

As previously communicated, the link to CMSNews, became unavailable due to technical errors. Furthermore, some inaccuracies relating to the publication and some of the articles were brought under our attention. In order to determine factual accuracy the Office of the Registrar at CMS conducted research and investigated possible inaccuracies. The research team finalised the project and an analysis report is attached for clarification regarding some of the articles. CMS therefore reopened the link and advise readers to read the articles in context of the analysis.



NATIONAL HEALTH INSURANCE IN CONTEXT

**April 12
2013**

Council for Medical Schemes (CMS) supports the Department of Health in its efforts to strategically review the entire health system of South Africa. CMS has in the past provided input to the technical sub-committees of the Ministerial Advisory Committee on the proposed National Health Insurance (NHI) system and submitted a formal document on the NHI policy paper.

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1. INTRODUCTION

The policy context to rolling out National Health Insurance (NHI) is one which is complex, and seeks to implement a unique policy reform within the South African context. NHI benefits as outlined in the Green Paper seek to *“ensure that all South African citizens and legal residents will benefit from healthcare financing on an equitable sustainable basis....NHI will therefore provide coverage to the whole population and minimise the burden of paying directly out-of-pocket payments for healthcare services...”* (NHI Policy Paper). The outcome of this reform will therefore have a massive impact to the majority lives that were not previously covered by private health insurance. And the supply side regulation as discussed by the Department of Health will curve escalation of private health care costs.

Formulation and implementation of such a policy reform needs an incremental approach, allowing enough time to experiment and evaluate which interventions work; the “big bag” approach would therefore not work within the South African context. The pilot process of NHI was therefore an important step towards implementation of NHI. Amongst other things, this approach seeks to collect information on how to improve health service delivery within districts; it also seeks to pilot pooling and purchasing of the Primary Health Care (PHC) package within districts.

CMS fully supports the NHI implementation by the Department of Health. Also, CMS has in the past provided input to the technical sub-committees of the Ministerial Advisory Committee on the proposed National Health Insurance system and submitted a formal document on the NHI policy paper. Amongst other things CMS has also undertaken the following projects so as to support the NHI process:

- Understanding of issues relating to utilisation of private health care in the medical schemes environment;
- Review of health quality outcomes within the medical schemes industry;
- Review of alternative health care delivery models within the mining sector;
- Prevalence of Chronic Disease in the Medical Schemes industry; and
- Risk measurement work to facilitate prospective and concurrent regulatory interventions within CMS.

2. EVOLUTION OF HEALTH CARE REFORMS

This section provides a brief overview of the evolution of health care reforms in the United Kingdom (UK), Netherlands, Belgium and Thailand. This analysis shows that an incremental approach is often applied when governments seek to improve health care delivery within their countries.

Use of NHS example should be contextualised

Page 2, in paragraph 15 of article 1 citation of National Health Service (NHS) as an example from the United Kingdom could have been contextualised to outline the NHS evolution stages as well as the differences between developed country reforms to a developing country. Furthermore, this outline could have provided more insight and lessons for the South African NHI system. As currently presented in the paper there appears to be a comparison between a matured health care system to the one within its inception phase.

International experience on the implementation of universal coverage often does not include a “big bag” approach but rather an evidence based incremental approach. The piloting phase of NHI in South Africa and the recent establishment of the Office of Health Standards Compliance along with the discussion around the establishment of the Pricing Commission are all common features of health sector reforms associated with achieving universal coverage. Table 1 below provides an outline of the evolution of various health care reforms.

Table 1 : Evolution of universal coverage reforms: examples from 4 countries

Country	Evolution of universal coverage
UK	Evolution of NHS between 1946-2007¹ (61 years) <ul style="list-style-type: none">- The NHS Act, brought before parliament (1946)- Establishment of NHS (1948)- Green Paper – A First Class Service (1998)- NICE established (1999)- Modernisation of NHS (1997-1999)- Harnessing information revolution to improve efficiency and quality (1998-2005)- Creating a Patient-led NHS (2005)- Hospital star/league tables abolished (2006)- Smoking in public places banned. Framework for Action established (2007)

¹ **Note:** this is not an exhaustive list of all the reforms that each country has undergone , this table seeks to illustrates that health sector reforms often takes time.

