SUBMISSION OF COMMENTS
ON
NATIONAL HEALTH INSURANCE
(NHI)
GREEN PAPER
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2 INTRODUCTION

The South African Medical Association (SAMA) is a non-statutory, professional association established to represent all South African public and private sector doctors. It is registered as a Section 21 company. SAMA remains the significant organisation that represent doctors interests.

Of importance in this regard is the role SAMA serves as a trade union for its public sector members and lobbying agent for its private practitioners.

SAMA represents a large proportion of the total national medical workforce with a membership of more than 17 000 doctors and is therefore the largest representative body in South Africa.

SAMA therefore welcomes this opportunity to comment on the NHI Green Paper - to participate and partner with government during these ground-breaking stages of what must be considered the most significant step in healthcare reform in South Africa.

The association, in the interest of its membership and the health of the nation, looks forward to continuous engagement with government as the process moves towards the White Paper and beyond.

To this end, this submission represents the culmination of meticulous consultation with and input from all members of and the specific practitioner service units within SAMA. This methodology was applied to ensure that all major role players within this broadly based association have had their opportunity to express their interests, views and suggestions on the Green Paper.

SAMA believes that it is imperative that the collective voice of doctors be heard on the contents of the Green Paper. Doctors play a fundamental role in the health of the nation both in the prevention of disease and importantly in the management of acute and chronic conditions.

On the strength of this, it is anticipated that the comments and suggestions presented by SAMA in this document will be recognised as valuable contributions to what will ultimately make the White Paper richer in every way towards building a badly needed effective and sustainable health service.

It is SAMA’s declared intention to be engaged at every stage of the NHI process and looks forward to making further submissions particularly at the White Paper and Draft Bill stages.
3 STRUCTURE OF THE SUBMISSION

a) Overall comments: General impressions and comments on major issues emerging from the Green Paper.

b) Expanded comments: More in-depth explanations on various issues of concern.

Fundamentally, the approach of the submission is to identify the challenges and opportunities presented to the medical profession in the NHI proposals – accompanied where possible by recommendations.

c) ANNEXURES: that contain Comments from SAMA special interest groups
4 OVERALL COMMENTS

4.1 The Green Paper and KEY Principles

SAMA resonates with and accords deserved recognition to the health funding and reform principles outlined in the introductory section of the Green Paper. These are:

I. The centrality of the PATIENT and Universal Access – this is long overdue and deservedly speaks to the constitutional right of every citizen in South Africa.

*The plain objective of the Green Paper is that NHI should enable every person in South Africa to have access to and receive good quality healthcare, thus ensuring a healthier nation.*

II. Clear understanding and assimilation of key concepts such as ‘Universal Access’, ‘Social solidarity’, ‘Cross subsidization’ and ‘benefit according to need’, is central to the acceptance of the proposals made for an NHI system.

III. The recognition that the Public Health Service needs urgent attention.

IV. Recognising the importance that cost management and the manner in which services are utilised - both in the private and public services – are also in need of attention.

V. The recognition of the increasing wealth gap in South Africa and how this can be counter-productive and potentially destructive to the health objectives of the nation (i.e. equity in healthcare).

VI. The recognition that health prevention and promotion, especially in primary health, has a significant role to play.

SAMA has traditionally embraced the principle of Universal Access to quality healthcare for all. At its July 2007 National Council, the following resolutions were presented:

- The disparities and inequities in the delivery of healthcare to the nation and the need for their redress in both the public and private healthcare systems
- The current national debate to find funding models and solutions that will ensure access, quality and efficiency
- That there is opportunity for SAMA to be proactive in influencing the development of government policy on healthcare funding.

Therefore resolves:

(a) That SAMA develops models and scenarios that aim at universal coverage while retaining what is good in the present system.

(b) That SAMA funding be made available to enable such initiative

(c) That SAMA interacts with all forums where funding of healthcare is being discussed to influence outcomes’.
This was followed up National Council at its August 2008 with the following statement:

National Council, noting the move towards National Health Insurance (NHI) for South Africa, and the internationally experienced challenges related to its implementation, resolves that:

1) SAMA reaffirms its endorsement of a system of Universal Access to healthcare for all South Africans;

2) SAMA reaffirms the position that Public and Private sectors both add value and must continue to contribute synergistically to the achievement of this objective under the banner of a NHI

3) SAMA continues to explore, prepare model(s), present, pilot and co-implement practical, viable ways to achieve these objectives;

4) Secretariat, BOD, EXCO and relevant Committees take all measures necessary in pursuance of the above;

5) Secretariat communicates this resolution and associated process to all SAMA structures to enable them to give feedback and participate meaningfully.

4.2 The Green Paper and Detail

A key concern for SAMA has been the lack of detail in the Green Paper. SAMA does recognize that this may have been intentional on the part of the Department of Health in order not to be prescriptive and inflexible in adopting inputs and suggestions.

Assuming we are correct in our understanding, of the intentions of the Department of Health, SAMA wishes to commend the Minister of Health for undertaking the NHI Roadshow. SAMA members have found these meetings informative in that they shed more light on the Green Paper. We trust that the Minister continues this interactive approach throughout the evolution of the NHI.

4.3 Role of the Public and Private Sectors

The Green Paper is explicit that NHI will be a single and publicly funded system and that there will be separation between the funding of health and the provision of health services. SAMA is encouraged by the recognition of the need for co-operation and partnership between the private health sector and the public health sector in the provision of services under the umbrella of the NHI. However, this remains one of the areas in the document where detail is lacking. SAMA is of the opinion that this shortcoming is the cause of much anxiety and speculation.

The primary cause of anxiety within the private sector is that the private doctors will be effectively absorbed into the public sector. The private healthcare system would cease to exist.

It was, however, encouraging to hear the Health Minister acknowledge at a recent consultative meeting that “it is neither necessary nor possible to abolish the private health sector” (Minister of Health, Birchwood Hotel, October 2011). SAMA would go one step further by arguing that that the private sector in this country should be viewed as a national asset.

The public and private sectors must work in harmony towards the common goal of equitable and quality healthcare.
4.4 The Green Paper and its Relevance for Doctors

SAMA recognises that NHI, successfully introduced and funded, will doubtless have an enormous influence on the future of health care and the manner in which doctors have traditionally delivered healthcare in South Africa.

Although the Green Paper puts forward the *pros and cons* relevant to the introduction of NHI, it also creates an opportunity for the medical profession to meaningfully contribute to the development and success of the NHI and its various elements. These include:

(i) the future of and development of hospital services,
(ii) the role of health sciences institutions,
(iii) quality and efficiency in health care
(iv) the contracting of family physicians and hospital specialists,
(v) the re-engineering of primary health care,
(vi) the design of the healthcare package,
(vii) the reimbursement mechanisms,
(viii) the partnership with the private sector,
(ix) emphasis on prevention and
(x) utilisation trends and referral systems.

The Green Paper specifically and repeatedly stresses that NHI will be introduced over a period of 14 years and that this major policy shift must be read in conjunction with the broader 10 Point Plan of the Government.

As such, SAMA stresses that the implementation of the NHI is linked to the success of the other points in the 10 Point Plan and the strengthening of the Public sector is key.
5 HUMAN RESOURCES AND PROVISION OF HEALTH SERVICES

The recent publication of the South African Human Resources for Health (HRH) Strategy for the Health Sector 2012/13 – 2016/17 has once more reinforced the challenge faced by the present health system with respect to the human resource shortage in all categories of health workers. This trend will undoubtedly continue under the NHI unless measures are put in place to counter it. These shortages are reflected in the Table 1 and are expanded upon later in this document.

Table 1:

<table>
<thead>
<tr>
<th>Staff Name</th>
<th>Base Year</th>
<th>2011</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled Nursing assistants</td>
<td>-8,381</td>
<td>-6,434</td>
<td>1,993</td>
<td>1,304</td>
<td>-723</td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td>21,010</td>
<td>22,471</td>
<td>4,470</td>
<td>4,061</td>
<td>3,046</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>-20,138</td>
<td>-19,805</td>
<td>-15,380</td>
<td>-8,990</td>
<td>-1,357</td>
</tr>
<tr>
<td>Professional Nurses</td>
<td>-20,736</td>
<td>-22,352</td>
<td>-22,121</td>
<td>-11,527</td>
<td>-898</td>
</tr>
<tr>
<td>Medical Practitioners</td>
<td>-4,145</td>
<td>-4,294</td>
<td>-3,930</td>
<td>-2,820</td>
<td>-1,213</td>
</tr>
<tr>
<td>Medical Specialists</td>
<td>-7,590</td>
<td>-7,471</td>
<td>-5,677</td>
<td>-3,158</td>
<td>-583</td>
</tr>
<tr>
<td>Dental Practitioners</td>
<td>0</td>
<td>168</td>
<td>480</td>
<td>603</td>
<td>519</td>
</tr>
<tr>
<td>Dental Specialists</td>
<td>-22</td>
<td>-24</td>
<td>-21</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Community health worker</td>
<td>-11,689</td>
<td>-14,651</td>
<td>-14,279</td>
<td>-3,006</td>
<td>152</td>
</tr>
<tr>
<td>Home based care worker</td>
<td>-7,360</td>
<td>-9,655</td>
<td>-9,874</td>
<td>-2,079</td>
<td>197</td>
</tr>
<tr>
<td>Other</td>
<td>-23,911</td>
<td>-20,995</td>
<td>-2,096</td>
<td>8,135</td>
<td>9,414</td>
</tr>
<tr>
<td>Total</td>
<td>-82,962</td>
<td>-83,043</td>
<td>-66,435</td>
<td>-17,475</td>
<td>8,568</td>
</tr>
<tr>
<td>% of total</td>
<td>n/a</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: HRH Strategy FOR the Health Sector 2012/13 – 2016/17

5.1 Private healthcare providers: A Doctor-led solution

In October 2011, SAMA established that there are 9438 registered general practitioners (GPs) in public, private, and academic practice. Unfortunately this figure includes GPs that are presently overseas. This, SAMA contends that this important and significant group doctors, should form the foundation for the re-engineering of primary health care. It will also be important for NHI, both in the short and medium terms, to involve and interact with this important resource and ensure that this capacity is fully utilized in the provision of primary care services.

It will be important for the NHI that GPs are recognized as the coordinators or clinical leaders of inter-professional teams (CHW, nurse, clinical associate, GP) providing primary health care (PHC). While it is argued, that due to frustrating medical staff shortages that South Africa cannot populate a doctor-based system, which systems are found in Cuba, Brazil, UK etc. SAMA feel strongly that the NHI PHC services must be doctor-led.

GPs have been increasingly sidelined in medical scheme’s benefit package design and as a consequence the role of GPs as gatekeepers to healthcare services has been progressively diluted. It is also hoped that the NHI does not adopt a ‘one size fits all’ approach, especially in areas where emergency facilities are inadequate. The model should include and make provision for institutions with emergency facilities to which GPs in a particular region can link up.

In this context it is important to reiterate what the Green Paper envisages for doctors presently working as GPs in the private sector:
• “It has been shown that there is a strong support for inclusion of Primary Health Care services within the benefit package for mandatory insurance. This should include private sector primary care services” (item 68)

• “In addition to the three streams, Primary Health Care services will be delivered through accredited and contracted private providers practising within a District” (item 85 of the Green Paper),

• “there are several ways in which private providers could participate in PHC services to the population”, but provision will be confined to a specific range of services. (item 86)

• “the DoH will remain a major provider of services through its national, provincial and district level structures and facilities”. (item 134)

All of the above opportunities for involvement of the private sector in the NHI.

A stated aim of the Green Paper is for GPs to provide the full range of PHC services preferably in one facility. Where a ‘one stop shop’ is not possible, the Green Paper goes on to state that NHI will make “comparable arrangements” for the patient not to be inconvenienced and to access these services elsewhere. However, we insist that these “comparable arrangements” must in no way allow any compromise to patient care. Nor must these arrangements be abused to penalise doctors cannot offer the “one stop shop” service.

This also applies to the Green Paper reference to multidisciplinary teams/networks. While this intention may be good, SAMA strongly feels that a GP who contracts as an NHI service provider should be allowed to do so without considering whether his/her practice is multidisciplinary or not. It is the doctor’s clinical skills, knowledge and experience as well as meticulous and efficient use of medical equipment and technology that enhances his/her quality of care and not the presence of other health disciplines that matters.

Finally it must be emphasized that GPs by the nature of their work, are primarily community based and many are well distributed in underserviced urban, peri-urban and rural areas. They could play a very important role in the envisaged “Municipal ward based PHC teams” – as mentors, resource people and for referral. It is SAMA’s contention that GPs should lead the teams.

SAMA is clear that while tapping into the skills and capabilities of private doctors/family physicians/GPs will undoubtedly contribute to improving access to doctors in the short term, this arrangement alone will not end the chronic doctor shortages in the public sector and more needs to be done to increase the output of doctors from training institutions.

The UK National Health System provides a good model of how GPs are appropriately utilised at the coalface of healthcare. If GPs are to be put at the centre of health delivery in South Africa, this needs to be explicitly stated in any future drafts of documents on the NHI.

When GPs are integrated into district teams, SAMA insists that a distinction has been drawn when contracting GPs. There should be distinction between professional contracting (so-called sessional doctors) and facility contracting. A professional should be allowed to contract out but still be eligible to do sessions.
5.2 Inputs from Doctor Grouping

SAMA represents a diverse range of doctors with specific fields of interest. These various groups will be affected in different ways during the course of NHI implementation. They have therefore each been given an opportunity to contribute their specific views on the Green Paper (attached as Annexures).

The groups are:

- SAMA Committee for Public Sector Doctors (CPSD) [Annexure A]
- SAMA General Private Practice Practitioners (GPPPC) [Annexure B]
- SAMA Private Specialists (SPPC) [Annexure C]
- SAMA Human Rights Law & Ethics [Annexure D]

5.3 Other health worker disciplines

5.3.1 Mid level workers (MLWs)

South Africa has long recognized the need for training mid-level workers with different skills. Given the shortage of health professionals the need to increase this category of health worker will become more acute, especially to be part of the envisaged district health and ward teams. The HRH Strategy for the Health Sector, 2012/13 – 2016/17, states that, amongst all MLW categories, Clinical Associates are the only MLW trained in a Faculty of Health Sciences; the rest are trained in Higher Education Institutions (HEIs), specifically at the Universities of Technology. In South Africa, Clinical Associates are trained at the University of the Witwatersrand (Wits), Walter Sisulu, and Pretoria Faculties of Health Sciences. Presently the training output of MLWs is relatively small and it is imperative that the NDoH gives more thought to the training of different categories of MLWs.

It is important to state that the use of mid-level workers should not become a substitute for the long-term plans of investing in the training of top quality doctors

SAMA must be satisfied that clinical associates will be sufficiently trained to fulfil their roles and that their deployment is well-regulated. It is imperative that the scope of practice of clinical associates is clearly defined. They are an important resource which extends the reach of the doctor, but cannot be used as a replacement for that doctor.

Attention has to be drawn to the fact that the introduction of mid-level workers has resulted in the phenomenon what is known as task-shifting. The World Health Organisation (WHO) has published Recommendations and Guidelines on Task Shifting. These recommendations stress the need for national consultation before governments adopt the task shifting approach. This national consultation must also include a detailed situational analysis as the key to selling this concept as it is essential to obtain endorsement by other stakeholders.

The outcome of such a consultation processes must be proper regulation. This will ensure effectiveness of the task shifting approach in addressing healthcare delivery problems.

There is evidence that task shifting is currently taking place in South Africa, especially in the remote rural healthcare facilities and possibly without proper authority or regulation. This is a challenge that places an obligation on authorities to put an end to such unregulated practices. With its current regulatory infrastructure, South Africa is well
positioned to handle regulatory tasks. Well-established functional regulatory authorities are already in place, looking after the various healthcare professions operating in the South African Healthcare System, e.g. HPCSA, Pharmacy Council and Nursing Council. However, to attain the quality assurance objectives that should go with any formal adoption of task shifting in South Africa, the role of these regulatory authorities will need to be applied with a co-operative cross-sectoral engagement between them.

