010:

	<b>Beneficiaries</b>	<b>Contributions</b>	<b>Reserves</b>	<b>Surplus/(Deficit)</b>	<b>Solvency Ratio %</b>
		<b>R'000</b>	<b>R'000</b>	<b>R'000</b>	
BankMed	202 189	2 754 249	1 590 744	160 459	51.2
Bonitas	618 464	6 907 418	2 633 417	277 578	36.5
Discovery	2 244 864	27 650 362	6 847 076	594 072	24.7
FedHealth	163 975	2 405 336	793 560	157 109	30.7
GEMS	1 458 437	13 387 762	943 593	(120 470)	7.1
POLMED	476 385	5 111 356	1 927 846	662 125	36.4

Source: CMS Report 2010. Note: The surpluses as stated above are after accounting for investment income of schemes. The budgetary process for medical schemes takes into account the impact of anticipated investment income.

- 8.5. This summary shows that, with the exception of GEMS, the major medical schemes are all in a sound financial position. Three points should be made in relation to the GEMS deficit. First, it does not include the R77.8 million profit that was made on the merger with Medcor (as disclosed in GEMS's annual financial statements). Second, the GEMS deficit is to a large extent the result of incorrect premium pricing. GEMS's gross health care expense per beneficiary per annum of R8 659 did not differ materially from that of Discovery at R 8 841 yet its premiums were significantly lower. Third, GEMS's solvency will be under pressure during the period in which it continues to increase membership significantly, and would be expected to stabilise five or ten years after its membership levels become fairly constant.
- 8.6. A comparison of statements of comprehensive income and expenditure of medical schemes over the past decade is also informative:

<b>Source Documents: CMS Annual Reports 2000 &amp; 2010</b>				
<b>Overview per beneficiary (real terms, based on CPI/X plus 3% (3% reflecting an adjustment for additional medical inflation), other than those items marked with an asterisk(*) which are escalated based on CPI/X)</b>				
	<b>2010</b>	<b>2000</b>	<b>Change</b>	<b>Average annual change</b>
	<b><u>Rand (R)</u></b>	<b><u>Rand (R)</u></b>	<b><u>%</u></b>	<b><u>%</u></b>
<i>Total Member Funds*</i>	3,921	1,964	99.6%	10.0%
<i>Gross Contributions (Income)</i>	11,602	11,888	-2.4%	-0.2%

<i>Healthcare benefit payout</i>	10,190	10,450	-2.5%	-0.2%
<i>Broker Fees*</i>	159	67	137.3%	13.7%
<i>Administration Cost*</i>	941	728	29.3%	2.9%
<i>Net Healthcare Result</i>	(55)	(386)	-85.7%	-8.6%
<i>Investment / Finance Income*</i>	265	218	21.1%	2.1%
<i>Net Surplus / (Loss)*</i>	343	56	515.1%	51.5%
GPs	744	883	-15.7%	-1.6%
Specialists & Clinical Support Specialists	2,556	2,042	10.5%	1.04%
Dentists	306	530	-42.3%	-4.2%
Dental Specialists	72	107	-32.7%	-3.3%
Supplementary & Allied Health Professionals	807	679	18.7%	1.9%
Hospitals	3,742	3,179	17.7%	1.8%
Medicine	1,688	2,814	-40.0%	-4.0%
Ex gratia	4	18	-75.3%	-7.5%
Other Benefits	310	164	88.8%	8.9%
Managed care	261	34	663.9%	66.4%

8.7. We make the following points in relation to this summary:

- (a) Medical inflation exceeds general inflation in most countries of the world. This is caused by, amongst others: the changing burden of disease, new technologies and increased medical cover offered by medical schemes (see paragraph 6.4.2 of our detailed commentary). In South Africa, the CMS has generally applied an additional 3% to CPI as an appropriate measure of medical inflation. We have therefore used a CPI (or CPIX) plus 3% adjustment to compare the “real” changes from 2000 to 2010 for medical scheme contributions and benefit payments. All other comparisons are based on CPI/X, given that these items are not susceptible to medical inflation.
- (b) The real increase in member funds of 99.6% over the ten-year period is mostly as a result of the introduction of a statutory solvency requirement of 25%. We note that many schemes have a solvency level well above 25%. The average increase of approximately 10% per annum in real terms reflects an industry that is in a sound financial position and is well managed.

