The Radiological Society of South Africa

The professional association of radiologists in South Africa, Namibia and Botswana

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National Health Insurance in South Africa

Comment by the Radiological Society of South Africa

Executive Summary

The RSSA

- Strongly supports universal access to health care.
- Believes that improvements in education, security, housing and job creation must run in parallel with an NHI initiative
- Believes that de-politicisation, zero tolerance of corruption, good management and oversight are essential for a State funded health care system.
- Has concerns that the costing funding model related to assumptions around percentage of GDP to be spent on healthcare is flawed, the full service envisaged is unaffordable and further consideration of this is required to prevent the dangerous raising of expectations and the disassembly of the private sector.
- Has concerns about the size of the tax base and the effect of additional taxation on the economy.
- Will cooperate fully with, and has suggested ways to, the DoH to maximize our resources, both human and physical, set appropriateness criteria for radiology and assist with coding.
- Will look at innovative ways to provide radiology services to capitated primary care givers and imaging services at all level of health care facility as the system matures

The Radiological Society of South Africa (RSSA) is grateful for the opportunity to comment on the policy paper '*National Health Insurance in South Africa*' released by the Department of Health on 12 August 2012.

The RSSA is the professional group of radiologists in South Africa, Namibia and Botswana representing radiologists in both public service and private practice. The RSSA has no statutory powers, its main functions being in the areas of postgraduate education, setting of standards and protocols and developing with authorised bodies, coding and tariff structures for reimbursement in radiology.

Radiology is one of the fastest growing medical specialties in the world, growth paralleling the development of imaging technology. The radiologist has the role of not only interpreting and reporting on images but also acting as a consultant to advise on appropriate imaging algorithms for specific clinical problems. The clinical radiologist has a crucial role to play in radiation control and safety in diagnostic imaging. Appropriate radiology will reduce downstream intervention and hospital costs. Radiologists are involved at all levels of imaging from Primary Health Care (PHC) to specialised quaternary hospitals.

The RSSA supports the guiding principles of the policy paper and the attempt to ensure that all South African will have access to quality healthcare with no regard to their socio-economic status. The RSSA congratulates the Minister on his efforts to improve health care for the majority of South Africans, which is compromised by both the large burden of disease and inefficient use of resources. However, there has to be a clear distinction between the funding and provision of services and care should be taken not to either, blame a functioning private sector for a dysfunctional public sector, or simply assuming that by increasing financial resources, delivery will improve.

While the abstract concepts of right to access, social solidarity and equity are unchallengeable and entrenched in the constitution, the tangible principles of

effectiveness, appropriateness, affordability and efficiency will rely on the systems put in place to control and manage them. Without control and management the objectives will not be achieved.

The RSSA also notes the problems identified in the private sector but regrets that mandatory membership of a medical scheme for all in formal employment, previously identified as a need to produce social solidarity within that sector, was not implemented. The private sector has its faults but is not as inefficient as depicted. Any move which depletes or destroys the capacity and skills in the private sector without adequate transfer of these to the public sector, will have a serious knock on effect on the economy of the country, especially in the areas of tourism and investment by multinationals in South Africa, both of which need first world health care.

Although these comments are nominally those of the RSSA, most of the issues are generic and are dealt with from the viewpoint that our members are of members of civil society and taxpayers. These generic issues are fundamental and if not handled correctly make the specific interest of a specialist group irrelevant.

The RSSA is a non-political organisation. Healthcare has to be political at a policy level but should not be politicised at an operational level. Health care systems belong to the people and if well constructed will outlast any Government. In a democracy political rulers will change and different political parties are given the privilege of looking after the healthcare system and the health of the nation.

Crucial to the success of NHI is the formation of an independent public service [1] to manage public health and healthcare systems, employees who know that their master is the people, through the government, and that their jobs are not at risk with political change. The National Development Plan [2] supports this concept as the plan acknowledges that there is always a danger in societies when "*the public service is insufficiently insulated [from political*

control], standards can be undermined as public servants are recruited on the basis of political connections rather than skills and expertise".

Without undermining the concept of Affirmative Action it will require the use of the best candidates for the job, irrespective of race or previously disadvantaged status.

Effective introduction of NHI will require implementation and a zero tolerance approach to corruption, tender manipulation and cronyism. There must be political leadership which clearly states that public money is for the benefit of the people not those elected to govern the people. World wide, the people have become intolerant of corrupt government, shown in regime change in the Arab Spring and the 'Occupy Movement', which is rapidly gaining support in both countries with minority regimes and democratically elected governments.

