South African Dental Association

Private Bag 1
Houghton 2041
Gauteng
South Africa

Tel: +27 11 484 5288
Fax: +27 11 642 5718

e-mail:
MSmit@sada.co.za
Direct fax to e-mail: 086 242 3857

www.sada.co.za

SUBMISSION OF COMMENTS

ON

NATIONAL HEALTH INSURANCE FOR SOUTH AFRICA (NHI)

WHITE PAPER v40
11 DECEMBER 2015

CONTENTS

1. Introduction

1. The **South African Dental Association (SADA)** is a non-statutory, professional association established to represent all South African public and private sector dentists in South Africa. It is registered as a Non-Profit Company and represents both general practitioner dentists and dental specialists in South Africa.

2. SADA's Constitution subscribes to the World Health Organisation definition of health as a basic human right and it supports all efforts to promote optimal health, including oral health in South Africa.

3. We recognise the fact that health care sector is in need of urgent reform, and we intend to participate as effectively as possible in this debate. The future of health care and, in particular, oral healthcare in this country is vital and SADA would like for the collective voice of the dental profession to be heard on the issue of National Health Insurance.

4. The Association, in the interests of its members, the dental profession and the oral health of the nation, looks forward to continuous engagement with any government process in the final development of the final NHI legislation.

5. We would request that this submission be read in conjunction with our comments on the Green Paper on NHI in 2011, together with our collective submissions made in the Oral Health Forum on the White Paper on NHI.

2. The Oral Health Imperative

6. Oral diseases qualify as major public health problems owing to their high prevalence and incidence in all regions of the world and, as for all diseases, the greatest burden of oral diseases is on disadvantaged and socially marginalized populations. The severe impact in terms of pain and suffering, impairment of function and effect on quality of life must also be considered.

7. There is a synergic relationship between oral health and overall wellness. A physical examination of the mouth and face can reveal signs of disease, drug use, domestic physical abuse, harmful habits or addictions such as smoking, and general health status. A number of signs and symptoms of disease, lifestyle behaviours, and exposure to toxins can be detected in or around the craniofacial complex.

8. A review of oral health linkages with general health reveals implications for the clinical practice of both medicine and dentistry. The recognition of well-known and established signs and symptoms of oral diseases may assist in the early diagnosis and prompt treatment of some systemic diseases and disorders. The presence of these signs also may lead to the institution of enhanced disease prevention and health promotion procedures.

9. Dentists and dental specialists play a fundamental role in the oral health of the nation and play a crucial role in the early diagnosis of many acute and chronic conditions, as well as the prevention of diseases.

10. We are very concerned that, in document of more than 90 pages, little or no provision is made for dentists and dental specialists in the provision of "oral health care services" at every level of care in the NHI, as part of the envisaged comprehensive package and in different designated hospitals.

11. The comprehensive package mentions "oral health services", however, this has not been properly defined and it is not clear whether it is the same as what is currently available in the public sector or even the private sector. In fact, it would appear that no general dental or specialist dental services are envisaged within the NHI system.

12. We also concerned that no provision has been made for oral health services at district hospitals and would recommend that general dental services are made available at these facilities. This is especially crucial when one considers that services at regional, provincial tertiary and central referral services (T2 and T3) makes no provision for general or specialist dental services. Usually patients admitted to hospitals will require surgical services in respect of trauma or accidents not to mention many children and adult patients who require dental services under anaesthesia.

13. Given that "some personal healthcare services will not be covered" by the NHI, it is possible that the package of NHI benefits may exclude certain, if not most, general and specialist dental services. Consequently it is anticipated that these services should form part of the top-up cover to be provided by medical schemes.

14. The Paper needs to provide very specific proposals on services to be provided in the public sector and to show differentiation from services that exist.

3. The South African Health System

15. The White Paper sets out, in no uncertain terms, its criticism of the current two-tier healthcare system. The need for the introduction of NHI is driven by the assertion that "post 1994" attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted.

16. The White Paper posits that the creation of a National Health Insurance (NHI) will improve healthcare equity by combining fragmented private and public health funding pools and eliminating out-of-pocket payments.