- (c) There has been an increase of 29.3% in real terms of administration costs over the 10-year period. This position has, however, been reversed over the period from 2005 to 2010, with the absolute increase averaging at 3.7% and a decrease in administration expenditure in real terms.
- (d) Payments to primary care providers, such as GPs and dentists, have decreased in real terms, mostly as a result of payments from medical saving accounts and benefit designs that are not focused on PHC.
- (e) The payout on medicines has decreased in real terms by 40% as a result of capping of chronic medication, the strict use of generics in formularies, the introduction of the single exit price, and payments from savings accounts.
- (f) There have been material increases in the payment of “other benefits” and payments on managed care programmes. The CMS Reports do not provide sufficient detail to comment on these items.
- (g) The real increase above medical inflation in payments to both hospitals and clinical specialists is approximately 17% over the ten-year period, or on average 1.8 % per annum. In the case of specialists, these increases can be ascribed to the introduction of PMBs which resulted in greater medical scheme coverage of medical care not previously available to patients. Another contributing factor is changes in traditional benefit design over this period, with open schemes introducing options with cover up to 300% of the traditional scheme rate. The increased burden of disease also had a major impact on utilisation of health care services. It should also be noted that the payment to clinical specialists include payments for consumables and the use of equipment, both being subject to exchange rate changes, new technologies and international market forces.
- (h) Increased hospital expenditure mirrors that of clinical specialists, with additional factors arising from exchange rate changes, new technologies and pressure on nursing salaries. It is noteworthy that there is no major variance in cost increases in respect of hospitals and specialists over the 10-year period.

8.8. The above analysis indicates that South African medical schemes are generally in a sound financial position. As indicated in the above table, both premium payments as well as total health care benefit payments per beneficiary have remained within the general medical inflation level of CPI/X plus 3% during the past decade. Member funds have also increased significantly over the same period. Moreover, further regulatory initiatives, such as the introduction of the REF and compulsory enrolment of all in formal employment, could further strengthen this position.

8.9. It is therefore incorrect for the Green Paper to state that the private sector “will not be sustainable over the medium to long term” (paragraph 15).

## **9. The diversion of funds from the private sector to the public sector is unjustified**

9.1. SAPPF is committed to assist in seeking to give all people in South Africa access to health care and the private sector has an important role to play in this regard. Nevertheless, if the private health care industry is seen as the source from which funding can be extracted in order to enable the State to spend more on the provision of health services for the poor, the reality is that the private sector will cease to be able to provide the excellent first world service that it currently provides to roughly 8.3 million patients (in the case of hospital care) and 12.5 million patients (in the case of ambulatory care). Let us be quite clear, there will always be private hospitals, but only the rich will be able to afford them – normal working, tax-paying people who currently form the bulk of private health patients will simply not afford them and will thus be forced to fall back onto the inferior public health system. This will not only swamp the already

overburdened public sector but will also amount to an unconstitutional infringement of the State's obligation not to infringe the right of access to health care.

- 9.2. The availability of high-quality, accessible health care is fundamentally important for the attraction of skills to, and retention of skills by, any country, including South Africa. If persons are not assured excellent health care for themselves and their families, they may decide to leave the country, if they have the means to do so. This would undermine economic development and job creation. The risk in this regard is particularly high in respect of skilled individuals who are generally mobile. It is therefore important that these persons continue to have access to the current excellent private health care system, particularly when the public system does not provide an acceptable alternative.
- 9.3. More importantly, the relatively small size of the population that contributes to private health care means that this private sector funding will have limited effect when spread across the entire population. Even if the private sector were to be eliminated in its entirety (and all of the current population on medical aid were to remain in the country), the diversion of these funds into the public sector would only lift the total per capita State spend to around R4 275 per person per year – less than US\$600 per person per year. This amount is too low to fulfill the goal of quality, universal access to health care for all.