SAMA emphasises that there must not be a compromise in quality for the sake of quantity.

5.4 Significant HR challenges for the medical profession

5.4.1 Shortage of Doctors

SAMA is acutely aware of the huge cost (R1.2 million) that goes into the training of only one medical doctor and laments the ceaseless emigration of South African-trained doctors. It must be cautioned that where the introduction of NHI is possibly done in a “cavalier” fashion, and in a spirit and manner that does not build partnership, this could well increase the risk of doctors leaving the country.

It is unfortunate that South Africa continues to “bleed” its well-trained doctors to other countries. The causative push factors are well documented in literature, and unless these are addressed the status quo will persist to the detriment of the healthcare system. Some of the common push factors are:

- Poor Remuneration
- Long Training, i.e. 2 years internship and 1 year community service
- Poor career-pathing
- Poor working conditions
- Poor accommodation
- Safety and security in the work place
- Inadequate resources
- Weak leadership
- Lack of recognition
- Stress due to heavy workload
- Perceived threats to independent/private practice

In addition, doctors have noted with concern that the high rate of litigation has resulted in many doctors shying away from Obstetrics & Gynaecology, contributing to shortages in that particular specialty.

SAMA recently noted that the government has reached an agreement with medical training institutions to train 40 extra doctors per year. While this is commendable, this is not enough to close the gap. Institutions of Health Sciences will need a radical change – many more professionals need to be trained for the NHI and this would require greater investment and recruitment of staff from other countries in the short term.
5.4.1.1 Recruitment of retired professionals

Subsequent to the release of the Green Paper, the Ministry of Health revealed plans to recruit retired doctors (and nurses) to boost medical staffing for NHI. SAMA notes, however, that although this noble gesture by government contributes in the short term to addressing the chronic shortages, it may not be sustainable in the long term. The key is to increase output from the medical schools and in this regard SAMA is pleased to note that some medical schools have already begun to increase their yearly intake of medical students. The proposed establishment of a 9th medical school in Limpopo is another development which should help meet demands.

5.4.2 Modification of scope of practice (SOP) of doctors

It appears from the Green Paper that the traditional role of a doctor may well change, with the likelihood of doctors sharing with or shedding off tasks to clinical associates, other categories of mid-level workers and the roles envisaged for community and district cadres.

Regarding scope of practice, the World Medical Association states that:

“Changing scope of practice manifests itself in a variety of ways among countries. In some instances, there is a trend towards autonomous performing of physicians’ tasks by other health personnel, while in other countries the trend is toward delegation with supervision by physicians. Regardless of what system is in place, the essential objective must be quality care for all patients”.

SAMA strongly supports the option of delegation of tasks to clinical associates with supervision by doctors. While the Government has hinted that South Africa cannot afford a Doctor-based system, SAMA is adamant that PHC services under an NHI should be doctor-led, and should have doctors playing a major role in supervision of clinical associates and other proposed district and sub-district cadres and teams.

5.4.3 The NHI and PROVIDER Accreditation

The Green Paper states that participation in NHI is voluntary but nonetheless in section 12 on page 31 goes on to state that this will be dependent or conditional on the Accreditation of the institution or practice through the “Office of Health Standards Compliance” (OHSC). This accreditation process lacks direction and detail and SAMA would propose that more detail is made available by drawing from the following models of accreditation:

(i) The UK model of accrediting GP’s
(ii) The Uitenhage/UDIPA model
(iii) Specific non-cost-based models developed by some of the managed care and medical schemes

Council for Health Service Accreditation of South Africa (COHSASA)

The Green Paper estimates that in the time period 2016 to 2020, three thousand (3000) GPs and networks will have been accredited and contracted and 6000 by 2021-2025.

, SAMA wants to stress from the outset that there cannot be a link between the accreditation service provider and the accrediting authority. The accrediting authority must ideally be an independent entity. There are existing organisations that are already providing this service in the private sector and such as COHSASA who not only accredit healthcare professionals and institutions but provide the means to measure themselves against internationally
accredited standards and monitor their improvements. This is done using quality improvement methods and a web-based information system.

What is unclear in the Green Paper is the fate of health establishments or medical practices that do not manage to get accredited. SAMA proposes that an independent and transparent appeals process be developed and implemented to offer non-compliant institutions and practitioners an opportunity to obtain accreditation. SAMA cannot reiterate enough that the process of developing and implementing the accreditation model, must be fair, transparent and inclusive.

5.4.4 The NHI and Doctor Autonomy

SAMA ascribes to the World Medical Association position that National Medical Associations must do their utmost to promote and support the concept of professional autonomy of doctors. The WMA Declaration of Madrid on Professionally-led regulation states that:

“Physicians have been granted by society a high degree of professional autonomy and clinical independence, whereby they are able to make recommendations based on the best interests of their patients without undue outside influence”.

Keeping this in mind we are concerned that certain of the Green Paper tenets may militate against this position, for example:

a) Point #112 on page 34 states that “accreditation will also take into account the need for particular providers within a particular area.” and requires more discussion and clarity because for SAMA members, this is reminiscent of the undesirable ‘Certificate of Need’ as provided for in the yet to be made effective section 36 of the National Health Act of 2003.

b) Multidisciplinary teams/networks and the stipulation that providers must be part of these. While the intention may be good, SAMA strongly feels that a GP who contracts as an NHI service provider should be allowed to do so without considering whether his/her practice is multidisciplinary or not. It is the doctor’s clinical skills, knowledge and experience as well as their efficient use of medical equipment and technology and quality of care that matters and not the presence of other health disciplines.

c) Point #107(c) states that “the public and private health providers contracted by the National Health Insurance, will be assisted in controlling expenditure through recommended formula, and adherence to treatment protocols for all conditions covered under the defined package of care.”

This is in direct contravention of the HPCSA Ethical rule 7(c) which states that: “A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to under-service, over-service or over-charge patients.”

It is proposed that the Office of Health Standards Compliance be the accreditation shepherd and watchdog which creates a conflict since the Department of Health will not only be one of the providers in the NHI, but also the accrediting body. SAMA therefore contends that the HPCSA must be the custodian of minimum care standards that are based on internationally accepted best practice models. I. SAMA reiterates its proposal that the Office of Health Standards Compliance be independent of the Department of Health.
SAMA insists that quality cannot be sacrificed in the name of cost savings, and that a doctor’s duty to their patient is their primary concern as espoused by the:

a) World Medical Association’s Declaration of Geneva that; “THE HEALTH OF MY PATIENT will be my first consideration”

b) Health Professions Council of South Africa Ethical Rule 27A “A practitioner shall at all times (a) act in the best interests of his or her patients; (c) maintain the highest standards of personal conduct and integrity;”

5.4.5 THE NHI and Professional accountability

It is stated in the Green Paper that “the District Health Authority will monitor the performance of contracted providers within a district and performance will be linked to a reimbursement mechanism.”

The Green Paper also mentions the establishment of the Office of Health Standards Compliance (OHSC)

Whilst there may be reasons to introduce these new interventions, they must not become disguises for retrospective managed care. In terms of the Health Professions Act, the Health Professions Council of South Africa is the statutory authority which governs the professional and ethical responsibilities and obligations of doctors. As such, any new legislation or system must not conflict with the Health Professions Act or its Regulations. Nor should the enforcement of professional and ethical standards vest in any other entity, the HPCSA.

5.4.6 The NHI and Health Facility Management and Administration

The Department of Health’s undertaking to concurrently overhaul the management of all public health facilities in line with the 10 Point Plan, is commendable as it is aimed at restoring and improving the functionality of these facilities and hence providing improved health care to the population. However, as this key initiative gets underway and for it to be successful, it is imperative that we learn from our past and consider the following:

(i) Recruitment of the most qualified professionals without prejudice, discrimination or preference based on population demographics;

(ii) The optimal solution to management of healthcare facilities would be to appoint healthcare professionals, with appropriate management qualifications and experience to run facilities at all levels of hospitals and facilities.

(iii) The prompt advertising and filling of posts and vacancies. The process of filling posts and vacancies must be transparent and equitable, and be expedited This also applies to District Management Teams. In this regard SAMA notes that during the recent public consultations, the National Department of Health clarified that during the Piloting period vacancies will be identified, managed and filled from a national basis and not a provincial basis.

(iv) Critically communities should be involved in this process. In this regard the existing hospital boards (with strong community representation) should be strengthened with community representation. Community organisations should also be encouraged to form voluntary groups that can provide important support to the effective running of a hospital

(v) Universities and Institutions should be encouraged to offer courses on hospital management and administration that recognises the importance of this area of work
to society. These course should form an integral part of the medical curricula at university level.

5.5 The NHI: Training, Recruitment and Retention of Professional Staff

If South Africa is to have a full complement of doctors, new and better mechanisms need to be employed in the training, recruitment and retention of healthcare workers.

5.5.1 Professional development and Inter Professional Learning (IPL)

The focus in the Green Paper on primary care and prevention bestows centrality to the services, particularly of the generalist doctor in the NHI. It is therefore important that this is not left to chance and that the importance of the primary care physician as well as the specialist is recognised i.e. that doctors be systemically capacitated to deliver best care, and that the DoH and institutions of learning consider at the outset putting in place programs that would optimise the skills of a GP (other than through conventional CPD programmes).

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 and would play a part in creating capacity within the district health teams. It is therefore important that the role of specialists is considered and provided for in any health reform proposal. The Draft Human Resources policy document sadly notes that MBChB is not being used to the fullest. We therefore suggest that the following elements be considered as the basic minimum skills as a pre-requisite to NHI contracting:

- All primary care physicians to be trained in the fundamentals of Obstetrics and child care
- HIV/AIDS and TB care course (Course offered by the Foundation for Professional Development or equivalent as a benchmark, plus regular participation in group discussions plus an annual refresher course).
- Chronic Disease management course which includes Hypertension, diabetes, obesity, COAD plus an annual refresher course
- Basic Emergency care course with ATLS and ACLS as benchmark, plus two yearly refresher course
- Basic Surgical skills for minor surgical interventions (1 to 2 hour operations) e.g. tonsillectomy, debridements, caesarian sections, appendectomies, haemorrhoidectomy, etc
- Course in High Care Management (to be designed)
- Basic Anaesthetics (for procedures under 2 hours)
- Basic skills in ultrasound, ECG, HSG, gastroscopy, etc

We believe that it is reasonable to expect an MBChB graduate to have these basic skills. The *quid pro quo* of this expectation is the enhanced appraisal level in terms of capitation amount. The intention is not to unnecessarily prolong the training period of doctors as many
of these courses and training should be offered and applied during the internship and community service periods.

5.5.2 Importance of District Health/ Rural in Academic Curriculum

While urbanisation is increasing in South Africa, a significant amount of people remain in rural areas. The Health Science institutions continue to be primarily urban based and hence the bias of training leans towards urban healthcare. This may be the correct strategy for the long term but in the medium to short term it will continue to contribute to the urban/rural divides. This also manifests in the significant differences in access to health care and the health outcomes in these respective communities.

The introduction of community service in 1994 has contributed to more doctors working in the rural areas and a changed health sciences curriculum that ensures that there is not a single institution that does not include rural health in their training. This undoubtedly needs to be commended but more effort and work is required if we are to overcome the inequalities. The following proposals are offered:

(i) Improving schooling in the rural areas
(ii) Increasing student intake in all health related training from the rural areas
(iii) Improving training support for young doctors going to the rural areas
(iv) Improving the primary care and hospital facilities in the rural areas
(v) Improving accommodation facilities at rural health institutes

The context of training is important. The pedagogic evidence is that it is best to train people in the context in which you want them to work. The district health and primary care systems should be developed as the basis for learning in health care. It will develop health workers who understand their communities and provide them with the skills and will-to-work within the NHI. The existing practice of training in tertiary and secondary care followed by deployment to PHC and districts is outdated and should be changed because it is counter-productive to train more health workers and then needing to re-educate them for NHI.

There are many practices in rural communities that are appropriate for student learning. These include multi professional practices, group practices and some solo practitioners - including general and specialist practitioners. It is important that such practices are accredited and supported to assist in the curriculum of medical students.

5.5.3 Training of Community Health Workers (CHWs)

Health professional training should occur in the same configuration as the cadre complement that will eventually work together in a multi-disciplinary team (i.e. professional categories who will be incorporated into the multi-professional team should be trained in a similar fashion, set-up or circumstances). This means that IPL is critical and that CHW training would have to become part of the formal training system in health care. As the approach is to have a multi-disciplinary team rendering Primary Healthcare, it is important that there be uniformity and synergy between the training of each of the members of that team. Specific and appropriate training should, therefore, be offered to Community Health Workers within Health Science Faculties. Effect would therefore be given to the principle of Inter Professional Learning.

5.5.4 Investing in training development: Local/ foreign training

Among the criticisms of South Africa’s attempts to address the human resources shortages is the apparent over-reliance on foreign trained health workers to staff and run hospitals, particularly those in rural areas. This approach, which does not work in the long term, is not
appropriate if not speedily altered, will make the PHC system unsustainable. One of the serious challenges posed by this stop-gap approach is that doctors from first world countries are not well trained and exposed to the South African health care context - including how to appropriately manage local pandemics such as HIV, Trauma, TB, Malnutrition, and others. Care should be exercised that in the desperation to shore up personnel numbers, quality of care is not compromised.

SAMA recommends that the resources spent on sending students for foreign training (e.g. Cuba) rather be spent to develop appropriate training sites in rural areas in South Africa. This will be a better investment to develop health workers for the NHI. Of particular importance is the development of Rural Training Schools of which there are several initiatives at the moment. These need to be supported.
6 HEALTHCARE PACKAGE

Item #63 of the Green Paper states that:

“(b) **Breadth of the cube**

This refers to services covered. The present system wrongly confuses healthcare with treatment of diseases. A comprehensive healthcare package includes:

- **Prevention of diseases, Promotion of health, Treatment of diseases where prevention has failed, Rehabilitative services**.

Item #69

SAMA wishes to expand on this framework and offers insights hereafter on various aspects pertaining to the development of the Health Care Package for the NHI.

6.1 Communication and information to the community

The success of NHI is dependent on many variables but given this major shift, involvement with all sectors of society is necessary and important. In order to make a success of the health packages, it is critical that the system be explained to communities and health workers. Effective communication will go a long way in bringing about:

(i) Understanding of how the NHI will work and how it differs from present system
(ii) Understanding of the funding model and what is going to be different for workers, employers and communities
(iii) Clear understanding by patients on how services should be utilized and the appropriate entry points to health care.
(iv) Changing the perception on using a health insurance card e.g. presently the attraction is to go to specialists and ‘fancy’ hospitals
(v) Understanding how the NHI system will differ with respect to referrals

The introduction of NHI will need a well-planned communication strategy. For example, the referral system needs to be well defined and communicated

Monitoring and evaluation especially in pilot sites is essential to ensure that problem areas are both identified and promptly addressed.

Patient centered care, collaborative care with the inclusion of the patient and the family as significant partners is critical. Quality of practice depends largely on the interaction and relationship between the health care provider and the patient and their family. The basic package, especially at primary level, should therefore be designed in such a way that it does not delineate providers from servicing non-curative health care like health promotions, nutrition, house visits etc. Not only should these practices be encouraged, but also be factored in when an NHI professional is appraised.

6.2 Health information systems

In today’s health care system the expression ‘information is power’ is apt and necessary for the future NHI health service. The amount of information required for managing the service, for policy making, for appropriate care and therapeutic decisions inevitably requires sophisticated IT systems. The private sector has made a lot of investment in this sphere and that expertise should be utilized in the NHI environment.
South Africa is investing in this area but at best this is uneven and infrastructure networks are still lacking in many parts of the country. The information about patient care is needed to structure the service packages. This information has to be accessible to health professionals at all times. The enhanced mobility of patients due to improved access will pose a challenge to provision of a seamless health care delivery, especially with regards to chronic care.