With the responsibility given by the government to manage the National Health Insurance fund, there must be transparency and oversight. Oversight of the fund should ideally be by a non-partisan body elected by and representing the people. Parliament would be the natural structure to do this if impartiality, cross party representation and non-partisanship are possible. Otherwise an extra-parliament body would be necessary.

The title of the policy paper is National Health Insurance but the majority of the paper describes the implementation of a National Health System, with coverage of all approved interventions from primary to quaternary level, with scant reference to point of service payment. Only cosmetic surgical procedures and 'expensive spectacle frames' appear to have been excluded which indicates that the envisaged coverage is extensive, matching that of much richer OECD countries. There is little mention of co-payment at point of service, without which there will be no brake on demand.

National Health Insurance is a mechanism to provide funding for the purchase of health care. This implies that both the public and private sectors would be

able to tender for work on an equal footing. Although the Minister has clearly stated that there is a place for the existing private sector, the anti-private sector rhetoric emanating from the Department of Health, gives an alternative impression. The Minister should clearly spell out the indicated direction and if there is place for private medicine and it is to be a partner in the provision of health services, these attacks on the private sector seem inappropriate.

The problems of the public sector cannot be blamed on the private sector. If the final plan is a completely State run system, this should be clearly stated and discussions commenced for the purchase of and integration of the private into the State sector. If a NHS rather than a NHI is contemplated alternative funding models should be considered.

Further comment is made on the assumption that there will an efficient, corruption free, NHI with the private sector forming an important part of the provision side.

Providing increased funding for health care will not automatically improve healthcare outcomes. Public health initiatives, sanitation, clean water, housing and job creation are essential as a parallel process. South Africa has an unemployment rate of 27%. Near or full employment is needed to successfully introduce a payroll based NHI and the tax base must be expanded to spread the payment burden. Australia and the UK have unemployment rates of 7.6 and 4.9% respectively. A NHI tax, which will effectively increase the level of tax for the 6M South African taxpayers, could be the straw that breaks the camels back leading to mass emigration, with depletion of both skills and revenue.

However, South Africa's National Development Plan [2] with its laudable but ambitious plans to grow GDP by 5.4% and reduce unemployment to 6% by 2030, will if achieved, negate some of the problems identified above.

GDP is a poor measure of the wealth of a nation when providing services to the individual members of the population. Comparing the percentages of GDP that different countries spend on health care and the assumption that equal percentages should achieve equal outcome may be a convenient way of justifying a predetermined outcome. On closer inspection it is not possible.

GDP *per capita* indicates the money available for all services per person in the country. The analogy of the approach that equal percentage's of *total* GDP in different countries will produce similar outcomes is: 'two men, one a highly paid executive and another a worker in his company, by spending the same percentage of their income can afford to buy the same car'. The analogy and the original concept are flawed.

To expand on this, the table below shows countries, which have a similar percentage of GDP spent on health care, in the 8-9 % range (WHO 2008) and the Purchasing Power Parity PPP in US $ per capita.[1]

Ranking	Country	PPP per Capita $	% GDP
31	Slovakia	1,849	8.0
29	Israel	2,093	8.0
123	Guyana	247	8.1
68	South Africa	843	8.2
24	Japan	2,817	8.3
27	Slovenia	2,420	8.3
65	Brazil	875	8.4
17	Australia	3,365	8.5
4	Norway	5,207	8.5
180	Guinea-Bissau	48	8.6
23	Italy	2836	8.7
19	United Kingdom	3,222	8.7
13	Ireland	3,797	8.7
135	Sao Tome and Principe	153	8.7
100	Georgia	433	8.7
54	Lebanon	1,009	8.8
18	Finland	3,299	8.8

These figures clearly indicate that using the percentage of GDP spent on health care is not a comparative indicator of the amount of money available for health care per person. Countries spending between 8 and 9% of GDP have $48 in the poorest country and $5,207 in the richest country in this band, to spend on healthcare for each of its citizens.

Professor Gavin Mooney, uses Australia and the UK as examples of countries which have launched successful National Health Services. [3] The situation is not comparable due to the level of unemployment, the tax base and the GDP per capita. To match the health outcomes of Australia, South Africa would have to spend 31.34% of its GDP on healthcare, obviously impossible.

This is exacerbated as the faulty logic has been used to suggest the South African percentage of GDP to be spent on health care could be contracted to a target level of 6,2%. At this level of expenditure, which is 1/6 of that spent on each person in the UK or Australia, only a very limited range of health interventions would be possible in South Africa, probably limited to the primary health care level. It would not support the extensive, district, regional, academic and specialized hospitals, envisaged in the green paper.