## **10. Reforming the private sector will promote universal access to health care**

- 10.1. In light of the relatively healthy state of the private health care sector and the significant demands on South Africa's limited resources, it is important that all existing health resources are maximised. It is therefore essential that both the public and private sectors should be strengthened. A weakened private sector that is likely to result if the Green Paper's proposals are to be implemented, will be seriously detrimental to any effort to rehabilitate the public sector and to eventually establish a unitary system of health care – one that is capable of providing quality care to all South African citizens and permanent residents.
- 10.2. As CDE recently stated, "reform of the private sector healthcare and of the market conditions under which it operates will be a step forward on the long road to universal access to quality healthcare and not, as the private sector's critics claim, a backward one" (CDE Report, pg. 7).
- 10.3. We therefore welcome the statements of the Minister of Health, at the time of launching the Green Paper, that the intent of NHI is: "to draw on the strengths of both healthcare sectors to better serve the public" and "to make sure that citizens are able to utilise both the public and private sectors in such a way that they complement each other rather than one undermining the other" (media statement by the Minister of Health, 11 August 2011, pg. 1 and pgs. 3 to 4).
- 10.4. The question is how can the private sector be reformed to make services more accessible and affordable and private sector providers more available to more South Africans? We seek to address this question in the recommendations that follow.

## **11. Recommendations**

- 11.1. In light of the above comments, SAPPF makes the following recommendations in relation to the content of the Green Paper and health reform more generally.

11.2. It is clear that the most urgent task currently facing South African health care is the rehabilitation of the public sector. The private sector, and particularly a reformed private sector, can contribute to this challenge by improving efficiencies and broadening access.

11.3. There are, in our submission, several reform measures that could be taken by the private sector to enhance its contribution to broadening access to health care services. These potential reforms include:

11.3.1 Establishment of large single or multi-specialty group practices

Solo health care practitioners should be encouraged to reorganise into large group practices, and regulatory changes should be made in order to allow for this reorganisation. This will result in economies of scale and create the flexibility for practitioners within those practices to better participate in health reform initiatives. These group practices could be situated in old-style medical centers equipped to provide all PHC and day surgery services in an out-patient setting. They should preferably be situated within easy access to at least two private group hospitals.

The structure of these group practices will allow for the allocation of responsibilities to activities such as teaching and training as well as deployment of private sector personnel to public health facilities.

11.3.2. Private hospitals tendering for the clinical case-load provided by these group practices

These group practices could then enter into DSP arrangements with medical schemes and ask the hospitals in close proximity to tender for the available case-load referred from those practices. This would encourage hospitals to compete on price to attract cases and not to compete for doctors on the basis of providing the most comprehensive equipment levels in their hospitals (which is currently understood to contribute to higher costs within the private sector). Linked to other quality care measures, this would promote quality care at an affordable price.

11.3.3. Establishment of alternative reimbursement models

Some, but certainly not all, health care services lend themselves to global fee payment arrangements. Other mechanisms, such as capitation models adjusted for risk and diagnosis related groups (DRGs), may also be utilised where appropriate. Fee-for-service models will still predominate in the specialist environment (due to the nature of specialist practices, which involve less regular contact with particular patients in relation to a narrower band of health care needs).

11.3.4. Using GPs to conduct the “specialist orchestra”

There is no doubt that a properly constructed GP-to-specialist referral network will bring benefits in terms of more appropriate referrals, optimising and sharing of data and better coordination of patient care. This referral relationship should be managed by the dictates of best patient care and not as a mechanism for schemes to use GPs to deny access to specialist services as “gatekeepers”.