17. The statements around single tier system seem to imply that any private demands for healthcare are a deviation from 'equity and access'. If one were to understand equity and access, it must be recognised and accepted that people access different services as a matter of choice and in an attempt to mitigate against the risks presented by poor delivery in the public health system.

18. The real problems in public healthcare are systemic and relate to lack of accountability and governance, poor management, and a failure to implement existing policies. The White Paper, however, makes no mention of the current institutional failures in the public health system. The most fundamental problem ailing our health care system is the failure of the public health care sector to meet the health care needs of citizens, as well as its failure to use our scarce public funding efficiently and appropriately to improve accessibility, quality of care and health outcomes.

19. It also appears that some parts of the White Paper still resonates some hostility to the private healthcare sector. It in parts blames the private sector for the ills of the public sector, making gestures towards a constructive relationship with private stakeholders, but falling well short of spelling out what the private sector might offer and how its contribution might be maximised. What is missing is a strategic realisation that expansion of a reformed private sector and improvement of the public sector can be complementary rather than contradictory movements.

20. The coexistence between a failing public health sector and a private sector that serves a significant portion of the population with high quality healthcare is the most contentious aspect of the health reform debate in South Africa. There is a widespread tendency in this debate to dismiss the contribution of the private sector to overall health outcomes, to be suspicious of the motives of private health sector players and to challenge the very legitimacy of private health provision. The government should use the opportunity created by the publication of its plans for an NHI system to initiate a calmer and more constructive debate on overall healthcare reform than has been the case so far.

21. We would argue that the private healthcare sector, in its current format, provides excellent quality healthcare that is highly regarded on an international scale. It further plays an important role in shouldering the burden of the state by providing quality healthcare services to the people of South Africa. In addition, the sector has had, and continues to have, a substantial effect on the economy by creating employment and income, investment opportunities and public funds, training and development programmes, international linkages, healthcare scalability through innovation and productivity gains.

22. The demise of the public healthcare sector and the lack of policy reform in the sector is the reason as a whole has increased the demand for the quality healthcare that the private healthcare sector provides. The sheer size of the population that demands services from private healthcare providers, even without medical scheme membership, indicates the demand for quality healthcare services, which is perceived not to be provided by the public healthcare sector.

23. The private healthcare sector serves an estimated 28% – 38% of the population and a large part of the impressive growth in the private health sector over the past few decades is related to the government's failure in providing adequate care to the people of South Africa.

24. Given the scale of the proposed outlay to integrate the private and public health systems, and the macroeconomic risks involved, it is important that the single tier system as proposed, is shown to be plausible. Failure of the single tier health system, which will depend on medical scheme members transferring in large numbers to mandatory coverage, will have macroeconomic effects due to transfer of consumption and production from more productive sectors to the public health sector.

25. As the proposals contained in the White Paper affects the existing and future right to healthcare in private and public sectors users, this is worrying. It fails to make a strong case based on clear evidence of institutional failures within public and private sectors and what their causes are. It also fails to provide feasible options to address the institutional failure, financial evaluations and an in-depth study of the preferred option including risk analysis.

4. Medical Schemes

26. The White Paper provides for a sharp curtailment of medical scheme benefits, limiting them to a "top-up" to the benefits provided by National Health Insurance.

27. The White Paper contains a proposal that it will require that medical scheme members pay 85% of their contributions into the NHI, for which they will receive only public cover in return. If the public sector services are inadequate, no-one will be permitted to insure themselves for any benefits covered by the NHI.

28. Consequently, if the public arrangements cannot afford adequate dialysis, heart transplants, cancer treatment or emergency care, no-one will be permitted to purchase them privately through their medical scheme.

29. Thus all medical scheme members and their dependents (numbering some 8.7 million beneficiaries comprising principal members and their dependents), would need to voluntarily transfer their complete or at coverage subject to some limitations to the public health system.

30. It must be appreciated that health status of members of medical schemes may be such that they do not necessarily require access to primary healthcare services; instead they may require direct access to health practitioners and hospitals for curative and hospital services. In addition, even in the face of cost distortions in the private sector, medical scheme members are prepared to pay a price in order to mitigate their risks against using public sector services.