SAMA therefore suggests that there be a tamper-proof health card to be used and updated every time a patient visits an NHI facility.

6.3 Quality of Care

It is SAMA’s view that improving the access to health care and developing a more comprehensive health package will not achieve the desired objectives alone. What is needed is to dramatically increase quality of care. Health workers need to improve the quality of interaction and care for the patient. There should be a concerted effort to deal with pervasive culture of negative attitudes and unprofessional behaviour from all health care professionals. This must begin in our institutes of learning and continue at our areas of work. Not only should a culture of excellence and professional etiquette be encouraged, but the Department of Health should initiate motivational programs in terms of awards and recognition.

6.4 Buy-in from practitioners

We maintain that it is important to implement the service packages in a participatory manner and make serious efforts to get buy-in from practitioners, patients and communities to make the service packages work for improved health outcomes. All health care professionals, both in the public and private sector, need to be given a chance to design what would work best in their respective environments, as well as to continuously make changes where the design does not lead to better outcomes.

6.5 Prescribed Minimum Benefits

Cognizance should be taken of the negative unintended consequences of PMB’s in order to avoid repeating the same mistakes from when the concept was originally developed. SAMA believes that NHI should be comprehensive enough to cover almost all health requirements of the population and suggests that this system of prioritizing certain medical conditions as PMBs be completely done away with. All medical conditions are PMBs and health workers should be reimbursed for managing them, and not only for treating certain diseases. (Regulation 8 of the Medical Schemes Act 131 of 1998 states that medical schemes must pay in full for all PMB conditions).

6.6 Continuity of Care

The NHI model of care should ensure functional continuity of care. Continuity of care should be measured in the information system.

The information available to the patient/family is a critical element to ensure continuity of care and continuation of care between different levels. The information available to the patient also increases the possibility for patient centred care and collaboration of the patient/family in their own care. This is critical for all the most important conditions in 3 of the 4 epidemics namely TB/HIV, maternal and child health and chronic lifestyle illnesses. Patient-retained records and standard patient/family retained information available to patients and families and being part of the care process and the consultation process. This needs to be done in such a way that patient confidentiality is not compromised.

In addition, the importance of the information system for healthcare providers in order to maintain continuity of care cannot be overstated. This is elaborated upon below.
The immediate integration of patient information between the private (whether NHI contracting or not) and public sector is critical.

6.7 Integration of Care

Integration of care is important. There should be a seamless continuation of care between all the different levels of care, including the General Practitioner. For this to work well, the information system should make information available to all practitioners from all the levels of care and the ability for practitioners to record their assessment, plan and actions to be fully available to the other practitioners in the different levels of care.

6.8 Starting with promotion and prevention and include self care

Health promotion, prevention, early detection, early management and self-care and continuation between these elements should form the basis of the care package. This should be an important element of care at all the levels of care. Information should be open and available for patients, families and practitioners to use the information and communicate with each other. Care at secondary and further should include and strengthen the same approach of promotion, prevention, early detection, early management and self-care.

This is not only important for community-based care, but also for every consultation at all levels of care. The integration and respect for these issues needs to filter through all levels of care.

In the appraisal for the performance of teams and practitioners, this should be a central issue of evaluation.

6.9 Community and home based care.

The development of Ward Health teams is a specific form of Community Oriented Primary Care (COPC) and is a welcome move. This moves the focus of care from institutions to communities and homes with a geographically based responsibility of a health care team. This should form the basis of the PHC in the DHS. It also provides the method for incorporating and integrating all community based care, private, public and NGO.

Making COPC functional and effective should be the first focus of NHI service delivery and service package. It is envisaged that care for all chronic conditions, geriatrics, and rehabilitations should be premised at the patient’s home. Not only would this move alleviate congestion at public health care facilities, but would also return health care responsibility in the hands of families and communities.

We suggest that this additional stream of care be added under PHC. A team led by a local GP, and consisting of other Municipality based PHC agents should be formed to tackle such cases as DOTs, HIV care and counselling, home-based wound care etc. Other areas most likely to be detected early and receive urgent attention would be drug and alcohol abuse as well as mental health.
7 FUNDING & REIMBURSEMENT IN THE NHI SYSTEM

The NHI green paper is not specific about several issues, notably with respect to the funding models to be considered for the proposed NHI system.

7.1 Financing the NHI

Funding remains the singular biggest challenge of an NHI system. Much debate and controversy reigns in the media and in other forums on the costing and funding of the proposed NHI system. There are various estimates depending on the viewpoint and background of various economists. There is probably insufficient information to outline true costs at this stage but the NHI plan from Government estimates that the expenditure on health in real terms will increase from approximately R125 billion in 2012 to R256 billion in 2025.

It is worthwhile to note that even without the introduction of an NHI system, health funding would steadily increase with the GDP, particularly if the budget spent on health increased from 12% to 15% as recommended by the WHO (so called Abuja target). This is 15% of Government spend not % spend of GDP, the global norm being that 5 – 6% of GDP spend should be on health. This means that in reality the potential gap between what is required and what is available will be less than it seemingly appears. Nonetheless, there is a gap in funding and the financing of this gap may come from a number of potential sources. Raising the funds through taxes is the most likely mechanism. As it stands currently there are approximately 13 million income tax payers in South Africa. This is normally paid as PAYE, SITE (Standard Income Tax on Employees), Capital Gains Tax etc. Several other sources of taxation also exist e.g. VAT, Capital Gains Tax etc. All considered there are only 3 likely sources of tax funding for an NHI system:

7.1.1 Surcharge on taxable income

This will be paid by everyone who currently pays income tax. It will therefore be an employee tax affecting mainly, though not exclusively, middle class employed and income tax paying South Africans. The alternative, or in addition, is a surcharge on existing company tax i.e. an additional tax levy on companies. It is critical to note that this type of company tax may have a negative effect in that a company tax may simply be recouped by a company or industry by shifting the increased tax burden to consumers by increasing consumer prices.

7.1.2 Payroll tax:

This is an employer tax which may either be structured as taxation for all employees on the payroll. This is analogous to the national insurance contribution in the UK.

7.1.3 Value Added Tax:

This would affect everyone living within South Africa’s borders. VAT in itself is the most progressive of taxes as it does extend to harness the wealth accumulated within the informal sector that ordinarily avoid the more formal taxation systems already mentioned. However VAT does not narrow the gap between rich and poor and should it be employed as a funding mechanism, more staple items need to be zero rated. This will avoid the burden being inappropriately shifted to the poor.

The NHI Green Paper does not specify whether a dedicated form of taxation will be used or a combination will be favoured. In addition there is no clarity on the percentage taxation being looked at. Currently medical scheme members pay between 9 and 14% of their income towards medical insurance. It is estimated that a health tax will probably be significantly lower should an individual choose to abandon their private health insurance contribution.
The tax deductibility of medical aid contributions is not directly related to funding the NHI but it has been suggested that a change is in the offing. Currently, all medical costs beyond a certain threshold are tax deductible. The total current tax rebate is approximately R15 billion. While there has been speculation that the tax rebate would be scrapped, the NHI green paper refers to its replacement with a tax credit.

Tax deduction across the board does inadvertently result in inequality as the amount deducted is related to the tax bracket. High income earners receive far more rebate on the same medical expenses than lower income earners. Hence, the aim of the tax credit is to eliminate this inequality by crediting tax for medical costs on an income related scale. Both tax deductions and a tax credit indirectly result in loss of revenue to the public exchequer and are a form of subsidisation of private medical schemes. This aspect is not addressed in the NHI green paper. Even so it may be of value to consider a comprehensive interregnum period while such a system exists pending the transition to a fully functional and well managed NHI system.

7.2 Reimbursement

Reimbursement under NHI is clearly a critical area for doctors both within the public and private sector. Should doctors earning capacity become less than that of other professionals it is logical that the brightest school graduates will shun the profession for another that offers better earning possibilities. One must also take into consideration that doctors need to be rewarded for their long and arduous years of study, which is even more so in the case of specialists. Finally it must be remembered that doctors bear all the risk in the provision of healthcare and are the final port of call for the sick and infirm, and as such function autonomously without the option to pass on their obligation to another.

All of these factors contribute toward the fact that only people of high intelligence and irreproachable moral and ethical standards must be attracted to the profession. Unfortunately these people have realistic expectations of being adequately and fairly remunerated for their services.

For the private sector, in particular general practitioners, the Green Paper, at Chapter 13, discusses two reimbursement models: performance based reimbursement or capitation.

7.2.1 General Practitioners

7.2.1.1 Performance Based Payment Mechanisms:

SAMA submits that this model can be evolved to become the healthcare funding prototype

In this reimbursement model which we call “Fee for Performance”, we propose that payment would be provided on a sliding scale linked to optimal clinical outcomes each time a service is rendered to a patient. This sliding scale would be based on internationally acceptable quality outcomes. Its major advantage is that it will promote quality outcomes for patients. Further there is room to develop an adequate rate based upon objective practice cost studies that can be established, which would ensure an equitable remuneration model for the doctor.

The potential disadvantage is the risk of over servicing with a consequent significant escalation of healthcare costs. This risk can, however, be addressed through the implementation of appropriate control measures, which SAMA is in a unique position to administer.

This model does present an advantage to patients, as they are assured that the doctor is rendering optimal service to them without undue emphasis on the money that the doctor will be paid. This model lends itself to encourage doctors to implement preventative
interventions, by reimbursing them for actively interacting with patients, and improving the health status.

In essence, with this “Fee for Performance” model, the harder the doctor works for their patients the better their reimbursement will be, and the healthier the patient. This incentive is clearly attractive to general practitioners and specialists and would entice them to stay within the system.

7.2.1.2 Capitation

At point 102, pg 32 of the Green Paper, the Captitation system is described in which payment is based on a defined and registered population adjusted for the specific disease profile within the area.

The advantage of capitation is it encourages preventative and proactive care from doctors. The disadvantage is that the financial risk is completely shifted to the doctor. In addition the system is open to abuse by the patient. Both these unintended consequences will lead under-servicing.

The practitioner does not have the wherewithal to be able to determine and quantify their risk and are therefore at the mercy of their patients as well as the body responsible for setting the capitation fee. Traditionally capitation fees are reverse-engineered from the starting point of what the payer can afford. This process cannot be sustained as the emphasis must be on a professional fee based upon audited practice cost studies. If this amount is not appropriate, then the professional will simply not contract to same and ply their trade elsewhere.

SAMA proposes that a hybridised payment system incorporating specific incentives for health related outcomes is possible provided that it includes a risk adjusted capitation rate which takes into account the age, gender and epidemiological profile of the registered population and is combined with a fee-for-service component. This model would go a long way in ensuring that doctors are remunerated appropriately for their services, in the event that there is insistence on a capitation based reimbursement model.

7.2.1.3 Factors for the Determination of Doctor Remuneration

Any attempt to calculate a tariff for the remuneration of doctors must take the following critical factors into account:

- Practice overhead costs
- Opportunity costs
- Risk factoring
- Direct and indirect labour costs
- Professional Indemnity costs
- Registration fees
- Administration costs
- Travel and incidental disbursements
- Impaired receivables
- Managed Care costs
- Consumables

Notwithstanding each of the costs listed above, the doctor must still earn a living, commensurate with the remuneration of comparable professions eg advocates, attorneys, architects, engineers, chartered accountants, executives of businesses, Directors General, and Ministers.
Kindly also refer to the “Annexure B” for the detailed input by the General Practitioners in Private Practice.

7.2.2 Specialist Private Practitioners

At present, the specialist private practitioner is the scarcest skill and resource in healthcare in South Africa. SAMA recognises this fact and insists that specific attention must be given to the retention and promotion of specialist practitioners’ interests.

Regrettably, there are no specifics in the Green Paper that address this vital component in healthcare. SAMA is eager to take up the cause of the private specialists and we therefore make the following recommendations which we trust will be incorporated into the NHI:

7.2.2.1 Remuneration

SAMA proposes that Specialists be reimbursed based on a strict fee-for-service model. The reason for this proposal is that it would be prohibitively expensive to design performance tracking mechanisms or capitation models for each of the specialities and sub-specialities. Further due to the specialised nature of their work, only specialists of equal standing and expertise have the capacity to evaluate and assess the quality of their fellow specialists. This negates the possibility of implementing a “performance based” reimbursement model for specialists.

7.2.2.2 Autonomy

With the mooted accreditation of private hospitals, the possibility of private facilities contracting with NHI and then paying specialists on a salaried basis has been raised. SAMA emphatically opposes this proposal as it flagrantly violates the sacrosanct principle of autonomy of doctors.

Kindly refer to “Annexure D” for a comprehensive and detailed input from the Specialists in Private Practice.

7.2.3 Public Sector doctors

The reimbursement of Public Sector Doctors remains a matter of critical importance to SAMA. We refer to the extensive and comprehensive submission attached to this submission as “Annexure A” for a full analysis of this issue. This submission was compiled by all the elected structures within SAMA that represent public sector doctor issues.

7.2.4 Diagnosis Related Groups

The proposal, at page 32, point 103, to move towards payment on the basis of Diagnosis Related Groups (DRGs). DRG codes are given to a patient with a diagnosis code and co-morbidities e.g. HIV with extra-pulmonary TB or HIVAN. The hospital would then be reimbursed for the complete care of that particular patient/DRG code, not each intervention or number of inpatient days.

Use of DRG codes for reimbursement of hospitals helps to adjust funding to the complexity of the health services provided. Unfortunately while capping the expenditure for a specific disease or procedure, it removes the possibility of the passing on of savings to the funder, being the NHI.

This will clearly require an extensive administrative upgrade of informatics in public hospitals to make this funding model feasible, irrespective of whether they are private or public sector facilities.
8 CODING

The Green Paper states that:

108. Coding systems are an important component of health informatics and reimbursement. National Health Insurance will adopt a coding system that allows providers to uniformly report on the services rendered or goods provided for the purpose of reimbursement. The coding system must allocate a code relating to a particular service so that the National Health Insurance would be able to reimburse for the service with a full understanding of the service delivered or goods supplied. It is also important that the coding system provides the necessary health information on the burden of disease for the purposes of planning and decision making.

109. The reimbursement system for inpatient services will be according to disease related groups. A case mix or grouper system will be adapted for the South African environment drawing on good practices that are internationally accepted and have been successfully implemented in other jurisdictions.

8.1 The Importance of Coding

(Recommendations of the Committee on Standardisation of Data and Billing Practices - final document - February 2003):

The quality and integrity of data is increasingly becoming important in the health care industry as health information management evolves from record management to data management. Around the world, coding systems now form an essential part of the health information system. They enable the description of diseases, medical and surgical procedures, reasons for visits, severity of illness, drugs utilised, laboratory tests, pathology specimens, patient outcomes and a variety of other aspects of health care services.

Coding is important in that it allows for easy storage and retrieval of information for patient care, research, performance improvement, and planning and facility management. It also enables fair reimbursement for health care services provided and communicates in a predictable, consistent and reproducible manner. In addition, coding enable reliable communication about healthcare data among many participants in the health care industry.

When researching for possible coding structures, the following should be carefully considered:

a) It is a well-known fact that no international procedural coding structure is a perfect fit for the South African Healthcare Industry – amendments will have to be made to adapt it for local conditions.
b) It must be determined whether any coding structure is compiled for billing and/or data purposes?
c) Is the system specific enough for billing and data purposes?
d) If the system is too complicated or difficult to use this results in a steep learning curve and leads to incorrect coding actions requiring significant human and technology resources to support the coding process.
e) If the system is too simple it creates the possibility of abuse of the system.
f) Will the system be suitable for South African conditions?
g) Has the structure been successfully implemented elsewhere in the world and is it fully functional?
h) Are interpretations of the codes, billing and clinical guidelines available to support the coding?
i) Which elements would have to change to adapt the system for use in South Africa? Would the changes be acceptable by the users of the system? Would the changes be easy to incorporate in the system?

j) Would the system be compatible to current practice management systems and medical scheme software?

k) What is the cost and effort involved in obtaining permission to use the system in SA?

l) What are the costs involved in re-training the current coders to be able to update the new structure.

m) What are the costs involved in re-training the current users to be able to utilise the new system appropriately and correctly.

n) Is a DRG-Grouper available? Would the DRG-Grouper for the procedural coding structure be compatible with ICD-10 (diagnostic structure)?

o) Would the system be suitable for fee-for-service practices?

p) Is the coding structure available in the English language?

q) Is the system suitable for both the public and private sector?

r) Does the system make adequate provision for inpatient and outpatient services?

s) Does a proposed new system provide for all the various subsets of coding for other healthcare providers? (radiology, pathology, anaesthesics, general practice, surgical specialties and consulting specialities)

t) Are crosswalks available to CPT®?

u) How are the interdisciplinary relativity units determined? Which factors were taken into consideration, e.g. time, responsibility, complexity, liability insurance, etc.