Netherlands	Evolution of universal mandatory health insurance 1941-2006 (65years) <ul style="list-style-type: none"> - Introduction of mandatory insurance (1941) - Regulation of price setting (1970) - Changes in reimbursement methods (1983) - Mandatory participation to universal mandatory health insurance (2006)
Belgium	Evolution of Socialist Mutual Health fund (159 years) <ul style="list-style-type: none"> - The State officially recognised sickness funds (1851) - Creation of “La Solidarite” 1st Mutual Help Society (1869) - Mutuality Act promulgated (1894) - The first compulsory insurance against accidents at work established (1903) - Draft agreement on Social Solidarity laying the foundations for the Social Security Act of 28 December 1944 - Introduction of social insurance (1945) - Health Insurance Act (1963) - Extension of Health insurance to public sector workers (1965) - Extension of health insurance to students, disabled people (1969) - A fixed budget for each subsector of health care was introduced (1991-1993) - The sickness funds are made partially financially accountable for their health care expenditure via a new payment system (1994) - A new law regarding the provision of complementary services (2010)
Thailand	Evolution of Universal Coverage <ul style="list-style-type: none"> - Medical Welfare Scheme (MWS) for the poor, initiated (1975) - Civil Servant Medical Benefit Scheme (CSMBS) established 1978 - Subsidized Voluntary Health Card Scheme (VHCS) began (1983) - The Social Security Scheme (SSS), launched (1990) - Implementation of Universal Coverage Scheme (UCS) of national health insurance (2001) - National Health Security Office (NHSO) transferred the devolved purchasing role to 13 regional branch offices (2006)

3. DECENTRALISATION OF HEALTH CARE SERVICES

Decentralisation of Health Care Services in South Africa

Page 2, paragraph 14 of article 1 argue that “...*decision making in the public system has been centralised (within provinces) and politicise...*” International experience on devolution of power displays that decentralisation of health services is a complex and fragile process. Care is needed to prevent increasing inequity, increased administrative costs, fragmentation, and avoid any weakening in strategic direction, national coordination and cohesion (Collins & Green, 1993). In order to prevent this, the decentralisation process needs to be carefully monitored on an on-going basis especially given the

legacy of apartheid and inequalities in South Africa. Since 1994 the health system in South Africa has been undergoing various reforms. The national vision for delivery of health services is primary health care (PHC) through a decentralised, municipal based, district health system (DHS) approach.

The implementation of the District Health System (DHS) in South Africa saw some progress in devolution of power and responsibilities from higher spheres of government to the lower spheres. In spite of the documented challenges the following progress was recorded in the past :-

- a) Functional integration of services delivery including:
 - Devolution of municipal health services to District Municipalities as per Cabinet decision in 2002 for implementation from 2004; and
 - Devolution of environmental health services from provinces to local municipalities.
- b) Rationalisation of health care services provided by provincial and municipal clinics to eliminate fragmentation and duplication.
- c) Appointment of Regional and District managers to coordinate care provided within districts.
- d) Use of a District Health Information System to enable better understanding of health challenges with regards to provision of care within each facility.
- e) Inter-sectoral collaboration between the Department of Health, provinces, local government and NGO's to improve the provision of district health services.

With regards to challenges on decentralisation the Department of Health's 2010/11-2012/13 Strategic Plan outlines that as part of overhauling the public sector, *"the department will strengthen the decentralised management of health districts for local accountability, the health sector will ensure that District Management Teams (DMTs) are established in all 52 Districts, and that all Districts establish District Health Councils."*

4. REVENUE GENERATION OPPORTUNITIES THROUGH PRIVATE WARDS

Over the past years, private wards have been implemented on a small scale within public hospitals in South Africa. The objectives for these wards include revenue generation as well as wider benefits to the public health system.

Some public hospitals have "Private wards /Folateng Units "

Page 3, paragraph 18 of article 1; argues that *"...the National Department of Health amongst other things has failed to implement the development of private beds in public hospitals..."* It is important to

note that there are private wards and/or Folateng Units within certain hospitals in the public sector. The key objective of these units/wards is to raise revenue for the public sector through creation of hotel facilities and to attract medical aid patients and private patients paying out-of-pocket. Table 2 below provides an outline of occupancy rates within some of these private wards between 2008-2009 in Gauteng and Western Cape provinces. As can be observed Charlotte Maxeke and Tygerberg hospital had high occupancy rates implying that there were private patients utilising these private wards.

Table 2 : Bed occupancy rates of Folateng wards (2009)²

Public Hospital	Bed Occupancy
Charlotte Maxeke	80%
Helen Joseph	40%
Pretoria west Hospital	50%
Sebokeng Hospital	21%
Tygerberg Hospital	67-70%

In addition to the implementation of private wards in Tygerberg hospital by 2003/04 it seemed to have lead to a total hospital revenue increase of 31 percent compared to the previous year (in real terms) (Wadee & Gilson, 2007). Wadee and Gilson further stated that *“there were visible benefits to the hospital as a whole resulting from the revenue raising potential of the private wards”*. They also observed that *“Even though revenue generated by the private wards was not retained directly by the hospital. Provincial Treasury through annual budget negotiations, allowed any over-recovery of fees above a predetermined amount to be allocated back to the hospital for expenditure on capital items...”* (Wadee & Gilson, 2007).