31. This provision around curtailment of scheme benefits in the White Paper is therefore extremely alarming to consumers and the industry, and will almost certainly be subject to legal challenge.

32. Many European countries have a National Health Service and private-sector complementary cover. This works well only if the National Health Service is a credible alternative to private cover and provides a high-quality service to the entire population. Given the size of the population, the burden of disease and the shallow tax base, it is unlikely that the public sector in South Africa will be able to meet these requirements. This aspect of the White Paper needs clarity and needs to be reviewed.

33. There is also strong emphasis in the White Paper regarding the elimination of 'out-of-pocket' payments. A broad benchmark/guideline offered by the World Health Organisation's (WHO) is that out of pocket should never exceed 15% of the total healthcare expenditure within any health care system.

34. Co-payments are typically raised as a serious concern in very low income setting where the only available service providers are in the private sector for example, Ghana and Vietnam. They do not apply to countries with well-funded free public services such as South Africa.

35. The emphasis in the White Paper on minimizing out-of-pocket payments as a public policy objective therefore appears to be misplaced. Health expenditure as total (% of GDP) in South Africa was last measured at 8.93 in 2013, according to the World Bank. The out-of-pocket expenses expressed as a percentage of GDP shows that South Africa performs well by international standards and considered normal for a country of its level of development.

36. The bulk of out-of-pocket expenses in South Africa are for non-catastrophic medical expenses incurred by families in the top income earners i.e. those covered by medical schemes. Therefore the elimination of out-of-pocket expenditure on health is not feasible nor should this be the government objective and, given that the affected population is largely employed, as opposed to the vulnerable population currently serviced by the public sector, it is unclear as to why there is a desire to address this issue as a priority.

5. Contracting Private Health Care Providers

37. The 'contracting in' of private sector general practitioners (GPs) into the public health services is a key aspect of the NHI which deserves more attention.

38. Relatively little attention has been paid to the important role played by frontline healthcare providers like dentists tasked with implementing the reforms, and whose services the scheme will rely on in order to function on the ground.

39. It is also noted with concern that in the 'general practitioner contracting model' no provision is made for expanding implementation to dentists and dental specialists. This is especially crucial when one considers the school health programmes and district specialist teams that are anticipated to operate.

40. One of the key objectives of the NHI pilot districts was test and refine the recruitment of General Practitioner participants, the implementation of school health programs, the referral pathways to a district clinical specialist as well as primary care outreach teams.

41. During the pilots, the expectation was that the department would try a variety of approaches and grapple with the complex technical issues involved in determining how best to provide services, such as what kind of public-private split they would require to meet their patients' needs. Unfortunately limited progress was made in this regard and resulted in substantial resistance to the NHI proposals and a general discontent by GPs.

42. All preliminary reports from NHI pilots appear to confirm that the DoH may face significant challenges in garnering the support of private sector. It is crucial then that ongoing research contributes to the evidence base about how to overcome these barriers in order to be of practical use to those tasked with developing and implementing policy.

5.1 Remuneration

43. There are no details and some of the immediate concerns we have on behalf of dentists as providers are that the White Paper does not contain details of remuneration models. What will happen when NHI Fund fails to pay on time? What will happen if the NHI Fund fails to make payment? How will health care service providers go about recovering what is due to them?

44. It is noted that the general practitioner contracting model states that tariffs to be charged will be determined by the NHI Fund without any negotiation by providers. Furthermore Private providers at the PHC level contracted will be reimbursed through a capitation model instead of a fee for

service model as it is happening currently. No details of the capitation amount or formula are provided. Clearly any contracting of private service providers would require an acceptable contracting programme.

5.2 Accreditation

45. The National Health Act (NHA) has established an Office of Standards Compliance (OHSC) within the NDoH with a central purpose is to supervise any health service providing services to the public. As accreditation and various other supervisory processes of the OHSC will impact on stakeholders with political influence, we believe it should be fully independent of government and the entities it regulates.

46. There is also no indication in the White Paper as to what the process may be followed in areas where an artificial shortage of providers is created because of providers not meeting the accreditation criteria. With accreditation as a pre-requisite for reimbursement, the OHSC will therefore serve a dual function in assuring/improving quality and 'licensing' providers to contract in terms of NHI.