8.2 Examples of international coding systems


The American Medical Association (AMA) describes CPT® codes as a listing of descriptive terms and identifying codes for reporting medical services and procedures. The primary purpose of the CPT® is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serve as an effective means for reliable nationwide communication among physicians (for South Africa – medical doctors), patients and third parties. The CPT® codes can also be used for claims processing and the development of guidelines for medical care review. The CPT® codes are revised every year by the CPT® advisory panel.

The CPT® identifying code is a five digit code which is linked to a descriptor comprising of approximately 7000 items. The items are divided into 6 sections namely; evaluation and management services, surgery, medicine, pathology and laboratory, radiology and anaesthesia.

The South African version of the CPT® is known as the Complete CPT® for South Africa (CCSA) and is based on the original CPT® codes together with South African specific codes. The CCSA incorporates the Resource Based Relative Value Scale (RBRVS) which provides a guideline for reimbursement of doctors’ services.

8.2.1.1 What Are CPT® Codes?

service a medical practitioner may provide to a patient including medical, surgical and diagnostic services. They are then used by insurers to determine the amount of reimbursement that a practitioner will receive by an insurer. Since everyone uses the same codes to mean the same thing, they ensure uniformity.

It should be noted that uniformity in understanding what the service is, and the amount different practitioners get reimbursed will not necessarily be the same.

CPT® codes are developed, maintained and copyrighted by the American Medical Association (AMA). As the practice of health care changes, new codes are developed for new services, current codes may be revised, and old, unused codes are discarded. Thousands of codes are in use, and they are updated annually. Development and maintenance of these codes is overseen by editorial boards at the AMA, and the publications of all the software, books and manuals needed by those who use them brings millions in income (*see note below) to the AMA each year.

8.2.1.2 Examples of CPT® Codes:

- 99214 may be used for a physical examination
- 90658 indicates a flu shot
- 90716 may be used for chicken pox vaccine (varicella)
- 12002 may be used to stitch up a one-inch cut on a patient's arm

8.2.2 DIAGNOSTIC CODING STRUCTURE FOR SOUTH AFRICA

The ICD-10 diagnostic coding structure was introduced in the South African healthcare industry using one schema for the whole healthcare industry. A National ICD-10 Implementation Task Team was established with the aim of implementing ICD-10 in South Africa.

8.2.2.1 National ICD-10 Task Team Review Document

8.2.2.1.1 ICD-10 implementation in South Africa

ICD-10 is a diagnostic coding standard owned and maintained by the World Health Organisation (WHO). This coding standard was adopted by the National Health Information System of South Africa (NHISSA), and forms part of the health information strategy of the Department of Health. The standard currently serves as the diagnosis coding standard of choice in both the public and private sector.

The purpose of ICD-10 is to translate diagnoses of diseases and other health problems from descriptions into an alphanumeric code, which permits easy storage, retrieval and analysis of the data. It also allows for the establishment of a systematic recording, analysis, interpretation and comparison of morbidity and mortality data collected within the country but also with other countries.

In the South African setting, ICD-10 coding is important in that it lends itself well to the improvement of efficiency of healthcare through appropriate and standardised recording of diagnosis, analysis of information for patient care, research, performance improvement, healthcare planning and facility management. It also enables fair reimbursement for healthcare services provided and communicates health data in a predictable, consistent and reproducible manner.

Discussions around coding for morbidity began around 1999 at the Private Healthcare Information Standards Committee (PHISC) and some healthcare stakeholders indicated that ICD-10 needs to be implemented in South Africa as a matter of urgency, for many reasons. At the same time, some discussions were taking place at NHISSA. In 2000, the Council for Medical Schemes, at the
request of the Minister of Health, held consultative meetings with providers and medical schemes in an effort to address concerns raised by health care providers with regards to poor payment of claims submitted on behalf of medical scheme beneficiaries. At the core of the problem was the need for greater standardisation of data collection, IT systems, and billing practices.

A process to standardise data and billing practices in the industry was started in 2001 with the formation of a Committee on Standardisation of Data and Billing practices. The Committee sought to address some of the concerns raised by providers and medical schemes. One of the key recommendations from the committee was the need for the development of appropriate coding standards for South Africa. In addition to this recommendation, the results of a survey conducted by the Council for Medical Schemes (CMS) to determine the type of information medical schemes were collecting and the quality thereof, revealed serious gaps and poor standardisation.

At the beginning of 2004, the CMS, the Department of Health and industry stakeholders formed a task team whose primary purpose was to develop recommendations for an appropriate strategic plan for the successful implementation of the ICD-10 in the public and private health sector.

This ICD-10 Review document outlines the progress made to date and the recommendations made by the task team and its subcommittees with regards to operational, technical, training and confidentiality issues pertaining to the implementation of ICD-10.

### 8.2.2.1.2 Rationale of the implementation of ICD-10

The rationale behind the implementation of ICD-10 is fourfold. Firstly, there was a need to standardise data collection processes in the industry. Secondly, regulation 5(f) of the Medical Schemes Act 131 of 1998 prescribes the manner of submission of claims by health services. Thirdly, there was a need to facilitate an efficient reimbursement system, for providers that was consistent with legislation and improves risk management practices by medical schemes. And lastly, the introduction of the Medical Schemes Act in 1999 saw the emergence of a minimum set of guaranteed benefits to be covered by medical schemes. Entitlement to these benefits is diagnosis-driven and is appropriately identified using ICD-10.

### 8.2.2.2 International Classification of Diseases (ICD)

Recommendations of the Committee on Standardisation of Data and Billing Practices - final document - February 2003

There are many coding systems for diagnosis and procedures around the world. Some of these coding systems are country specific. However, many countries tend to use the ICD or its derivatives. This system was developed as collaboration between the World Health Organisation (WHO) and 10 international centres in order that medical terms reported by medical and other personnel can be grouped together for statistical purposes. The ICD was developed out of a need for a standardizing classification concept and terminology in the medical field. It is designed to promote international comparability in the collection, processing, classification, and presentation of morbidity and mortality statistics. The reported conditions are translated into codes through the use of classification structures and the selection and modification rules contained in the applicable revision of ICD, published by the WHO.

The ICD is revised periodically (almost every 10 years) to incorporate changes in diagnostic terminology and advances in the medical field. WHO is currently in its tenth edition of the ICD. This differs from the ninth edition in several ways although the overall content is similar. The ICD 10 differs from the ICD 9 in the following ways:

- ICD 10 printed in three volume sets- as opposed to two-volume set
• It has alphanumeric categories rather than numeric categories

• Some chapters have been re-arranged, some titles have changed, and conditions have been regrouped

• Minor changes have also been made in the coding rules for mortality

The ICD is also used for a variety of other purposes including but not restricted to standardizing definitions: e.g. underlying cause of death, live births, maternal deaths and many others.

In South Africa, this coding system is currently being used by certain healthcare funders and health service providers for the classification of diseases for purposes of clinical risk management, claims processing and benefit design. It is also used in government for classification of diseases and recording of causes of death.

8.2.2.2.1 Extract from the World Health Organisation website regarding ICD

“ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. The classification is the latest in a series which has its origins in the 1850s. The first edition, known as the International List of Causes of Death, was adopted by the International Statistical Institute in 1893. WHO took over the responsibility for the ICD at its creation in 1948 when the Sixth Revision, which included causes of morbidity for the first time, was published. The World Health Assembly adopted in 1967 the WHO Nomenclature Regulations that stipulate use of ICD in its most current revision for mortality and morbidity statistics by all Member States.

“The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality and guidelines.

It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States”.

8.3 Important information to consider when deciding on a new coding structure

a) There is great value in using existing procedural and diagnostic structures due to current users being familiar with the system.

b) There exists significant intellectual property to assist in broader implementation of existing coding systems.

c) It is much more cost efficient to expand current systems than to implement new ones.

d) The procedural coding structure (DBM/CPT®) and the diagnostic coding structure (ICD-10) can be operated independently but must complement each other. This would also assist in vetting the systems independently.

e) It is recommended that a single procedural coding system be used for both in-hospital and out-of-hospital services to reduce confusion and the administrative burden. It also serves to create a standardised billing platform.
f) Current users with years of experience of an existing coding system are well suited to be mentors for new users of that system which minimises implementation costs and timeframes.
9 QUALITY AND EFFICIENCY

The Green Paper offers promises and potential for improvement of quality of healthcare services in the NHI.

For example, the Green Paper indicates that the first 5 years of NHI will include piloting and improvement of a number of specific areas. One of the stated areas is Quality Improvement (item 162).

The Green Paper also states that selection of 10 districts for piloting will be based on many factors, including a facility’s compliance with quality standards (item 160). Section 99 of the Green Paper mentions that “All health establishments (public and private) that wish to be considered for rendering health services to the population will have to meet set standards of quality. There are SIX core standards that form part of a comprehensive quality package. These standards deal with key quality principles that will improve SAFETY and facilitate access to healthcare services...”.

The proposed Office of Health Standards Compliance will also have continuous quality improvement as its core focus.

These proposals are welcome and it is the hope of SAMA doctors that these good intentions come to fruition and are implemented practically.

9.1 Existing Quality Related Challenges at Healthcare Facilities

9.1.1 Long waiting periods

The long waiting periods for patients at South African state facilities is well documented and need not be repeated here. SAMA offers the following recommendations to improve this aspect in the interest of delivering quality care.

9.1.1.1 SAMA suggests the following interventions to alleviate the long waiting periods in hospitals:

- Proper patient education about the type of services and the best time to access them
- Overhaul the entire filing system; improve on technology like computerized filing systems
- Proper appointments should be made, and patients should follow them so that files can be opened well in advance of the appointment
- Integrate services where possible; one-stop shop will save a lot of time and improve on-time efficiency.

9.1.2 Safety

The importance of safety and security cannot be overstated. Security in the hospital is a concern not only for the staff members but also for the patients. An unsafe hospital is unsafe for both the staff and the public. SAMA is concerned about the many complaints it receives from its members regarding unsafe working environments. Unfortunately the medical profession has borne the brunt of security lapses and has dearly paid through the deaths of some of its own.

SAMA takes this opportunity, therefore, to highlight some of the challenges already noted:

a) The real security threats are not targeted. Health workers are subject to an indiscriminate search policy at facilities. For example staff members are searched by guards at the gate, looking for hospital property while members of the public walk in and out of the health...
facilities without undergoing the same checks. This has led to members of the public entering hospitals with dangerous weapons at times.

b) The current procurement system has not really assisted as many of the company directors awarded contracts have no security experience. They often maximise profits while exploiting their employees. This results in unhappy personnel being responsible for providing health workers with security.

c) Different health facilities across and within provinces have different standards in terms of the security offered. There is no standardisation. It is unclear what compliance standards these companies are expected to deliver upon.

d) The hospital management has no authority to hire and fire. Even in instances when a security company has failed to deliver appropriate services, the management in the hospitals have no authority or powers to terminate their contracts.

e) Security personnel are often situated mainly at the gates. Often none are present in the critical areas within the premises such as casualty and maternity wards.

f) Security personnel are unarmed. Criminals are fully aware of this and thus health facilities are easy targets for criminals.

g) There are often too many points of entry into the facilities. In instances where there is a shortage of security personnel, this leaves other access points exposed of inadequately staffed. In some facilities the fences are not maintained and the public have made their own gates through the defects in the fences.

h) Access is also not well controlled. Rowdy groups and inebriated people are frequently allowed to enter hospitals and even the casualty section. This often puts staff and patients at risk and also makes it difficult for the health workers to render services.

i) The lighting in dark passages and at doctors’ residences is often none existent. These poorly lit areas leave staff exposed.

j) There is a serious lack of security equipment in the facilities. Criminals can therefore access the hospitals with dangerous equipment at will.

9.1.2.1 **SAMA recommends the following interventions to address safety concerns:**

- We propose that the state creates a system of appointing its own qualified security personnel.
- Department of Safety and Security should be given that mandate of providing all our hospitals with security. Security personnel in hospitals should be employed government personnel.
- The hospital management should be given the authority to hire and fire security companies.
- There should be standardisation of the level of security that is offered at all health facilities. This should be the same across all provinces.
- Regular security risk assessment should be conducted to ensure that compliance standards are adhered to
- Dedicated security personnel should be allocated in areas such as casualty, maternity, neonatal and psychiatry wards. Other wards should be patrolled at defined intervals, with more of these being conducted at night.
- Staff residences should also be patrolled at regular intervals.
- Adequate lighting should be provided in dark corridors and open places, and these too should be patrolled regularly
- At least two security guards in each shift should be armed and trained to protect the staff and the patients.
• Each facility should have a maximum of two gates, one for staff members and one for the public. These would be easier to control.
• Access control should be stricter. No inebriated people or rowdy groups should be allowed into the facility, unless such a person is a patient requiring urgent medical attention.
• Access to areas such as casualty should be restricted. Escorts should use waiting areas and not enter the consulting area. Only with the permission of the treating doctor should family be allowed in. Access to maternity and neonatal wards should be restricted to parents only.
• All entry points should be equipped with metal detectors and scanners. CCTV should be installed. It is important that these are maintained and serviced regularly
• It should be standard that all hospitals have palisade fencing. This too should be well maintained
   On-call rooms for doctors should be close to where they are stationed and should be secure. If this is not possible, the doctor should be escorted by security personnel at night.

9.1.3 Pharmacy services

There are notable loopholes in the drug storage, dispensing and distribution system. One of the key problems is poor procurement and supply systems for drugs. There is no uniformity in drug control. For example, in some provinces certain drugs are motivational items while in others they are not. In addition, there is the lack of coordination with the private sector. This poses a serious risk of drug resistance.

We propose that there will be benefit it dispensing of ARV solely at the ARV clinic could be extended to other departments to reduce congestion and long queues at the main pharmacy. Another proposition would be to have pharmacist or a pharmacy assistant assigned to dispense chronic medications in the medical OPD the same way they do in wellness clinics.

9.1.4 Laboratory services and other diagnostics

SAMA echoes the sentiments of the Minister of Health about too much wastage through unnecessary laboratory tests. In some rural hospitals and clinics, the turn-over for results is too long, up to two weeks for some. Specimens have to be transported long distances for tests because of lack of expertise and/or equipments. Under the worst circumstances, a lot of results of these tests remain unchecked, or uninterrupted.

The following Table offers SAMA’s recommendations in this regard:

- Attach a price next to each test so as to put monetary value on tests - this may discourage unnecessary tests
- Each province should have its own fully functional central laboratory and radiology departments
- Efforts should be made to improve on the turnover of results, especially in the rural clinics and hospitals. Reporting should be improved, where severe abnormalities should be reported telephonically to expedite treatment.

9.1.5 Medical Equipment

Medical devices/technology/equipment is an essential building block of a quality health system. These can be bought, leased or rented. Adequate planning is required from the local facility to overcome bureaucracy within the procurement process that leads to slowed service delivery and staff dissatisfaction.
The current NHI green paper document does not address the issue of medical technology/equipment planning, commissioning and investment. Various models of procurement have been adopted under different health financing models. However the principles of transparency, safety and staff training are critical. Policy around medical devices is necessary. There is no sufficient data available at present to assess progress/backlog and to determine current expenditure.