Further, using the DoH figure of per capita annual expenditure of the medical aid group in South Africa of R11,150.00 this converts to US$ 1579, which is 50% of the cost of providing a full service in the United Kingdom, if outcomes are similar, full service provision in South Africa's private sector is cheap by international standards and the approbation aimed at the South African private sector is unjustified.

The UK spend on healthcare has increased by 113% in the last 10 years compared to the South African figure of 121%, confirming the view that escalation of healthcare costs is not a problem unique to the South African private sector. Also of interest is that in South Africa in the same 10-year

period, food prices have escalated by 111%, salaries by 113% and public hospital expenditure by 227%.

The report highlights the deficiencies in the public sector. Health outcomes are poor; the logical conclusion is that the public sector is poorly funded and badly managed. Unless management is improved, even a complete transfer of funding from the private to public sector will do little to improve access, quality and outcomes.

The RSSA has concerns that the human resources and skills needs will not be met and that the complexity and cost of a national patient record system has been underestimated. No mention is made of the existing compulsory ICD10 coding, used by every practitioner.

Cooperative Initiatives with the DoH suggested by the RSSA for NHI funded Primary Health Care Roll Out

1. The RSSA is keen and willing to interface and cooperate with the department of health in the pilot phase of NHI.

2. An extensive network of radiology facilities is in place in the private sector. These are available for use for NHI funded primary heath Care. The RSSA will prepare an audit of facilities in private practice which can be used in conjunction with the State sector. The RSSA will look at innovative ways of increasing capacity in the private sector.

3. The RSSA has developed and placed in the public domain a 5 digit coding and billing system for radiology, this has been in place for several years, is the funding industry standard and is continually being updated to cope with changing needs. This is ready to be submitted to the DoH once the currently stalled coding process starts again. The RSSA is ready to submit this structure to the HPCSA as part of its current ‘ethical tariff’.

4. The RSSA has been granted the right to use the American College of Radiology Appropriateness Criteria in South Africa and without amendment attach it to the RSSA coding system. This is the basis for internationally accepted guidelines for appropriate imaging. This will be made available to the DoH and should be used to prevent resource wastage by inappropriate imaging..

5. The RSSA will assist in the development of limited radiology guidelines for primary health care.

6. The RSSA has extensive experience in managed care methodology, and is prepared to assist the DoH in the development of new funding models for primary health care radiology. If a capitation model is used it should be designed to prevent both over- and under-servicing. There is a very significant difference between capitating the primary care provider and requiring him or her to buy imaging services and capitating radiologist. The first leads to under-servicing and the later to over-servicing. Incentives should be aligned to imaging norms and not simply number of referrals or cost. If a fee for service model is used the RSSA will assist in setting the appropriate levels of reimbursement and the development of peer review systems to ensure correct usage of radiology. The RSSA is setting up a task team to look at these models.

7. Most private radiology practices are digital, with images being stored on a Picture Archiving and Communication System (PACS). The RSSA will look at the feasibility of a national 'cloud' based data storage facility to link, eventually with a State system.

8. The major change in radiology with digitisation is teleradiology. The radiologist does not need to be physically present at the site where the x-rays or scans are performed. This means that radiologists can be more productive with images taken to the radiologist rather than *vice*

versa. With high speed Internet images can be transmitted nationally and internationally. The RSSA strongly endorses this as a method to improve access to specialist opinion but would insist that to ensure quality any practitioner performing telemedicine reporting on South African images and X-rays should be registered as a specialist radiologist with the HPCSA and be available for clinical consultation.

9. The RSSA has an extensive Continued Professional Development programme in place. This is currently aimed at radiologists but could easily be extended to doctors in primary care to ensure efficient appropriate use of imaging facilities.

10. The RSSA is willing to engage with both the DoH and the HPCSA to look at ways of using the existing private radiology infrastructure for training both radiologists and radiographers and innovative ways of funding such initiatives.

11. The RSSA has ongoing involvement in human resources planning through the Colleges of Medicine of South Africa.

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December 2011

References:

1 Mafunisa, M.J. Journal of Public Administration, Vol. 38, No. 2, June 2003

2 The South African National Development Plan, 11/11/2011

3 Mooney, G. NHI History Repeats Itself, Mail and Guardian, 23 August 011

4 Health Statistics,2011, World Health Organisation