47. If one considers the use of accreditation internationally, it seems that only a few countries have implemented accreditation programmes for individual doctors or other healthcare professionals (as opposed to healthcare facilities), and with limited success. It seems that the costs of accreditation in terms of time, money and dedicated personnel, are prohibitively burdensome.

48. Across the world, accreditation is most often voluntary and therefore used as a method for improving quality, rather than being mandatory and a pre-requisite for contracting or determinant of government funding.

5.3 Single Fund & Strategic purchaser

49. The White Paper envisages the creation of a single-payer fund, pool resources and purchase services for the entire South African population. Funding sources have not been finalized and the White Paper is silent on this issue.

50. In addition, limited attention is given to the administration costs and, more importantly, the administrative complexity, involved in managing an initiative of this magnitude.

51. Strategic purchasing requires a substantial investment in information systems, skilled personnel, strong leadership and most importantly impeccable governance arrangements. As the NHIF would sit with an enormous pool of money, mismanagement or corruption within the NHIF could destroy the entire health system.

5.4 Single payer

52. The White Paper introduces the blueprint for implementing a single-payer health care system in South Africa – an entirely government-funded system in which all South African citizens have free access to health care services at the point of service.

53. In a single-payer system the paying entity, NHI Fund, is in an unusually strong bargaining position as result of its monopoly. Such a market is usually associated with imperfect competition and very low prices, since healthcare providers to seek their services to the insurer or Fund. The savings are, however, accrued at the expense of provider.

54. The payment system in the South African health sectors is not a straightforward task. The White Paper must consider there are many options and even more hurdles to overcome when trying to establish a uniform reimbursement system.

55. Furthermore, the single-payer health care system is advocated as this will allegedly promote lower monetary costs, but it ignores the lack of access to medical resources.

56. In a recent Canadian study some of the key aspects of the health care systems of Canada and the United States were compared, including the supply of medical resources, access to technology and effective health insurance coverage. The institutional environments in the US and Canada differ markedly. America places reliance on voluntary self-provision, as we do in South Africa, supported by taxpayer-backed assistance to people with low incomes, while Canada has a single-payer system, paid for by taxes, which is tantamount to NHI.

57. The US does not promise "free health care for all" while Canada does. Canada's problem is that, despite its relative wealth, it cannot deliver on its promise of "free health care for all". Canadian government data, according to the study, shows that an estimated 1.7 million Canadians (aged 12 and older) were unable to access a regular family physician in 2007.

58. As Canada is unable to meet its "free" health care promises it has to resort to denying people health care, placing them on months-long waiting lists for physicians, specialist consultations, MRI scans, CT scans, surgical procedures, a host of services that in the US are immediately available.

59. Even in South Africa's public health services, waiting times are shorter than those often experienced by Canadians. South Africa's per capita public healthcare spending is similar to that of Chile, Brazil, Argentina and Russia. All it needs is improved quality, which does not depend on money alone.

60. The White Paper continues to assert that private healthcare system is unaffordable due to inefficient payment system in the private health sector the fact that the fee-for-service model leads to over servicing. In view of this there is a requirement to make a case for its absorption into the public system (through the NHI mechanism). Such allegations are anecdotal and not supported by empirical data.

61. As the debate continues as to the escalation in private health costs, it must be remembered that the private health sector needs to cover overheads and consider issues such as:-
    - Inspections, lists of basic requirements, core standards and regulation which are not being adhered to in the public health sector;
    - Dental equipment and consumables are expensive and most of the equipment and consumables must be imported and due to the weakening rand the cost of thereof escalates by the week;
    - Equipment must be serviced and replaced as per original equipment manufacturer recommendations.

6. Financing the NHI

62. We expected that the 90 page document would provide clarity on how the NHI would be financed and how much would be needed to run this ambitious plan. It does, however, contain very little about how much it will cost taxpayers to finance. In fact, the White Paper contains the same financing numbers as the Green Paper. There are no changes to the GDP forecasts, and no further cost modelling seems to have been done since the release of the Green Paper, some 5 years ago!