10 TIMEFRAME FOR NHI ROLLOUT & PILOTTING IN DISTRICTS

The timeframe for the roll out of NHI as well as the proposal for the pilot in the 10 districts is not a major concern at the moment.

11 PARALLEL PROCESSES TO NHI ROLLOUT

Improving public health infrastructure and services is a priority. The ongoing improvement of infrastructure and the building of new hospitals is a step in the right direction.

SAMA welcomes the ongoing improvement of hospital management and also welcomes government’s efforts to improve production of medical doctors, particularly the building of a new medical school in Limpopo.

12 CONCLUSION

The accuracy of predictions on the success or failure of the NHI will be determined by the inputs from doctors that are included in the next NHI policy document. SAMA and its doctors look forward to participating with Government in moulding a sustainable healthcare system for all South Africans through this vital reform mechanism.

As such SAMA trusts that its contributions will be of value and will be taken into consideration during all phases of the NHI implementation process.
INPUT TO SAMA’s NHI GREEN PAPER RESPONSE BY:

13.1 SAMA COMMITTEE FOR PUBLIC SECTOR DOCTORS (CPSD)

This document incorporates inputs by various structures falling under the CPSD.
13.1.1 JUNIOR DOCTORS ASSOCIATION OF SOUTH AFRICA (JUDASA)

13.1.1.1 Standardization of Skills Development Training for All Health Workers:

Skills development training courses (e.g. ATLS) should be standardized and availed to all health professionals at all hospitals under NHI, as part of improving the quality of health care services. The funding for such training should be centrally coordinated by the National Department of Health.

Currently the availability of such training for workers is left at the discretion of hospital managers. As a result, some hospitals offer skills development courses for their health workers, whilst others do not, and this disadvantages the health workers and the patients they serve.

13.1.1.2 Strengthening of the OHSC:

The Office of Health Standards Compliance (OHSC) should be strengthened not only to set quality standards for all NHI accredited institutions, but to deregister those that do not meet quality standards as set by the OHSC. It should also be independent of the Department of Health, as reflected in the main SAMA submission.

13.1.1.3 NHI Should Run Concurrently with Rural Development:

An NHI implemented in isolation will not address all the problems that lead to ill-health and that influence the quality of health care and human resource challenges. Hence NHI should run concurrently with a robust Rural Development programme to address key areas of development such as quality basic education, telecommunications, roads and transport, water and sanitation, and decent housing.
3.1.2 ACADEMIC DOCTORS ASSOCIATION OF SOUTH AFRICA (ADASA)

3.1.2.1 Education

Education is one of the key elements needed for the implementation and successful running of NHI.

Both people at the grass roots and health workers, and anything/anybody in between, should be educated about NHI.

a) Community
   a. The community should understand who needs to consult where
   b. They should also be able to understand why they get turned away at certain levels of health care, for them to start at another level.
   c. Tertiary institutions to perform tertiary work, same as quaternary institution

b) Health Professional
   a. Should be work-shopped to understand their limitations
   b. Therefore, early referrals should be encouraged, where necessary

3.1.2.2 Infrastructure

The government’s plan to build 5 more new flagship hospitals is greatly welcomed. However, the success of NHI does not rest on these new hospitals only, therefore, older hospitals e.g. Charlotte Maxeke, Steve Biko, Inkosi Albert Luthuli, etc., should be refurbished where necessary or high standards of maintenance should continue.

3.1.2.2.1 Hospital environment (Physical environment)

Better hospital physical environments yield better patients outcomes and increase staff effectiveness, reduce errors and therefore staff satisfactions (Ulrich et al. The role of the physical environment in the hospital of the 21st century: A once-in-a-lifetime opportunity)

Hopefully, this shall be taken into consideration as these hospitals are designed and ultimately commissioned

a) Output
   a. Outputs in tertiary services have in the recent past, been very limited.
   b. Factors contributing to these reduced outputs include, but are not limited to:
      i. Reduced theatre time, especially for surgeons. These, as a result of several bottlenecks which include companies not being paid or paid late, lack of streamlining in the procurement sections, old infrastructure (building/equipment, aircon, etc.) which from time to time need maintenance, etc.
      ii. ICU’s not being able to accommodate the number of patients that the hospital admits because of a limited number of ICU beds; again faulty or old equipment, lack of staff, etc.
   c. Wards
      i. Climate change has brought very obvious changes to our weather patterns,
ii. Summers are very hot and winters very cold. Our wards should cater for both extremes of weather patterns. It is therefore imperative to have climate controls in our wards in an attempt to increase patients and staff comfort.

13.1.2.3 Equipment

a) It is imperative that all spheres of tertiary and central hospitals, as well as district and regional hospitals, should be equipped with the necessary equipment that will allow them to carry out their mandates without hindrances. These equipments should conform to the world standard.

b) The equipment should come with a service plan and/or replacement plan. The lives of some equipment may be 3, 5, 10 yrs, etc. It is unacceptable that currently in public hospitals, equipments that are 20 to 30 yrs old are still being used. This compromises service delivery.

c) It is assumed that the new hospitals will be equipped with the necessary equipment. It is important that the other existing hospitals equipment be upgraded as well.

13.1.2.4 Staff

a) Tertiary and central hospitals should be given more powers to train staff. This entails expansion in training facilities, and trainers themselves.

b) Centres of excellence should be developed by:

   a. Establishing programmes such as “training the trainer”. Making funds available for trainers to go and gain more knowledge related to their fields for 3-6 months on an ongoing basis, with the aim of coming to plough back.

   b. Government should be commended for trying to train more doctors and nurses. But we are now 20 yrs behind because of previous closure of nursing colleges and therefore training of these health professionals should be treated as urgent.

   c. Attention should be paid to the training and improved production of support staff in the country viz: physiotherapists, radiographers, occupational therapists, dieticians, etc.

   i. No health service can function adequately without the support of these professionals.

   ii. Equipments and improved remuneration of these professionals should be looked at as well.

13.1.2.5 Research

a) Funds should be made available for the establishment of research labs especially in the tertiary and central hospitals.

b) Coupled with research labs, hospital information systems should be markedly improved. Currently a lot of data and material that could be used for research purposes is lost because of poorly managed patient information.

c) Government should be encouraged to enforce databases for the different departments and institutions, so as to improve on quality control.

d) These measures may encourage staff to be more involved in research especially in institutions where these research labs are not available.
a. Industry should be encouraged to sponsor these research labs.

13.1.2.6 Diet

Hospital patient’s diet should be improved markedly as this plays a major role in improving/increasing patient’s survival in hospital.

13.1.2.7 Budgets

a) Currents efforts to improve funding are commended. This is also addressed in the green paper. For a nation to be economically productive, it also needs to be healthy emotionally and physically. As it is said “Mens sana in corpore sano”.

b) Better health funding should be encouraged all the time.

13.1.2.8 Other Issues to Address

1) It is imperative that the following three areas be addressed adequately. Failure to address them shall result in absolute failure of NHI.
   a) Management
   b) Information technology (HIS- included)
   c) Logistics( including revenue collection.
2) We need to re-establish the clinical guidelines programme
3) The Cuban Training Programme must be terminated
4) ADASA needs to develop novel ways to train South African doctors
5) ADASA and SEHDASA will compile a regulating document on RWOPS and other models which should be presented to the Ministry of Health
6) Hotline and electronic system must be established for members to voice complaints and challenges
7) SAMA to demand stricter control of “backstreet” abortions;
8) GP’s to abolish the practice of inducing abortion and not carrying through the procedure
9) The nurses fraternity must offer more supportive services to CTOP patients, especially teenagers
10) SAMA together with the Department of Education must work together to develop a comprehensive plan on reproductive health
11) SAMA calls on the HPCSA to regulate the use of the title “doctor”
12) Professionalism in the medical fraternity must be re-established, re-engineered and revitalised
13) A rural development programme, including recreational & educational facilities, must be established
14) The district health services cannot be managed by the current managers of the health districts under the current system
15) Work with DENOSA on our common issues to have a strong voice in submission of our proposals for NHI
16) Workshops are coordinated to guide supervisors and employees on developing the PMDS document
17) SAMA, together with the Department of Health, to develop a PMDS document that is doctor specific
18) SAMA supports the idea of having central hospitals fall under the jurisdiction of the National Minister of Health
19) The National Health Ministry should urgently standardise the implementation of the Joint Health agreement between universities and the Department of Health
### 13.2 SAMA COMMITTEE FOR PUBLIC SECTOR DOCTORS (CPSD) OPERATIONAL PLAN

#### STATUS OF TASK

<table>
<thead>
<tr>
<th>STATUS OF TASK</th>
<th>COLOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN = COMPLETED</td>
<td>GREEN</td>
</tr>
<tr>
<td>IN PROGRESS AND ACHIEVABLE</td>
<td>ORANGE</td>
</tr>
<tr>
<td>POSSIBLE BUT NEEDS RESOURCES OR HAS SOME OBSTACLE</td>
<td>RED</td>
</tr>
<tr>
<td>POLITICAL MATTER TO BE TENDED TO BY ONE OF THE SPECIAL INTEREST GROUPS (SIGs)</td>
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</tr>
<tr>
<td>PARTNER WITH FPD TO ACHIEVE THIS OBJECTIVE</td>
<td>MAROON</td>
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#### 13.2.1 GOAL 1: STIMULATE DEBATE ON NHI

**13.2.1.1 Objective 1- Provide information to members**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create electronic platform</td>
<td>GM and Communications</td>
<td>immediate</td>
<td></td>
<td>Complete setup of dedicated email, website post and blog</td>
<td>Website development, IT and Communications input</td>
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<tr>
<td>Post relevant documents on the electronic platform</td>
<td>NHI task team to create relevant documents</td>
<td>Oct 2011</td>
<td></td>
<td>Uptake of document</td>
<td></td>
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<tr>
<td>Create compact version (media statement)</td>
<td>NHI task team</td>
<td>Oct 2011</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create special edition of Medigram (hardcopy)</td>
<td>SAMA communication (hard copy)</td>
<td>Dec 2011</td>
<td>Jan 2011</td>
<td></td>
<td>• Printing Costs</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Communication to cut costs</td>
</tr>
<tr>
<td>Special coverage in all SAMA publications</td>
<td>SAMA communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consolidated Document on SAMAs view of NHI- well researched quality document</td>
<td>HP Committee and NHI task team</td>
<td>Sep 2011</td>
<td>Jan 2012</td>
<td>Comprehensive Document with multiple inputs</td>
<td></td>
</tr>
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**Total budget for objective**
### 13.2.1.2 Objective 2- Create platform for debate

<table>
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<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
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<td>Provincial visits and road shows</td>
<td>SAMA Head office in consultation with branches--</td>
<td>Dec 2011</td>
<td>Feb 2012</td>
<td>Number of branches visited</td>
<td>WILL REQUIRE BOARD APPROVAL (R100000)</td>
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**Total budget for objective**

### 13.2.2 GOAL 2: INCREASE DOCTORS IN THE PUBLIC SECTOR

#### 13.2.2.1 Objective 1- Increase production

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
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<tr>
<td>Define the requirements to increase production and alternative solutions to increase production</td>
<td>CPSD through SIGs</td>
<td>immediately</td>
<td>February 2012</td>
<td>Document that compiles the solutions to doctor shortages in SA</td>
<td>Get university reports to minister on increasing numbers. Then develop solutions.</td>
</tr>
<tr>
<td>Audit in February 2012 on intake versus output once a year</td>
<td>SAMA Research unit working with SIG</td>
<td>February 2012</td>
<td>May 2012</td>
<td>Ration of input: output of students</td>
<td>Will require visit to the 8 medical schools (could be coupled with SIG visits)</td>
</tr>
<tr>
<td>Commission a study to investigate reasons for poor completion rate</td>
<td>SAMA Research unit</td>
<td>May 2012</td>
<td>July 2012</td>
<td></td>
<td>Office Based do not additional resources (lends on outcome of above survey)</td>
</tr>
</tbody>
</table>

**Total budget for objective**

#### 13.2.2.2 Objective 2 - Promote professionalization of medical education- good teachers

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit UFS to see best practice</td>
<td>ADASA/SEDHAS  A</td>
<td>May 2012</td>
<td>May 2012</td>
<td>Compile report of best practice</td>
<td>Consider having CPSD meeting here. Budget from SIGs</td>
</tr>
<tr>
<td>Meet the committee of Deans to encourage lecturers to undergo teaching training</td>
<td>ADASA to lobby</td>
<td>Mar 2012</td>
<td>Mar 2012</td>
<td>Number of universities who institute formal teach the teacher programs thereafter</td>
<td></td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.3 GOAL 3: TO INCREASE NUMBER OF DOCTORS IN PUBLIC SECTOR

#### 13.2.3.1 Objective 1 - Improve retention of doctors

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create rating system for all hospitals in SA (and create document of minimum standards)</td>
<td>GM, Communications</td>
<td>Oct 2011</td>
<td>Ongoing</td>
<td>Number of hospitals that are rated by doctors</td>
<td>NIL- Electronic, Data to be analysed by KMRD</td>
</tr>
<tr>
<td>Work closely with FPD and AHP to use district</td>
<td>Head of Pubsec and FPD</td>
<td>Feb 2012</td>
<td>Ongoing</td>
<td>Number of case managers and</td>
<td>Partner with FPD</td>
</tr>
<tr>
<td>Model of HR case mangers to solve doctors’ HR problems</td>
<td>SIGs as part of university road shows, to work with PSU</td>
<td>Mar 2012</td>
<td>Aug 2012</td>
<td>Number of talks given on OSD by SIGs</td>
<td>University road show budgets</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Empower and educate on OSD and monitor implementation, as well as PMDS</td>
<td>SIGs as part of university road shows, to work with PSU</td>
<td>Mar 2012</td>
<td>Aug 2012</td>
<td>Number of talks given on OSD by SIGs</td>
<td>University road show budgets</td>
</tr>
<tr>
<td>Expand activities of IR to include retention of doctors issues</td>
<td>Head of Pubsec</td>
<td>Feb 2012</td>
<td>Apr 2012</td>
<td>More longer term but can currently use IR centre</td>
<td></td>
</tr>
<tr>
<td>Lobby for RWOP’s and RWIP’s</td>
<td>SIGs to work together</td>
<td>Mar 2012</td>
<td>Aug 2012</td>
<td>Position document on RWOPS</td>
<td>Nil</td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.3.2 Objective 2 Improve recruitment of doctors

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of number of funded vacant posts per facility (number and percentage that are funded)</td>
<td>Public Sector Unit, KMRd and AHP to collaborate on this project</td>
<td>May 2012</td>
<td>Dec 2012</td>
<td>Number of facilities audited</td>
<td>Office based</td>
</tr>
<tr>
<td>Survey doctors (why they don’t go to rural facilities and why they leave the public sector)</td>
<td>Public Sector to work with KMRD and SIGs</td>
<td>Mar 2012</td>
<td>Dec 2012</td>
<td>Position Document to lobby government</td>
<td></td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.4 GOAL 4: REDUCE THE BURDEN OF NON-COMMUNICABLE DISEASES

#### 13.2.4.1 Objective 1 - Re-establish guidelines generating structure at SAMA

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify priority diseases</td>
<td>SAMA (and FPD)</td>
<td>01/01/12</td>
<td>Ongoing</td>
<td>Guideline on DM,HPT, asthma, Ca Cx (6 per year)</td>
<td>Expert committees and appointment of clinical guidelines consultant</td>
</tr>
<tr>
<td>District level implementation</td>
<td>SIG</td>
<td></td>
<td>At least 6 revised guidelines per year</td>
<td>IT, SNT, expert panels</td>
<td></td>
</tr>
</tbody>
</table>

**Total budget for objective**

#### 13.2.4.2 Objective 2 - Mobilise support for the cancer registry

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>EST(SAMA)</td>
<td>Feb 2012</td>
<td>Aug 2012</td>
<td>Updated comprehensive national registry</td>
<td>FPD has Seconded staff to NIOH. Use this resource.</td>
</tr>
</tbody>
</table>