11.3.5. Training of clinical nursing assistants and other categories of health workers, including those that work in the PHC setting

There is clearly a shortage of health workers, including new medical graduates, in the country. Encouraging private sector practitioners to teach and train health professionals and aspirant health professionals (and other health workers) would reduce the extent of this pressing problem.

#### 11.3.6. Encouraging retired doctors to return to practice

Another means of reducing the human resources shortage in the public sector is to encourage retired doctors, or doctors otherwise nearing the end of their careers, to practice in the public sector by providing incentives for them to do so (such as favourable pension packages). For example, the offer of a contract for a defined period in the public service linked to a pension at the end of the contract would, in our view, attract many older specialists back into the public service.

#### 11.3.7. Termination of RWOPs

We submit that the practice of Remunerative Work Outside the Public Service (RWOPS) should be halted as it undermines the quality of specialist care in the public sector. The conditions of service of State-employed specialists should be made more attractive to compensate for their loss of private income (arising from the termination of RWOPs) and to retain them in the public service on a truly full-time basis.

#### 11.3.8. Establishing correctly constructed DSP networks

DSP arrangements should be entered into for the benefit of patients and not third parties. Quality assessment and outcome measurements are a prerequisite to achieving cost-effective care through such arrangements. Potential or actual savings, cost reductions or containment is for the patient only.

Appropriate, fair and transparent professional remuneration must be provided for in DSP arrangements. Specialist remuneration should be based on the following:

- (a) the actual costs of specialist practice must be covered. These costs have been established through extensive, independent cost studies undertaken as part of the RPL process;
- (b) a sliding scale to take account of the level of experience and duration of qualification of the relevant specialist. Paying the same for the least experienced with the poorest outcomes as for the most experienced with the best outcomes will not work;
- (c) a system of tiered consultations (i.e. where the level of remuneration varies depending on the length of the consultation) must be implemented; and
- (d) the rate of reimbursement for consultations and procedures should be equivalent, or should be higher for procedures (currently, the so-called Rand Conversion Factor is higher for consultations than procedures).

While the implementation of cost-based tariffs may at first appear inflationary, the implementation of a cost-based tariff could be realised gradually over a number of years. This will ultimately result in greater stability amongst providers and greater prospects for reasonable growth in the numbers of providers.

#### 11.3.9. Use of PPPs and contracting to provide services to the public sector

In our submission, DOH and the provincial departments of health have, to date, not made sufficient use of the mechanism of PPPs as a means of improving access to health care. The private sector could make a useful contribution to service delivery in the public sector through PPPs. In particular, the use of PPPs should be extended to encompass not only health care infrastructure, but also facility management and the provision of clinical services.

In addition, specialists could be contracted to provide services to public sector patients through appropriate contracting mechanisms.

#### 11.3.10. Further consolidation of medical schemes

The consolidation of medical schemes would further enhance economies of scale within the medical scheme industry. While the Green Paper refers to the decline in the number of medical schemes in recent years, we are of the view that there remains an over-supply of schemes and that the market should ideally be consolidated further.