63. The NHI will require a monumental amount of money to run and will be the second-largest fiscal risk, after nuclear energy, the nation faces. This in an economic climate where the International Monetary Fund (IMF) anticipates that the South African economy will barely grow in 2016, revising its forecast to just 0.7% from its 1.3% estimate published in October.

64. The document outlines "five alternative tax scenarios for funding the NHI shortfall by 2025/26". These include the "introduction of a payroll tax, a surcharge on taxable income and increases in the rate of value added tax". This means that, in effect, the state's calculations for the financing of the NHI amount to nothing more than speculation on the best-case scenario.

65. It must also be remembered that the public health system is however already funded using the broadest revenue base possible, i.e. general taxes. In an environment where 2% of the South African population is estimated to pay more than half of income tax, there are limits to the revenue that can be generated from the general tax system.

66. If NHI is to be financed predominantly from health insurance contributions and general tax revenue, this demands an economically active working-age population that is large enough to ensure the funding mechanism is sustainable in the long term. This calls into question the sustainability of the funding for NHI. The challenges currently facing South Africa require not only improved health care services and financial protection for the poor, but are more far-reaching. Government's response will need to address basic education, employment and economic growth, poverty and income equality, to mention a few.

67. Overall the financing provisions raise more questions than answers. Before detailed input can be provided regarding specific contribution rates, it is necessary for National Treasury and the Department of Health to refine the cost estimates for funding National Health Insurance in South Africa by looking more closely at the comprehensive package of benefits to be offered, the long term fiscal implications and the effect that various contributions would have on households.

7. Health Human Resources

68. The White Paper does not adequately address one of the very limited resources within the South African healthcare environment – although a presumably global shortage of qualified healthcare specialists exists in every country. In South Africa the low number of specialists are even more dire when compared to other developing economies. Without the buy-in from the medical professionals, the success of the NHI becomes questionable.

69. In January 2016, British doctors went on strike for the first time in 40 years. Tens of thousands of junior doctors walked out in response to the government's policy proposals to amend their contracts. The first concern here is that striking is not a tool used infrequently by unions in South Africa. In fact, the nation has one of the highest rates of industrial action in the world. In a likely strained and underfunded NHI, working conditions will deteriorate, and striking will be commonplace.

70. The second concern is that, with unattractive job prospects within the public sector, and with no real private sector to look to as alternative, junior doctors will increasingly move abroad for career advancement. South Africa competes with the global demand for doctors as South African doctors are highly regarded due to their professional and language skills.

71. Doctors that exit South Africa's healthcare sector have a twofold cost to the economy: the loss of the expected return on investment from subsidising students of medicine, and the implicit costs to the economy associated with a doctor shortage. More doctors and high-qualified professionals are leaving the country to get better salaries and better working conditions. Therefore, every year, South Africa is losing about 17% of its doctors and studies have shown that since 1994, 1.6 million skilled professionals have left the country. This is an existing and highly undesirable phenomenon and exacerbating it should be avoided at all costs.

72. Greater involvement by the private sector in medical training should be investigated and encouraged as a matter of priority, especially in light of the demand that the NHI will create for more doctors. The private sector can also be used to help address the need for more healthcare resources in rural areas, where South Africa's doctor shortage is especially acute. More doctors will be available for community service and internships in rural areas if larger numbers of students are trained.

73. South Africa's doctor shortage is also worsened by restrictions on allowing foreign nationals to practise medicine in South Africa. Foreign doctors experience severe delays and inefficiencies in registering with the FWM and the HPCSA and 'non-exam track' doctors report waiting months and years for registration with the HPCSA. Many of them express extreme frustration at the process, and instead seek work in other developing countries where registration procedures are run more smoothly. The irony is that foreign nationals present a low cost and effective mechanism for addressing doctor shortages in the short term.

8. Implementation Timeframes

74. It is anticipated that the NHI system will be implemented in different phases over the ensuing years and it is expected to be up and running by 2025. There is no clarity provided on what will happen to access to healthcare between the first and second phases, especially for those who are contributing to medical schemes.