**Total budget for objective**
### 13.2.4.3 Objective 4-Advocate for circumcision

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult and neonatal circumcision at all provinces</td>
<td>Health policy committee of SAMA with urology society</td>
<td>Apr 2012</td>
<td>Oct 2012</td>
<td>Number of circumcised males</td>
<td>Staff training awareness (FPD ahf funds for this)</td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.5 GOAL 5 REDUCE THE BURDEN OF VIOLENCE AND INJURY

### 13.2.5.1 Objective 1- Reduce rape statistics

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase crisis centres access</td>
<td>Institutional SAMA doctors</td>
<td></td>
<td></td>
<td>Minimum 1 crisis centre per district</td>
<td>SAMA member involvement</td>
</tr>
<tr>
<td>Empower stakeholders with knowledge and skills to manage victims of Violence and Injury</td>
<td>SAMA branches</td>
<td>Feb 2012</td>
<td>May 2012</td>
<td>Competent staff Medical Curricular change</td>
<td>Work with FPD who already have funding for this</td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.6 GOAL 6: IMPROVE OBSTETRIC MANAGEMENT

### 13.2.6.1 Objective 1- Improve ANC

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve outreach</td>
<td>All experienced O&amp;G</td>
<td>Feb 2012</td>
<td>May 2012</td>
<td>Visit@ least 1 hospital/month</td>
<td>Vehicles/equipment</td>
</tr>
<tr>
<td>Education &amp; training</td>
<td>All experienced doctors</td>
<td></td>
<td></td>
<td>ESMOE program training with attendance registers</td>
<td>Books, computers,</td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.6.2 Objective 2 Optimised postnatal care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equitable staffing between ANC &amp; PNC</td>
<td>O&amp;G doctors to highlight to Mx</td>
<td></td>
<td></td>
<td>Meeting of staffing norms</td>
<td>Staffing norms</td>
</tr>
<tr>
<td>Multidisciplinary co-operation within PNC</td>
<td>O&amp;G and related disciplines doctors</td>
<td></td>
<td></td>
<td>Documented joint ward rounds and review meetings</td>
<td></td>
</tr>
<tr>
<td>Improved auditing in maternal healthcare provision</td>
<td>All discipline doctors</td>
<td></td>
<td></td>
<td>Documented meetings with HoD accountability to DoH</td>
<td></td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.6.3 Objective 3 Timeous, appropriate HIV therapy for pregnant mothers

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL DOCTORS to do HIV C&amp;T and therapy</td>
<td>All doctors</td>
<td>Dec 2011</td>
<td></td>
<td>Numbers of patients with no</td>
<td>FPD has funding for training</td>
</tr>
</tbody>
</table>
Initiation, as well as TB treatment training

Decentralising ART to doctors

HoD

Number of patients initiated and reduction of numbers

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education on HIV at each consultation</td>
<td>All doctors</td>
<td>22 August 2011</td>
<td>Ongoing</td>
<td>No. Of patients tested for HIV</td>
<td>Posters, Videos</td>
</tr>
<tr>
<td>Fast track MMC</td>
<td>All Doctors</td>
<td>Jan 2012</td>
<td>Ongoing</td>
<td>100% of junior doctors trained on circumcision</td>
<td>Equipment, Roving trainers</td>
</tr>
<tr>
<td>Conduct HCT campaigns</td>
<td>All doctors</td>
<td>01 December 2011</td>
<td></td>
<td>70% of individuals counselled test for HIV</td>
<td>Consider partnering with PPD and DPSA project</td>
</tr>
</tbody>
</table>

Total budget for objective

**13.2.7 GOAL 7: COMBAT HIV AND AIDS**

### 13.2.7.1 Objective 1- Reduce New HIV Infections

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate a doctor driven “Man for health” campaign</td>
<td>Provincial representatives</td>
<td>01 December 2011</td>
<td></td>
<td>All provinces launching campaigns by 01 December 2011</td>
<td>Finance, Human</td>
</tr>
<tr>
<td>Create a SAMA adopt a primary health care clinic model</td>
<td>All doctors</td>
<td>Jan 2012</td>
<td></td>
<td>All clinics having a SAMA mentor</td>
<td>Human</td>
</tr>
</tbody>
</table>

Total budget for objective

### 13.2.7.2 Objective 2- Increase access to antiretroviral treatment

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding of research</td>
<td>EST</td>
<td>2012</td>
<td></td>
<td>One study into new treatment options funded in 2012</td>
<td>Finance</td>
</tr>
</tbody>
</table>

Total budget for objective

### 13.2.7.3 Objective 3 - Investigate new treatment options for HIV

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
</table>

Total budget for objective
### 13.2.7.4 Objective 4 - Strengthen prevention of mother to child transmission

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsel and test all pregnant women on HIV</td>
<td>All doctors</td>
<td>22 August 2011</td>
<td>Continuous</td>
<td>100% of pregnant women tested for HIV</td>
<td>Testing kits</td>
</tr>
</tbody>
</table>

**Total budget for objective**

### 13.2.8 GOAL 8: IMPROVE MANAGEMENT OF THE SERVICES

### 13.2.8.1 Objective 1 Management Support

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsibility</th>
<th>Start Date</th>
<th>End Date</th>
<th>Outputs &amp; Indicators</th>
<th>Resources Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem identification to pick up problems – such as shortages</td>
<td>SAMA development of tool and distribution to its members, Work with FPD who is currently training for the standards and office of compliance</td>
<td>Jan 2012</td>
<td>Dec 2012</td>
<td>Tool production and pilot @ 10% of all provincial hospitals</td>
<td>IT development similar to CHIP and PPIP</td>
</tr>
<tr>
<td>Management training via strategic partnerships of SAMA</td>
<td>SAMA National Chair &amp; CPSD head</td>
<td></td>
<td></td>
<td>Training program development and piloting</td>
<td>FDP management training course &amp; organisational support</td>
</tr>
</tbody>
</table>

### 13.2.9 STAFF REQUIREMENTS

<table>
<thead>
<tr>
<th>New Employees Required - Summary</th>
<th>APPROVED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal #</strong></td>
<td>Position</td>
</tr>
<tr>
<td>Knowledge Management and Research Manager</td>
<td>FEB 2012</td>
</tr>
<tr>
<td>Clinical Guidelines Consultant</td>
<td>May 2012</td>
</tr>
<tr>
<td>Field workers for various audits (contract)</td>
<td>Mar 2012</td>
</tr>
</tbody>
</table>

**Total for Department**

### 13.2.10 ASSETS REQUIREMENTS

<table>
<thead>
<tr>
<th>Assets to be Purchased - Summary</th>
<th>APPROVED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal #</strong></td>
<td>Asset Required</td>
</tr>
<tr>
<td>Field Survey and analysis software</td>
<td></td>
</tr>
</tbody>
</table>

**Total for Department**
13.3 THE SAMA GENERAL PRIVATE PRACTICE PRACTITIONERS (GPPPC) COMMITTEE

The NHI Green Paper is vague on details on exactly how the GP will fit into the Primary Health care model. However at the recent road shows the MOH emphasised that this is deliberate as the DOH want to collaborate with all stakeholders and get as much input and suggestions. Dr. Aaron Motsoaledi admitted that there is such vast differences from region to region that one model to fit all will not work. The DOH will look at a hybrid funding model with elements of capitation, fee for service, salaries, DRGs and incentive options.

Therefore SAMA PPU can assist in giving guidance and assistance to the profession and the DOH when looking at specific models for specific regions, can assist in designing an NHI system that benefits not only the entire South African population, but also the medical profession.
The declaration of *Alma Ata* states that Health was a basic human right that cannot be restricted to those who can afford private healthcare. This declaration was adopted in the World Health Organisation (WHO) and Section 27 of the South African Constitution.

South Africa is challenged with a fourfold pandemic:

a. Maternal and child mortality – 1% of global burden – 2-3% higher than comparable countries
b. HIV/AIDS - 17% of world burden South Africa 23 times more than other comparable countries. TB – 5% of world burden South Africa 7 times more than other comparable countries
c. Non communal disease - <1% of global burden – 2-3% higher than comparable countries
d. Violence and Injury – 1,3% of global burden injuries – 2-3% higher than comparable countries injuries and 5% of global homicides’.

Of priority is to Increased Life expectancy, since South Africa had the lowest life expectancy of all countries with similar sized economies.

The DOH wants to address these challenges by addressing 5 critical matters:

a. Infrastructure development and improvement
b. Increasing human resource capacity, improving quality and enforcing accountability.
c. Improvement of the quality of health in the public sector.
d. Re-engineering the primary healthcare system by moving to a preventative healthcare model.
e. Reducing the cost of healthcare in both the private and public sectors.

The GP can assist in all of these critical matters considering the following research outcomes:

- 30% - 70% of patients for average GP belong to a medical scheme
- 75+% of GP’s has a good understanding of manage health care
- 80% of GP’s have capacity to see more patients
- 38% of GP’s said that better remuneration will let them work in public sector
- 27% said better working conditions will let them go back to public sector
- GP’s are prepared to work a certain amount of hours in the public sector
- 55% of GP’s will apply for NHI
- GP’s in South-Africa is an experienced and skilled human resource as showed in the picture below
It is known that the Private sector consumes 5% of GDP and the Public sector consumes 3.5% of GDP with the poorest health outcomes. This main contributors being:

- Hospital Centralism
- Fragmentation of delivery of healthcare
- Uncontrolled commercialism of the private sector that needs firm control.

Considering these facts as well as the graft below.
A shift in private health care spend can contribute considerable in releasing current monies to be spend on healthcare and not on non-healthcare cost.

It is therefore important to integrate private and public healthcare at the level of primary healthcare. With current Health reform policy can shift the focus back to Primary Care away from hospital focused care. To do this Medical Aids benefit design need to be addressed urgently.

### 13.3.1 How would the GP get involved?

The point of entry to all patients should be at primary care level at ward or district level.

All willing and able GP’s would integrate in the evolving Primary Health Care model as being proposed by the Green Paper. Within the current wards and districts their current location and infrastructure could be used to develop proper multidisciplinary clinics with sections that focus on wellness and prevention. Current partnerships with existing medical aids and partners can be used and harvest to finance the integration and collaboration and development of these clinics and practices so that there are not duplication of all of these projects for each medical aid and NHI but proper integration of all services at primary level. This will increase the scope of practise of the GP as well as up skill them and increase their income base. With information sharing between the Department of Health and the local GP’s and assistance from SAMA the logistic of specific areas can be dealt with individually to ensure that the GP’s comply with the Municipal ward-based teams. These clinics will shift the Medical Aid and NHI patient back to the District specialist teams’ level and Primary Physician if a higher level of care is needed. Some of the existing bigger practices can also be integrated into the district health systems and the more experienced GP’s working in areas where there is no applicant or shortage of resources can full fill the duty of the Primary Physicians. This can assist in addressing the shortage of doctors and nurses as the personnel in the practices can be utilised.

With proper collaboration and integration GP practices can change into proper NHI primary facilities or can work in collaboration as an extension of a bigger group as a virtual practice. The actual detail will be determined regionally and according to the local requirements and resources. Within these practices future Family Physicians and other members of the multidisciplinary team can be trained hands on with a senior GP’s or professional guiding and overseeing the training.

Small rural practices can link up with bigger practices to provide a more comprehensive service with the GP acting as manager of the region.

It is important that SAMA assist in the development of accreditation of GP practices to upgrade all practices over the next 5 years. All practices need to be involved and will be audited and certified by the COHSASSA. SAMA will assist in the pilots as far as possible to gain insight and to play a facilitating role and leadership role for future development. Furthermore the GPPPC wants to:

- Reclaim scope of practice of GP’s
- Delivery at primary level – measured outcomes – bring down overall cost. Determine the value of GP’s in terms of financial remuneration
- Re-skill of GP’s to what is practical and improve IT and administrative management of surgeries to be more effective in a managed care set-up
- Learn GP’s to work as a team in both state and private sector and to trust each other
- Bottom up approach with financing and GP driven managed primary care – what does the patient need – not to fit sick patient in a financial model
• Link with DOH in this planning with – National, Provincial, District Health
• Plan and prepare GP’s for the future healthcare scenario as team leader within primary care/district health
• CPD activities to suit special needs for the appropriate re-skilling and not rehash what GP’s know well.
• Planning around Primary Healthcare facilities with short-stay and emergency facilities to which individual GP’s in the region can link up with to ensure that no single GP are left out of the loop.
• All the above to influence the millennium goals of the Department of Health

13.3.1.1 School Health Services

As indicated in the Green Paper School health services will be delivered by a team that is headed by a professional nurse. The services will include health promotion, prevention and curative health services that address the health needs of school-going children, including those children who have missed the opportunity to access services such as child immunization services during their pre-school years.

As School health is an integral part of the comprehensive package of primary health care services that must be delivered to every school in the district. Also here the GP working in an accredited practices can be the referred doctor to which the professional nurse refers problematic cases that needs attention with general state of physical, mental health and well-being and further referral. This will apply to school going children including pre-Grade R, and Grade R up until Grade 12. As practices will get involved with preventative care and wellness and will have a multidisciplinary focus other areas of the school health programme which include focus on child and sex abuse, oral health services, vision screening services, eradication of parasites, nutritional services, substance abuse, sexual and reproductive health rights including family planning services, and HIV and AIDS related programmes could be

13.3.2 The proposed Capitation fee system

A specific capitation model to fit all will not work. The Minister of Health indicated that the Department of Health would explore various options as well as different option for different regions.

Various models exist currently in the private sector. What is clear is that all of these models are based on financial models that will suit the medical aid industry and their risk and not the need of the patient. The GP takes considerable risk, remains out of pocket and the basic healthcare needs of the patient are not addressed. The following graphs are proof thereof:

GP payouts from 1980-2009 compared to total health payout
It is of utmost importance that proper models need to be developed in collaboration with the GP and the PPU to ensure that the model ensures that the **GP remains financially viable** and that the **full primary health care needs of the patient are addressed in this model to prevent unnecessary high upstream cost**. The use of quality assurance measurements by the profession for the profession will promote and ensure good clinical and ethical practise and prevent unnecessary price wars between practices in close proximity. All of above will also prevent a further brain drain and rather promote members of the profession in other countries to return and become part of the Primary care environment.

These models should not only be based on current practise cost but best health outcomes. Best Health outcomes in a Primary set up, wellness and prevention and all expenses relating to the perfect model in a specific set up need to be included in the calculations. As in other professions a rating towards years of experience, extra qualifications and location should also be factored in.

In order to calculate the cost associated with the provision of service and performing of procedure, a number of variables that contribute to costs have to be taken into account. Thereafter the conversion of the costs to a cost per minute or capitation fee or variable combinations must be calculated. The first is based on certain standard volumes of available time and certain productivity factors. It allows for a multiplication of the cost of the variables with the average duration of the procedures and services in order to arrive at a cost for service and procedure.

**Practice costs**
In the case of medical practitioners these costs should represent the running costs (exclusive of value added tax) of a medical practice including the costs pertaining to the acquisition and maintenance of furniture, fittings and equipment, the staff salaries, provisions for bad debt and the professional income of the medical professional to whom the practice belongs.

**Time factor**
The time factor should represent the average time that a procedure or service takes.

**Responsibility factor**
The fact that different procedures and services require different amounts of knowledge, skill and judgement and that there are different risks attached to certain procedures and/or services, relative to others, is acknowledged. These may vary from practice to practise depending on the type of practise, location, services available or on offer.

### 13.3.3 Labour

The labour component represents the human resources that are associated with the rendering of services and procedures. These human resources can either be directly involved in the rendering of services and the performing of procedures or provide indirect support to those that are directly involved in the provision of services and/or the performing of procedures.

#### 13.3.3.1 Direct labour

The direct labour component refers to the direct or “hands on” involvement in a service or procedure. In most instances this would involve the medical professional’s time and he/she may or may not require the assistance of an assistant, such as a professional nurse, radiographer etc. The involvement of the latter should however be based on standard medical practice.