- 11.4. Moreover, private medical schemes could be strengthened by introducing the currently-shelved REF and through compulsory enrolment in medical schemes for all in formal employment. These measures will carry the benefits of increased risk-pooling within and between medical schemes, including greater scheme stability. Furthermore, consideration should be given to the establishment of low-income medical schemes, including analysing whether there is merit in relaxing certain types of PMBs in respect of those schemes. The WHO recognises all of these mechanisms as desirable means to increase access to health care.
- 11.5. In assessing meaningful health care reform, it should be borne in mind that health care (perhaps more than anything else) obeys the law of diminishing returns. The more one spends (in a well-structured system), the less improvement one gets in health outcomes per Rand spent. The most cost-effective health gains are those that involve other Government Departments, such as water services and sanitation. Without clean and safe water to drink and food security, the diseases of poverty will not be controlled by relatively more expensive curative health care systems. These vital aspects of basic health must receive priority.
- 11.6. South Africa has a fairly low density of population, and efforts to improve access to health care (as demanded by the Constitution) must take this into account. The fact that health care is free at the point of service is irrelevant if the cost of transport to get to the point of service is beyond the means of the patient. The challenge in this regard is particularly significant in rural areas. South Africa therefore needs to have good outpatient GP services available universally to all its people before more elaborate and exponentially more expensive health care systems are considered. Fortunately, the GP component of our private system is well situated; while rural towns have recently lost many doctors, the overall geographic spread is still reasonable (and is certainly better than the spread of State clinics or hospitals). Close to most concentrations of people, you will usually find at least one GP working in his or her own facility at no cost to the State. These GPs often provide a service to many very poor patients at low cost. Transport costs are also low as patients can usually walk to the GPs rooms (or their mobile clinics), which is very important for those that can least afford to incur those costs. GPs operating in the private sector therefore have much to offer in terms of primary care. If these GPs are properly paid (a decent fee-for-service rate) to see these patients, and have the financial means to order simple tests and treatments for them, the improvement in truly accessible health care for poor patients would be massive.

- 11.7. Allowing for the establishment of low-income medical schemes would, in our submission, be a significant practical step towards promoting access to GPs in order to service patients' PHC needs across the country.

## **Appendix B: Annexures**

Annexure A: Table entitled "Sources of Medical Funding and Medical Inflation"

Annexure B: Graph reflecting per capita health expenditure in various countries in 2005

Annexure C: Table reflecting inflationary escalation of the RAMS tariff from 1968 to 2010

Annexure A: Table entitled "Sources of Medical Funding and Medical Inflation"