75. During the second phase, registration take place and NHI cards will be issued for use in designated facilities. However, only during latter part of phase two will the NHI purchase primary healthcare services and only at that stage will Office of Health Standards Compliance certify public health facilities and not at the end of the first phase, as would seem logical in order to service those who received NHI cards.

76. Finally, it is only during the third and final phase over the last four years of the NHI time frame that private sector providers will be contracted to provide higher levels of care including specialists. This means that patients requiring these services who are unable to obtain them at NHI facilities will not receive care they require.

9. Malpractice indemnity in an NHI System

77. The existing arrangements for malpractice indemnity insurance differ, depending on whether care is delivered in the private or state sector. At present healthcare professionals working in the private sector are responsible for ensuring that they have their own professional indemnity arrangements in place. The patient's access to compensation may be put at risk if the practitioner fails to put adequate and appropriate indemnity arrangements in place.

78. Patients treated in the public sector would bring any claim for compensation for negligent treatment against the state. Treasury regulations accept that the state is vicariously liable for the acts or omissions of state employees, thus the state would be responsible for the payment of compensation due to the patient.

79. If after the introduction of National Health Insurance (NHI) state patients receive care in the private sector, it will be important that there is clarity as to where liability for negligent treatment, and with it the requirement for indemnity, lies.

10. Conclusion

80. The implementation of the National Health Insurance in South Africa is a noble attempt to address the inequities and scarcities of healthcare resources in the country.

81. It has to be acknowledged, though, that no country can ever fully satisfy demand for health services. Even the most comprehensive health systems leave many wanting more, unhappy that they have to wait to see a dentist, that they have to settle for cheaper generic option, or that they do not qualify for the expensive procedures that can improve their quality of life.

82. We are of the view that the White Paper lacks significantly in respect of detail, which limits us in terms of our comments on the proposals contained in the White Paper. It does not introduce substantially new information (compared to the Green Paper), it is long on rhetoric and thin on substance, and many stakeholders may find it difficult to contribute meaningfully during this consultation period.

83. It is not clear that the White Paper correctly diagnoses the problems. One cannot therefore be sure that the correct solution is being suggested. The challenge facing public healthcare is not the two-tiered health system and inequalities between public and private healthcare, as suggested by the White Paper.

84. The proposal of NHI Fund therefore does not seem to add any value to the health system and, before these proposals are made, it is necessary to review the present institutional weaknesses in

the public system the creation of the Fund is seeking to address. In the absence of such a review, there is a possibility that poorly informed strategy could see more funds wasted on poorly executed programmes.

85. It White Paper furthermore fails to provide specific details of benefits including oral health services provided by the dental profession, issues surrounding private sector involvement, the mechanisms the state will use to purchase healthcare services from providers, what it will cost, and how it will be paid for or an explanation of the constrained role for medical schemes and the private health-care sector.

86. Adopting a blueprint for health reform from developed countries, without regard to local challenges, would probably result in failure. While South Africa's status as a developing country does not preclude the success of universal healthcare, as evidenced by certain international models, its success is threatened by corruption, mismanagement of resources, and poor-quality institutions. Therefore, before implementing a policy with such significant implications, the issues of corruption, poor governance and political transparency must be addressed and corrected.

87. Impressive plans have been made for overhauling the present healthcare system, including various hospitals and clinics. Perhaps this upgrade, seen as an interim measure, should be critically analysed for not only success of the overhaul but also for maintaining this large-scale plan. Implementing health reform should be a step-wise process, and moving forward should be based strictly on successfully accomplishing the previous steps. Failure will almost certainly lead to massive costs for the South African people, monetarily, medically and existentially.

88. Rather than build a new system on poor foundations, existing facilities need to be overhauled. Increased transparency, as well as improvement in challenges such as cleanliness, personnel attitudes, and long waiting times may secure public 'buy-in'. Without these and other changes, public and health care providers' confidence will not be inspired – and, even more importantly, the system may fail in its goal of bringing about equitable resource allocation and improved healthcare.

89. On the whole, the White Paper on NHI avoids the issues of accountability and systemic reform, proposing instead that massive and plainly irresponsible tax increases be used to channel additional funds to an unreformed public health system. Despite the enormous scale of the proposals, the White Paper still fails to provide any rational business case.