#### 13.3.3.2 Indirect labour

The indirect labour component refers to the human resources that are required to support the normal functioning of a medical practice. Examples would include the receptionists, accounting staff and cleaning staff, all of whom are not directly involved in the clinical management of patients.

### 13.3.4 Utilisation statistics

The utilisation statistics refer to the frequency of occurrence of each service and procedure within each practise.

Using the above information various payment models for practices can exist

- % is a basic monthly salary
- % is capitation for their patient population
- % is fee for service
- % is a regional allowance
- % for experience

Finally the following issues needs to be discussed and clarified when developing these models

- Professional indemnity – Must be part of calculations under practise cost or either be factored in under the basic salaries.
- As an ‘employee’ the Basic Conditions of Employment Act come into operation which is something not relevant at present to the GP in private practice as owner in his private capacity. Therefore SAMA will need to bargain for benefits on behalf of the private GP practitioners who will fall under the employ of the DOH.- sickness benefit, Leave pay, family responsibility leave, PAYE, UIF, locum fees, etc.
• The profession and SAMA need to advise on IT programmes, software switching houses, treatment guidelines and protocols.

South Africa needs enabling environments that will be sustainable both in private and in public sector no matter what healthcare funding arrangement are used. Mutual respect, input, full participation and most important the acknowledgement of the intellectual contribution amongst all stakeholders and more specifically, the service providers in healthcare, can speed up the process significantly.

Therefore from GPPPC perspective we will facilitate and prepare our members for this new environment and get our own house in order.

We do expect all other stakeholders not to be side-tracked by our differences and on what is wrong but rather to focus on solutions.
 INPUT TO SAMA’s NHI GREEN PAPER RESPONSE BY:

13.4 THE SAMA HUMAN RIGHTS, LAW AND ETHICS COMMITTEE (HRLE)

13.4.1 Management of Health Facilities and Health Districts.

13.4.1.1 Introduction

At a recent meeting of the HRLE committee, a report on maternal services revealed that patients had to endure and were subject to abuse from staff and were denied right to health in the process of seeking general medical health and maternal services. Hence some women had to deliver their babies in unhealthy poor conditions and became abused physically and psychologically. The conditions described in the article are not very different from the experiences of other South Africans seeking medical services in other parts of South Africa. Inadequate health provision in unhealthy, poorly equipped and managed hospital facilities is a violation of fundamental human right to health. In addition to the poor management and disrespect for people seeking care, there is violation of patient’s rights and failure to give dignity to the people. In most cases patients suffer dearly to an extent where some of them lose their lives, their babies or their relatives.
13.4.1.2 **Health Facilities**

According to the Green Paper, health facilities will be the structures where health services are rendered i.e Municipal ward-based Primary health care Agents, school based primary healthcare services run by school nurse, primary health clinics, hospitals-district hospital as the primary hospital where first contact of patients will be with principal specialists ie Obstetrician and Gynaecologist, Anaesthetist, family physician, paediatrician, a principal midwife and a principal primary health care professional nurse, secondary, tertiary and quaternary. It is the presence of these highly specialised groups of service providers who will be able to reduce child and maternal deaths and hence bring dignity to the people and feeling of having a right to health.

Management of these health facilities is going to be a very important aspect of service delivery at local level especially at primary level of care as this is the first port of call for most people seeking medical services. Any health facility is managed by various people at various levels of service starting at the gate with security personnel up to the level of head of the facility. The personnel at the facility depending on size and services provided will/should have the following structure.

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13.4.1.3 **HEALTH DISTRICTS**

Health districts are going to be the composition of health services provided by wards agents in school clinics and in primary health centres. The most important contribution to this system will be the presence of critical medical specialist teams with midwives as mentioned above to reduce child and maternal deaths in these areas of service delivery. The district health facility will be the centre of most of the services with specialist available at the level of primary health care. This is the level where there will be services aimed at identifying and managing diseases at early stage hence reducing preventable and unnecessary referrals to secondary or tertiary level of care.

For the system to function as mentioned by the minister of health there is going to be a need to increase substantially the numbers of medical and nursing personnel. If the required infrastructure and personnel is achieved, it is then that some of the ambitions of the NHI will be achieved and each and every South African would be able to receive the dignity they aspire to when accessing health.

At present there is a shortage of health facilities in most areas in South Africa especially in the rural areas where there are long distances to get to a health facility, let alone having the desired ward agents, school nurses who are lacking even in the urban areas.

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13.4.1.4 **SUMMARY**

It clear that a lot needs to be done at primary levels of care as these are the areas which have been neglected in the past few years as the health services have declined over a number of years in South Africa. Both infrastructure and personnel have to be revived with building of new facilities in some areas. It is imperative for government to improve or build roads where necessary for people to access the health services using public services. Management has been a problem in most areas hence the need to retrain and train more people to manage the facilities. Experienced medical and nursing staff will have to be recruited back to the poorly serviced primary care areas in South Africa.

The provision of some of the basic requirement for basic health care services will restore the dignity and access to health that South Africans have been promised in the Constitution.
Most of these issues can be achieved by working together in the next 5 years as envisaged in the NHI Green paper.

13.4.2 DOCTORS’ RIGHT TO EARN

13.4.2.1 Introduction
The medical profession is one of those professions which are held in high regard in society and tends to get most of the attention in terms of rights, law and ethics compared to other professions. This maybe because they work with people and empathy should be at the top of their list in care. Their ability to earn and be wealthy also seems to be under scrutiny. True as it is maybe, it is also reasonable for society to realize that there are huge costs involved in the long training and subsequent responsibilities associated with the profession after qualifying. There are also expectations to be fulfilled of their lifestyles as well as societal expectations. Some of the expectations tend to border on assumption that doctors should have limited access to wealth and its visibility because of the assumption that their wealth is from proceeds of practice and attending to patients only. At times the perception is that they are supposed to charge low to average fees so are their incomes as ill health is not a commodity and never planned like some elective cosmetic surgery procedures.

13.4.2.2 What does it take to become a doctor?
This is a profession that takes long to train and demanding in terms of intellect, personality and hard work. One needs to be very smart to start off, needs to be disciplined and work well under pressure. Good interpersonal skills would help too. Above all, one should want to be a doctor for a good reason-- you really have to have a drive rewarding. There are a lot of educational requirements which can take at least 11 years after high school to complete. In addition to education criteria, a doctor should be patient, compassionate and hard working. It also takes a lot of determination to become a doctor.

13.4.2.3 What is a doctor’s career like?
One really should want to help people, have aptitude for science, and be mentally stable with good coping skills. Most of all it's a big commitment. Throughout the world the medical profession is one of the well-respected professions as doctors are looked upon as saviours of lives and hence looked upon as one of those professions in the upper class in society as well as judges, lawyers, accountants and other prestigious professions. What makes the doctors to be in this class is the educational level and the financial status they belong to rightfully or wrongfully.

In most countries governments subsidize most students to train as doctors in the form of loans or grants; and few doctors are subsidized by their parents. Some of the students depend on their families for assistance over and above the subsidies, loans provided by government, banks and other organizations. When medical students qualify as doctors, they are mostly faced with huge debts to pay back. These monies have to be paid back in monitory form mostly or they have to work in the government institutions for a number of years equal to the number of years of training. Some of the doctors after qualifying have to pay back their families and assist these families in educating their siblings. At times there is expectation to assist their extended families too in addition to the fact that they have to start their families too. Together with the financial responsibilities to pay back, other family responsibilities, community and societal expectations are also there! The young doctors, besides the huge debts they have to pay back, have their own personal lives to start supporting and shaping.

In view of the above facts and issues related to responsibilities of hard work over long working hours, doctors have to earn substantial sums of money to:

1. Pay back the study loans and other debts.
2. Finance their expensive insurance covers –personal, professional and business
3. Start families and children to educate
4. Pay Housing bonds etc.
5. Start up business practices while also working in government for sessional work to supplement incomes

These are some of the reasons doctors need to earn high salaries/incomes whether they are self-employed or other. The financial rewards are predominantly from enthusiasm, hard work and long working hour of sacrifice and commitment.

13.4.2.4 How much do doctors make and how many hours do they work?

There is plenty of discussion about the amount of money doctors make and contentions that doctors make so much money they must automatically be rich. This profile is changing, especially as we understand the costs of medical school in terms of both time and money, the average wage of doctors, and the high costs of things like maintaining medical practice insurance. Moreover, doctors often work long hours up to 60 hours a week depending on which specialty, work load, size of populations and environment at the expense of their families at times.

According to the US Department of Labour, in mid-2000, the median starting wage for general practitioners, those who completed three to four years of medical school after getting a bachelor’s degree and did at least one year of residency training, was about $137,000 US Dollars (USD). (Approx. R548000) (Note that this is a median figure, which means half of doctors starting their careers made less than this amount. In today’s market in the US, this amount is not high and would place doctors firmly in the middle class, and in some parts of the US, this amount as a sole income would mean some penny pinching).

It is true that higher salary ranges may be viewed as quite comfortable. Some of the highest paid physicians are those who specialize in anaesthesiology and surgery. These specialties can require up to seven years of additional training prior to becoming board certified. Some of the doctors, who make the most, also trained the most, and may have completed ten to eleven years of training after graduating from college with a four year degree, thus a total of fifteen years preparation.

Another reason why doctors make so much money or seem to is due to the cost of medical malpractice insurance. Some doctors will pay as much as a third of their salary, a fairly standard fee for the beginning obstetrician/gynaecologist for instance, per year. The exorbitant fees, which continue to rise to protect against potential lawsuits may make a serious dent in what actually constitutes take home pay, so that some physicians will make significantly lower incomes per year. It’s also important to consider the demands of the profession.

In South Africa salaries in the public sector have been very low and this has resulted in most doctors working in the private sector or leaving the country to be able to fulfil some of the obligations and responsibilities mentioned above which doctors are confronted with after qualifying. It is also the prerogative of each and every one to live the lifestyle he wishes for his family after years of hard work studying and hard work practicing as a doctor.

In a study done by Steven F Koch and Jean Slabbert, “Analysis of specialist surgeons and their practices “in Gauteng (2007-2008) published in April 2011, with assistance of SAMA/ FDP (Foundation for Professional Development) they report that a great number of doctors left South Africa to different countries overseas i.e. America, Canada and United Kingdom mostly. About 24 000 doctors had remained in the country, according to the Lancet (2000), due to the loss to health that cost the South African government a lot of money to the value of about $37million. In this study they also noted that it is the new patients and procedures that bring in more money as the cost are higher than repeats and follow up patients. Also in the same study the average earning
ranged from about R92500 –R148000 per month. This varied with doctor’s experience and years of practice.

13.4.2.5 EMPLOYMENT CONTRACTS - RWOPS, RIGHTS, LAW AND ETHICS

In most countries doctors after qualifying have to work in government institutions because of professional training requirements. In South Africa it is for a minimum of three years before they can go to private practice or decide the route they want to follow in the medical profession. A majority of doctors remain in the government employment for a while for further experience before they leave to work in the private sector. Other doctors choose to remain in government academic environment for further studies and some remain in the academic environment forever to work, train other doctors and in research work.

In any contract which is always legally binding, there are stipulated and agreed upon conditions by both parties. One of those conditions is to work for a stipulated number of hours serving the people who present at the facility. Most of the patients have no alternative for private health care whether they like the public sector or not. As mentioned above at times working hours are longer than anticipated. It has therefore been problematic, unethical and illegal for some doctors not to be available to attend to students and patients at times because they are held up in session work thus denying the patients and the students the services and academic time due to them.

In the past few years government salaries have not been attractive for most doctors to remain in the public sector and doctors were allowed to do some work outside the government institution to earn extra incomes whilst also obtaining training in certain skills. This has been beneficial for some doctors (e.g. Cardiac catheterizations, Gastroscopies, etc) and certain other procedures which are not performed regularly enough or none at all in government institutions because of lack of adequate equipment or not frequent enough for training purposes. This has been and still is necessary for doctors to practice their skills all the time because their work is on living human being and it would be and has been disastrous to have doctors operating or performing procedures with poor skills! By doing this extra work they may be earning an extra income which they are justified to earn if the conditions are work and earn- in- training and they need the extra finances.

The South African Constitution and Bill of Rights,(2) 1996 section 22 on freedom of trade, occupation and profession, allows anyone with skills and qualification to trade or practice a profession as mentioned above, has the freedom to do so. In The Bill of Rights Handbook by Iain Currie and Johan de Waal, chapter 22, section 22.3pg 491, on occupational freedom, the public has an interest in allowing individuals to work for their own living rather than being supported by public funds. It also has an interest in benefiting from the skills of a particular individual. Although section 22 does not expressly mention the freedom ‘to pursue a livelihood’ (a formulation which often appears in international human rights instruments) this aspect is, by implication included within the scope of s22…..It is therefore more than a right to provide materially for oneself, but is aimed at enabling individuals to live profitable, dignified and fulfilling lives.”

The legal extra work outside government is referred to as RWOPS (Remunerative work outside the public service). This is offered as part of contract, if the doctor wishes to do RWOPS or not, with the fulltime contract with the arrangements involving the head of that specific unit. The reason is that he should be aware of where the doctor works for sessions at certain times of the day for extra work. This is meant for patients and students to be covered by other colleagues and the doctor’s RWOPS time not to co-inside with patients’ and students’ teaching or supervision time. Unfortunately this arrangement has been abused by some and has resulted in unhappiness with the other colleagues and subsequently students, registrars and patients not being attended to at times. This has happened to such an extent that the national Minister of Health has got to know
about the situation of abuse denying the patients, students and other the services that the doctor is supposed to render to the patients and students at a salary that he earns.

It was only in 2009 when significant salary adjustments known as Occupation Specific Dispensation (OSD) were made to adjust salaries of health professionals to encourage doctors and other health professionals to remain in the public sector. This was also done to improve services to assist in preparation for the proposed NHI (national health insurance) among other things.

However, despite the increased salaries with OSD, especially senior categories of medical professionals, there have been complaints and concerns from the Minister of Health himself that the system of RWOPS is continuing and abused at the expense of students and patients in the government sector - as already mentioned - despite what seemed to be adequate salary adjustments brought about through OSD. He raises this because he was under the impression that OSD would have solved some of the problems of low salaries and RWOPS duties would be reduced so that doctors could spend more time in public hospitals. Unfortunately this has not been reduced to the expected level. He mentions this in almost all the road shows as he addresses doctors in preparation for the NHI.

This raises the question of a doctor's right to earn a living!!

At the beginning of the article a question is asked “How much do doctors make and how many hours do they work?”

It is difficult to say and determine one’s needs by others. There are average salary scales which are usually acceptable according to the average lifestyles of people at certain categories and levels of education and profession. However, in society some people live at levels above the average of their colleagues and hence their financial requirements are more to cover all their specific needs and responsibilities. That being so, it is then one’s right to work as hard as one wishes in order to be able to cover his lifestyle and hence exercising his right to earn a living. The most important issue is that this should not be at the expense of neglecting his duties for which he is earning an income when he is not there. This becomes problematic as unethical and illegal for some doctors not to be available to attend to students and patients at times because they are held up in session work thus denying those services and education time due to them.

In a book “Common law right to earn a living” by Timothy Sandeur,(3) he describes different situations of people who had been denied opportunities to trade, own property or do certain jobs in America. One example is Allen v. Tooley, a suit against an upholsterer who had not served an apprenticeship before taking up his trade. Coke, who by this time had become Chief Justice of King’s Bench, ruled that “no skill there is in this, for he may well learn this in seven hours” (80 Eng. Rep 1055 [1614]), at1057). As unskilled labour, it was not subject to the licensing restrictions appropriate to more technical trades: “by the very common law, it was lawful for any man to use any trade thereby to maintain himself and his family; this was both lawful and very commendable, but yet by the common law, if a man will take upon him to use any trade in which he hath no skill the law provides a punishment for such offenders, and such persons were to be punished in the court leet, and by actions brought, as by the cases before”(1055).The court also cited the example of a blacksmith who injured a horse because he was not skilled in his trade.