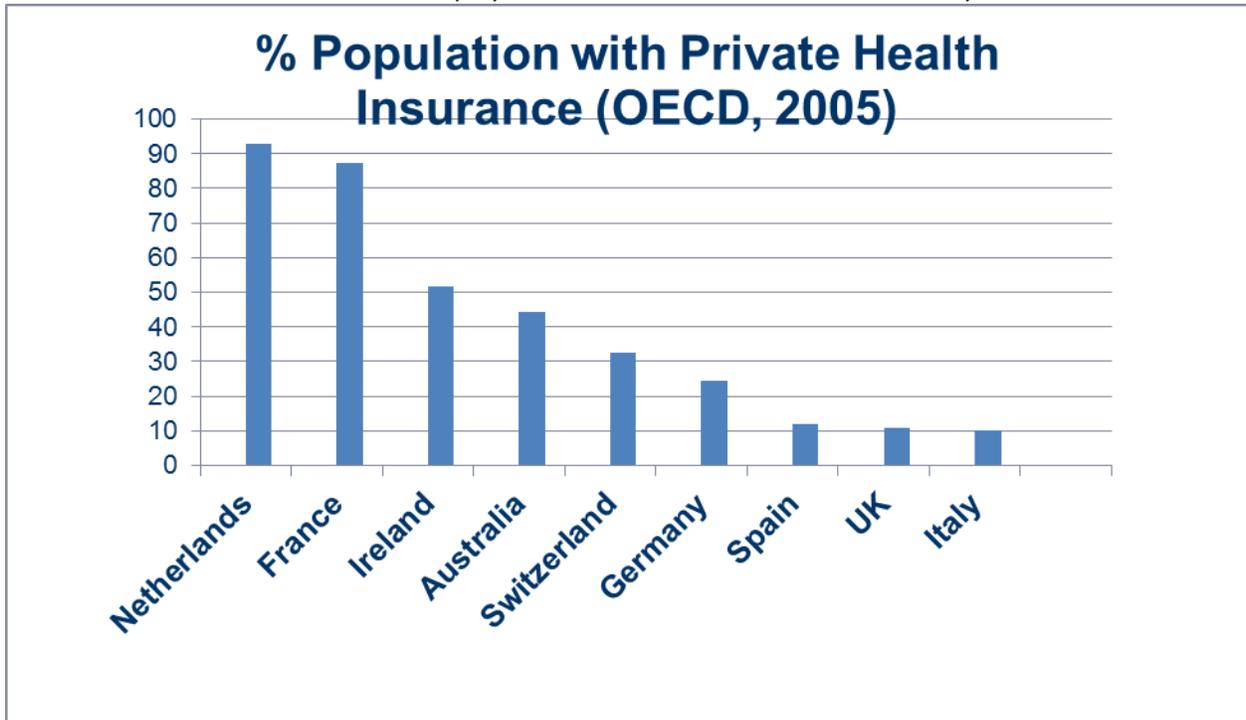
Sources of Healthcare Funding and Medical Inflation																					
Health expenditure in public and private sectors																					
2006/2007			2007/2008			2008/2009			2009/2010			2010/2011			2011/2012			2012/2013			
Outcome			Outcome			Outcome			Estimate			Estimate			Forecast						
R million	GDP %		R million	GDP %		R million	GDP %		R million	GDP %		R million	GDP %		R million	GDP %		R million	GDP %		
<b>Public sector</b>																					
National Department of Health	3,136	0.17%	3,829	0.18%	4,755	0.20%	5,134	0.21%	5,301	0.20%	5,604	0.19%	5,826	0.18%							
Provincial Departments of Health	51,938	2.83%	60,645	2.91%	72,444	3.12%	87,596	3.58%	93,465	3.46%	101,435	3.42%	107,833	3.27%							
Defence	1,602	0.09%	1,743	0.08%	2,024	0.09%	2,265	0.09%	2,468	0.09%	2,634	0.09%	2,855	0.09%							
Correctional Services	234	0.01%	261	0.01%	282	0.01%	300	0.01%	318	0.01%	339	0.01%	359	0.01%							
Police	234	0.01%	298	0.01%	463	0.02%	405	0.02%	577	0.02%	721	0.02%	787	0.02%							
Local government (own revenue)	1,317	0.07%	1,478	0.07%	1,625	0.07%	1,793	0.07%	1,829	0.07%	1,865	0.06%	1,977	0.06%							
Workmen's Compensation	1,415	0.08%	1,287	0.06%	1,415	0.06%	1,529	0.06%	1,651	0.06%	1,718	0.06%	1,821	0.06%							
Road Accident Fund	488	0.03%	764	0.04%	797	0.03%	740	0.03%	860	0.03%	980	0.03%	1,039	0.03%							
<b>Total public sector health</b>	<b>60,364</b>	<b>3.29%</b>	<b>70,305</b>	<b>3.38%</b>	<b>83,805</b>	<b>3.61%</b>	<b>99,792</b>	<b>4.07%</b>	<b>106,469</b>	<b>3.94%</b>	<b>115,297</b>	<b>3.89%</b>	<b>122,496</b>	<b>3.72%</b>							
<b>Private Sector</b>																					
Medical schemes	58,349	3.18%	65,468	3.15%	74,089	3.19%	81,128	3.31%	88,754	3.29%	96,653	3.26%	105,255	3.19%							
Out of pocket	26,596	1.45%	31,183	1.50%	34,270	1.48%	36,498	1.49%	38,833	1.44%	41,125	1.39%	43,551	1.32%							
Medical insurance	2,056	0.11%	2,179	0.10%	2,452	0.11%	2,660	0.11%	2,870	0.11%	3,126	0.11%	3,404	0.10%							
Employer private	982	0.05%	1,041	0.05%	1,172	0.05%	1,271	0.05%	1,372	0.05%	1,494	0.05%	1,627	0.05%							
<b>Total private sector health</b>	<b>87,983</b>	<b>4.80%</b>	<b>99,871</b>	<b>4.80%</b>	<b>111,983</b>	<b>4.83%</b>	<b>121,557</b>	<b>4.96%</b>	<b>131,829</b>	<b>4.88%</b>	<b>142,398</b>	<b>4.80%</b>	<b>153,837</b>	<b>4.67%</b>							
Donors or NGO's	2,503	0.14%	3,835	0.18%	5,212	0.22%	6,319	0.26%	5,787	0.21%	5,308	0.18%	5,574	0.17%							
<b>Total</b>	<b>150,850</b>	<b>8.23%</b>	<b>174,011</b>	<b>8.36%</b>	<b>201,000</b>	<b>8.66%</b>	<b>227,638</b>	<b>9.29%</b>	<b>244,085</b>	<b>9.04%</b>	<b>263,003</b>	<b>8.86%</b>	<b>281,907</b>	<b>8.55%</b>							
<b>Total Tax Revenue</b>	<b>481,197</b>		<b>559,773</b>		<b>608,795</b>		<b>571,492</b>		<b>643,239</b>		<b>721,749</b>		<b>807,896</b>								
<b>Tax Revenue as GDP %</b>	<b>26.2%</b>		<b>26.9%</b>		<b>26.2%</b>		<b>23.3%</b>		<b>23.8%</b>		<b>24.3%</b>		<b>24.5%</b>								
<b>Budget Deficit</b>	<b>11,004</b>		<b>18,278</b>		<b>-27,267</b>		<b>-177,324</b>		<b>-174,904</b>		<b>-166,588</b>		<b>-156,417</b>								
<b>GDP</b>	<b>1,833,191</b>		<b>2,081,626</b>		<b>2,320,117</b>		<b>2,449,858</b>		<b>2,699,888</b>		<b>2,967,560</b>		<b>3,295,748</b>								