5. FINANCIAL PROTECTION

5.1 Contributory schemes do not always respond better to family and community preferences

Page 1, in paragraph 5 of article 1; stated that *“...contributory schemes ...respond better to family and community preferences....”* cannot be supported by the beneficiary complaints data presented below. CMS resolves thousands of complaints every year - and this number keeps growing. As consumers of health care, beneficiaries of medical schemes should get value for their hard-earned money and must continue to enjoy protection against unpredictable and potentially catastrophic health events. CMS consistently adjudicates complaints from members of medical schemes where some schemes fail to

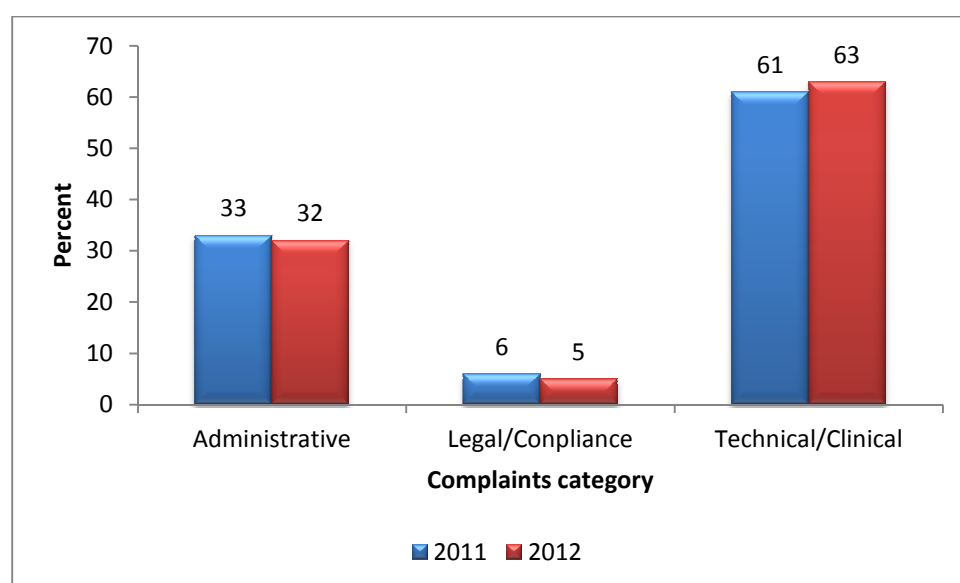
² Source: Health Systems trust article and Gauteng Health report on Folateng Units within the province.

offer the desired financial protection for their members. Below is an analysis of CMS 2011 and 2012 valid complaints.

The Office of the Registrar adjudicated on 5556 valid complaints in 2011 and 5698 valid complaints in 2012, 34% of these complaints in 2011 and 33% in 2012 were ruled in favour of the complainant. For the complaints ruled in favour of the complainant in the technical/clinical class of complaints, 56.07% in 2011 related to the short-payment or non-payment of PMB claims, which increased to 59.79% in 2012. Short-payment of PMB claims mostly relate to claims that are settled at “scheme rate”, which increased from about 16% in 2011 to 26.52% in 2012. Non-payment and short-payment of benefits in the administrative class of complaints ruled in favour of the complainant where at 22% for both 2011 and 2012.

Figure 1 below provides an illustration of valid complaints between 2011- 2012. An in-depth outline of these complaints is attached in annexure 1.

Figure 1: Complaints ruled in favour of the complainant for 2011 and 2012



5.2 Fraudulent activities are not only a characteristic of non-contributory tax-based health schemes

Page 1, in paragraph 5 of article 1: stated that” *inefficiencies and corruption are a characteristic of a non-contributory tax-based health scheme ...*” on this issue, CMS would like to highlight its experience

on matters relating to misappropriation and misuse of medical schemes' funds within the medical schemes market.

Over the past years, CMS has identified several issues relating to misappropriation of members money at a level of the trustee boards and executive management of medical schemes. Notable misappropriation and misuse of these funds happened where trustee boards and executive management have financial interests.

CMS has therefore investigated and litigated on issues such as:

- 1) Irregular and exorbitant remuneration for trustees and executives.
- 2) Trustee and executives have been discovered contracting for schemes with their family owned companies.
- 3) Instances where there has been investment in entities unauthorised where trustees/ executives hold shares.
- 4) Use of medical scheme funds for leisure by executives, their families and friends.
- 5) Ambiguous donations and sponsorships.