A legal redress, the court explained, was already available in the form of a suit for damages. “Unskillfulness is a sufficient punishment for him,” said Lord Coke (1059). As William Holdsworth writes, the common-law “judges favoured the principle [of free trade] just as they favoured the principle of freedom of alienation, because they were hostile to all arbitrary restrictions on personal liberty, or rights of property, for which no legal justification could be shown” (1938, 11:477–78).
In The Case of the Tailors, Coke wrote again that at the common law, no man could be prohibited from working in any lawful trade, for the law abhors idleness, the mother of all evil . . . especially in young men, who ought in their youth, (which is their seed time) to learn lawful sciences and trades, which are profitable to the commonwealth, and whereof they might reap the fruit in their old age, for idle in youth, poor in age; and therefore the common law abhors all monopolies, which prohibit any from working in any lawful trade. (77 Eng. Rep. 1218 [1615], at 1218) In these cases, Coke defended economic liberty to protect not the rich but the poor by striking down the legal restrictions on the freedoms that gave them a chance to work their way out of poverty. The wealthy benefited from monopoly practices.

In comparison to the quotes above, where there are some similarities with regards to acquisition of skills and right to practice a trade and improve skills, one thinks of situation where doctors would like to improve their skills in certain procedures e.g. gastroscopies, cardiology procedures, radiology etc. and they find that the hospital they work in has no equipment or equipment is outdated and/or at times not enough patients to practice on, it is then understandable and expected that they would make arrangements with institutions where the facilities are because as quoted in the article above “unskillfulness is a sufficient punishment for himself”. However it would be illegal and unethical for them to leave the hospital without proper arrangements and sacrifice the patients and students for more pay (RWOPS) as these are not usually done for free! This case scenario is common in most government hospitals where there is a lack of equipment and few skilled people to perform certain procedures as most specialists are in private practices with equipment and skilled doctors.

13.4.3 Conclusion

As indicated, to be a medical doctor is not easy. It is demanding, hard work and financially challenging as it takes long to qualify with the basic degree and specialization. It is expensive to study and the end of the training there are lots of debts to pay. This necessitates working hard and long hours to be financially able to pay back the debts incurred and sustain one’s lifestyle, needs, desires and ambitions with family.

Of importance is the medical professional has to work legally and ethically so as not to inconvenience others i.e. his colleagues, patients and other affected people as the constitution provides him that right to work, earn a living and skills.

Though there are certainly physicians who may charge too much or make too much, the run of the mill doctor is not making a lot, and has put in a lot of sacrifice to receive the training they need. They work in high risk profession, which can be emotionally challenging and difficult, may remain in debt for many years while they pay off student loans, and due to cost cutting, may be increasingly overburdened by complex demands of the health insurance industry.

13.4.4 References

2. The Bill of Rights Handbook “by Iain Currie and Johan de Waal, chapter 22,section 22.3 pg 491
3. “Common law right to earn a living”:by Timothy Sandeur,
I NPUT TO SAMA’s NHI GREEN PAPER RESPONSE BY:

13.5 SAMA SPECIALIST PRIVATE PRACTICE COMMITTEE

There is no doubt that the healthcare system in this country is in need of an urgent reform. As stated in the body of this commentary SAMA is in support of universal access to healthcare. This is not only a response to the dictates of the Constitution but an imperative that is dictated by the ethos of our Profession. The question that begs to be answered though is whether a National Health Insurance is the appropriate funding model.

We are aware that the challenge for all of us including the policy makers is not an easy one. It presents opportunities and risks for both the Public and Private sectors. We would therefore urge everyone to recognise that despite the noise and the accusations and counter accusations that each sector has a lot to contribute to the success of the proposed reforms. I would further suggest private sector should be looked at as a national asset. The view that the Private sector is responsible for the current crisis in the Public Sector is not supported by the available evidence (see CDE and Econex reports)

The Minister of Health has himself publicly acknowledged the problems that prevail in the Public Sector and has given an undertaking to ensure its rehabilitation prior to the implementation of the NHI. The specialist group in SAMA are in support of most of the healthcare reforms as proposed. We further suggest that whatever the approach is adopted
the launch of the NHI should conditional on the implementation of all the elements of the DoH 10 point plan. Whilst we acknowledge that the Private sector has a major challenge in terms of access by the majority of the population, the assertion that it only services 16% is not entirely accurate but services up to 35% of the population (CDE report). The recent CDE report further makes the following points:

There is no doubt that beneficiaries of private medical insurance have access to much better healthcare than those who depend solely on the public sector.

. However, the private sector:

a) Serves more people than just the rich: up to 35 per cent of the population, if out-of-pocket-payments are included as well as medical scheme members
b) Reduces the burden on the public sector
c) Has less ‘excess capacity’ than has been claimed
d) Faces input costs and barriers to market activity which drives up prices.

The SPPC support the proposals made for the re-engineering of the current Primary Healthcare Model.

It is important that in the design of any delivery system that an integrated approach is followed. This implies not looking at health in isolation of other government interventions in areas like education, water and sanitation, housing, poverty alleviation etc.

A lot has been said about the unsustainability of the Private Health Sector with claims that the problems are related the “high service tariffs, provider-induced utilisation of services and the continued over-serving of patients on a fee for service basis”.

It is our view that these assertions are unsubstantiated and are a reflection of the deep-seated negativity that exists in certain sections of our society towards the sector. We respectfully submit that the current state of the problem calls for a lot of pragmatism from all stakeholders. The ideological rhetoric that characterises some of the debates and some of the assertions made in the green paper are indeed not helpful. It is also not helpful to attribute the current failings of our Public Health Care system to the Private Sector only.

A case has been made that the Private Sector should be viewed as a national asset. We would therefore propose that the current debate should be about how the resources in the Private Sector can be accessed.

It is our view therefore that in the implementation of the reforms that the whole process is transparent, consultative, well researched, flexible, contextualised and be relevant to our situation in this country. We are mindful of the fact that that the NHI is only a financing mechanism. It has now been widely acknowledged by leading policy makers that there is an urgent need for the complete overhaul of the organisation, management and leadership in the public sector.

We would like to address the following issues that were highlighted in the Green Paper that pertain to the Private Sector.

- Distribution of human resources
- Payment of specialists under the NHI
- Escalating specialist costs
- Coding Systems

13.5.1 Distribution of Human resources in South Africa
One of the often quoted statements by my analysts and commentators, also mentioned in the Green Paper is the skewed distribution of personnel “in favour of the Private Sector.” A recent study by the economic consultancy group Econex has shown that this is not entirely correct. They have found that South Africa has only 27,432 doctors practising in total (17,802 general practitioners (GPs) and 9,630 specialists. They go on to state that contrary to popular perceptions about the spread of resources, the majority (61.9%) of GPs work in the public sector. While more specialists (56.2%) work in the private sector, the population ratios are also not as skewed as commonly believed. We therefore dispute the assertions made in the Green Paper on this matter.

13.5.2 Payment of specialists under the NHI

There is no clarity on this matter in the Green Paper. A few payment mechanisms have been mentioned without defining exactly what is meant. The following is an attempt to respond to each

i) Capitation: The managed care industry has experimented with this method in this country for many years. The international experience is that it tends to put cost ahead of the patient needs and invariably leads to underservicing.

ii) Global budgets and DRGS whilst suitable in the hospital environment will not address the remuneration of doctors as they work independent of the Private Hospitals and are not employed by them.

iii) The so-called case based approach has similar challenges as above.

iv) Fee for service. Whilst this method is shunned upon by the authors of the Green Paper this seems to be the only method for specialists. The issues of over servicing could be addressed by introducing profiling/benchmarking of practices and comparing usage and claims data with peers. The private sector funding industry has some experience in this.

v) Mention is made of adherence to certain treatment protocols. No mention is made who will develop these. We strongly urge that there should be direct involvement of the profession in their formulation.

13.5.3 Healthcare Coding Systems and Remuneration

We agree the coding systems are a vital part health informatics and reimbursement. They provide important information on disease profile, burden of disease, usage, financial impact of certain interventions, planning etc.

It is important to again stress that private specialists work independent of Hospitals and have to be reimbursed separately for inpatient services.

13.5.4 Unit of Contracting Providers of Health Services

The Green Paper states that accredited providers will be contracted and reimbursed on the basis of the payment levels determined by the National Health Insurance. There is no clarity what those payment levels will be.

We would like to state that serious consideration needs to be given to the following:

i) All specialists have a right to make a decent living

ii) Any payment level should take into consideration the costs of rendering a service with a reasonable return on investment

iii) Price control under the guise of cost containment will not be acceptable

iv) No patient must be penalised simply because of using the services of a non-accredited service provider especially in an emergency.

Failure to address the above issues may lead to may result in non-participation or providers leaving the profession.
The fairest way of calculating a salary is to compare the total career earning potential of a
doctor with that of another profession. When looking at Time Value of money calculations it is
quite easy to determine what someone must be paid order to even out the time taken for
studies in order to compare apples with apples.

The first thing that must be taken into consideration is that doctors start working harder than
other students from Grade 1 at school. They have to maintain high marks throughout their
school career in order to meet the strict qualification criteria required to study medicine. It can
be argued that these criteria be relaxed, but that is an extremely short sighted view, since you
need dedicated and studious individuals to study medicine, due to the fact that the profession
deals with real life or death situations.

Doctors study for 6 years, do two years internship and one year community service before
being allowed to register as a private general practitioner. This means that they only start
practicing their profession and building a nest egg 9 years after beginning their studies. And
the earning capacity lost in those years needs to be compensated for.

If they decide to specialise, they then have to work as a medical officer for an average of 2
years and then specialise in their chosen field for an average of 5 years. It must also be
remembered that super-specialists study for up to 8 years. This means that most specialists
only start practicing their profession 16 years after starting their university studies - on average
10 years after other professions.

When determining the opportunity cost of this delay in earning a commensurate salary, one not
only has to determine what another professional will be earning by the time a specialist or GP
qualifies, but how much they were earning while doctors were studying. The reason being that
a salaried individual functions in a risk free environment and has the opportunity to start
investing their money earlier. The economic reality of compound interest gives them the
chance to spend a longer time preparing for their eventual retirement, which any insurance
company will confirm. Retirement funding is more dependent on time than value.

13.5.5 The Role of Co-payments under an NHI

As far as the issue of co-payments we would like to make the following points:

- We wish to again emphasise that patients should not be punished for using un-
  accredited service providers especially in emergency situations
- Treatment protocols and Guidelines will have to be formulated with the active
  participation of the profession especially the various specialist societies
- The benefit package will have to be defined
- This will apply the referral system that is referred to.

13.5.6 Role of Medical Schemes

We welcome their continued existence in an NHI environment. We agree that there is vast
experience in this sector in the area of administration and management of funds, including
data collection.

We do not at all agree with the view that this sector is under any financial threat. Such
unsubstantiated statements are not at all helpful. One just has to refer to
the 2010/2011 Council for Medical Schemes Annual Report which 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%.

13.5.7 Escalation of Specialist Costs
The issue of rising costs in the Private Sector is complex one and the picture painted in the Green Paper is very simplistic at best and that is not supported by the current evidence. It is also not helpful to blame specialists and Private hospitals without a thorough analysis of increased usage, increasing burden of disease, an aging population in some sectors and the role played by the administrators of the schemes.

Information gleaned from the Council for Medical Schemes’ (CMS) Annual Reports from 1997 to 2009/2010 shows a different picture. Graph 1 demonstrates the annual medical scheme contributions per beneficiary to medical schemes over the last 30 years, starting in 1981 to 2009. It is interesting to note that should medical scheme contributions have kept pace with inflation, your average medical scheme beneficiary should only be paying R1933.81 per year (R161.15 per month) by 2009, instead of the R10517.77 (R876.48 per month) as is the case.

Graph 1

Medical Contribution Inflation v.s. CPI 1981-2009

For years medical schemes and administrators have blamed the medical profession for this situation, but as Graph 2 reveals, it is the insidious escalation of non-healthcare costs that...
have driven this healthcare inflation. What is blatantly obvious is that the birth of an entirely new industry called managed healthcare in 1997, which was theoretically created to bring down healthcare costs, became the driver of healthcare inflation. Non healthcare costs grew from 7.1% of medical scheme expenditure in 1997 to 15% in 2005, and has decreased since then to 12.4% by 2009. What must be kept in mind is that every cent spent on non-healthcare expenses, is money that is not utilised for patient care.

When you add up the non-healthcare expenses, the result is a staggering R10.6bn for all medical schemes in 2009. The sub-components if this non-healthcare expenditure as expressed in Graph 3 are:

a) Administration costs of R7.5bn,

b) Managed healthcare costs of R1.9bn,

c) Broker fees of R1.2bn.

The most important concept to keep in mind when considering administration fees and managed healthcare costs is that these companies charge the medical scheme every time they perform an intervention. They therefore spend money to save money.

Graph 2

Healthcare spend v.s. Non-healthcare spend as % of Total

Graph 3
In the 2009 Council for Medical schemes annual report (Page 214) the Registrar wrote

“Administrators and businesses associated with administrators often provide managed healthcare services. In many instances, these services are merely additional layers of administration costs with questionable benefits for the schemes themselves.” The proof of this statement becomes obvious when one tracks bills paid from medical scheme members’ savings accounts and compares it to administrator expenditure, as shown in Graph 4. The green personal medical savings account cones and the blue administrator cones track almost identically year after year, a trend that cannot be discounted as a coincidence.
When remembering that R10.6bn was spent on non healthcare costs and then comparing that to the R5.6bn in gross earnings that GPs received in the same year and that Specialists earned a total of R16.7bn (which includes radiologists and pathologists who contributed R4bn of this), the picture starts to emerge as to who is responsible for driving up healthcare costs.

These non-healthcare costs exclude contributions used to shore up schemes’ reserves, and are paid out of member risk contributions. Up to now member contributions to personal medical savings accounts were included to demonstrate total scheme income, but this is incorrect since the savings portion of the contributions never belongs to the scheme, and although it is a healthcare expense borne by the member, it always remains the possession of the member. The most realistic way to adjudicate the ratio of medical schemes’ non healthcare expenses in relation to money spent on reimbursing doctors for their services, is to add it to the risk pool expenditure of medical schemes.

Graph 4 shows that GPs and specialists together only consumed 25% of total medical scheme expenditure in 2009, (Excluding personal medical savings accounts), while hospitals on their own consumed 35%. Non healthcare costs at 13% were twice as much as GP costs of 6% and only marginally less than specialists’ costs of 19%. What is interesting is that allied healthcare workers at 6% now consume as much healthcare resources as GPs do.

The conclusion to be drawn from this graph is that the enforcement of PMB legislation did not drive up utilisation by doctors, in fact GPs (Red Bars) and specialists (Blue Bars) combined are now only consuming 25% of medical scheme funds compared to 27% in 1997. The medical scheme service providers that benefited from PMB legislation are:
a) Administrators managed healthcare companies and brokers (Pink Bar), who doubled their market share from 7% to 13%.

b) Hospital Groups (Orange Bar) who increased market share from 29% to 35%.

c) Allied healthcare professionals (Light Blue Bar) who now consume 6% of risk pool funds compared to 0% in 1997.

It is unacceptable that the administration of patients’ funds should be more expensive than providing healthcare. The only logical solution to this situation would be to advise medical scheme members to cancel their medical scheme membership, purchase a cheaper hospital plan from an insurance company and rather save the balance. They can then pay cash for their doctor visits all the while building up cash reserves that by virtue of compound interest will become significant investments over time. Unfortunately South Africans have a poor savings culture, and lack the self discipline to benefit from this solution. But medical schemes have to significantly reduce their administration and hospitalisation costs to reduce healthcare inflation. It is now becoming clearer as to why there are fewer GPs entering and staying in private practice, and why many specialists are leaving the country, because it is not financially viable for them to remain.