\*Includes selected public entities

Source National Treasury Social Security and Health Care Financing 2010

Annexure B: Graph reflecting per capita health expenditure in various countries in 2005

Private health insurance continues to play a role in most countries with full NHI systems



Annexure C: Table reflecting inflationary escalation of the RAMS tariff from 1968 to 2010

RAMS/BHF value of one unit in 1968 was 48 cents			
<i>Year</i>	<i>Inflation (CPI/X)</i>	<i>Calculated (CPI/X Adjusted) Cents</i>	<i>Historic RAMS RCF Cents</i>
1968	2.75%		48.000
1969	3.75%	49.320	
1970	5.26%	51.169	
1971	7.50%	53.861	
1972	6.98%	57.900	
1973	8.70%	61.942	
1974	14.00%	67.331	
1975	12.28%	76.757	
1976	10.94%	86.183	
1977	11.27%	95.611	
1978	11.39%	106.387	
1979	14.77%	118.504	
1980	15.84%	136.007	
1981	13.67%	157.551	
1982	13.53%	179.088	
1983	10.60%	203.319	
1984	13.17%	224.871	
1985	18.52%	254.486	
1986	18.30%	301.617	
1987	14.72%	356.813	
1988	12.50%	409.336	
1989	15.50%	460.503	
1990	14.43%	531.881	
1991	16.37%	608.631	
1992	9.51%	708.264	
1993	9.55%	775.620	
1994	9.83%	849.692	
1995	6.93%	933.217	
1996	9.31%	997.889	
1997	6.17%	1090.793	
1998	8.95%	1158.095	
1999	2.24%	1261.744	
2000	6.99%	1290.007	
2001	4.59%	1380.179	
2002	13.51%	1443.529	
2003	-1.63%	1638.550	
2004	2.20%	1611.841	
2005	2.02%	1647.302	
2006	4.82%	1680.577	
2007	7.57%	1761.581	

2008	9.36%	1894.933			
			Consultations	Procedures	(RPL 2009)
2009	6.03%	2072.299	1135	703	
			Consultations	Procedures	Scheme Rate 2010
2010	3.39%	2197.258	1355.5	839.5	

*(Personal Communication, Dr Greg Ash 2011)*