In order to address such matters, CMS legal fees along with inspection/ investigation fees have increased significantly due to prospective, concurrent and retrospective regulatory interventions where corrective measures such as the removal of the Board of Trustees, publication of Fit and Proper Standards, publication of Corporate Governance Guidelines, trustee training and education, inspection of medical schemes, placing schemes under curatorship and close monitoring of schemes through risk measurement tools have been applied.

All these initiatives are geared towards improving corporate governance within the medical schemes industry since such transactions have massive opportunity cost for members threatening access to health care, equity and outcomes.

Beyond CMS experience, other stakeholders within the industry have published studies or commented on the magnitude and the degree of fraudulent behaviour involving providers, members, some administrators, some brokers, and other parties.

The above illustration indicates that contributory schemes also experience challenges with regards to fraud and misappropriation of medical schemes' funds.

6. REIMBURSEMENT OF PRIVATE PROVIDERS

NHI reimbursement methods

Article 8's discussion on reimbursement of doctors does not take into consideration responsiveness of clinical practice to health care quality outcomes and important measures to contain escalation of costs in the private sector. CMS believes that reimbursement of doctors should always take into account affordability and health quality outcomes.

There is numerous evidence indicating that the way in which doctors are rewarded for their services has a significant impact on the health care system as a whole. Fee-for-service reimbursement method has massive problems when compared to capitation payments or payments by DRG's. In a fee-for-service market providers might increase their returns by producing more services. This increase in volume will have an impact in the overall health expenditure whilst reimbursement models such as capitation may be efficient as it encourages doctors to compete for patients on the basis of the quality of their care, so that by attracting patients their income increases.

7. CONCLUSION

Some of the current articles covered in the last CMS News are very broad in nature and reflect opinions expressed by the contributors. Limitations thereof are that most of the covered articles do not reflect challenges experienced by both public and private health care markets. Furthermore, the definition of universal coverage is applied with no reference to equity. However, it is known and accepted that the public and private health care in South Africa currently is highly inequitable and there is no universal coverage for the entire population.

In conclusion, the contextual factors influencing service delivery within developed countries are not always the same as those experienced by developing countries. The articles reviewed do not cover these characteristic differences in detail.

8. REFFERENCES

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9. ANNEXURE 1

Nature of Complaint	Nature of Complaint 2	Nature of Complaint 3	Nature of Complaint 4	2011	2012
ADMINISTRATIVE	Contributions and benefits	Annual Increase		1	
		Benefits suspended – non-payment		1	6
		Contributions misrepresented		14	9
		Incorrect Contributions		5	19
		Limits on benefits		6	2
		Other		3	
		Premium increase without prior notice		1	4
	Inaccessible networks	Provider not accessible		1	2
		Restriction on Choice of Provider		1	2
	Information not received from the scheme	Brochures / BOT information not received		2	
		General customer service		21	30
		Incorrect information from scheme		31	26
		Membership Certificate / Tax Certificate not received		7	7
		Other		3	1
	Medical Savings Account	Clawback of funds		3	3
		Other			1
		Refund not received / processed		3	9
	Other			1	
	Payment of benefits	Paid from incorrect benefits		10	10
		Reversal of a claim	Claim paid in error	6	2
			Member terminated	4	2
			Section 59 / Reg 6	1	3
			Sub-limits in option	3	4
		Short payment	Administration error	20	14
			Other	1	
			Section 59 / Reg 6		1
			Sub-limits in option	79	77
		Unpaid account	Account not received / submitted / stale	46	79
			Administration error	30	41
			Benefits exhausted or excluded	10	36
			Incorrect information on account	18	13
			Legal fees / interest	1	1
			Member terminated	5	6
			No Banking Details	2	1
			Other	2	4
			Refund not received / processed	24	34
			Section 59 / Reg 6	2	3
			Sub-limits in option	162	106
	Pre-authorisation	Information Outstanding		24	25
		Late authorisation penalties		1	2
		Non-disclosure investigation			7
		Other		35	5
	Rejection of membership application	Dependent not eligible		5	3
		Discrimination		8	6
		Other		4	
LEGAL / COMPLIANCE	Fraudulent assignment			2	
	Governance			2	2
	Incorrect Advice				1
	Late joiner penalties			15	9

	Membership status	Other			3
		Suspension	Contributions not Paid	4	13
			Other		1
			Unauthorised Deductions of contributions	2	4
			(blank)	6	
		Termination	Contributions not Paid	9	7
			Material Non-Disclosure	9	2
			Other	16	2
			Unauthorised Deductions of contributions	6	11
		Misrepresentation			1
	Other			1	2
	Unethical conduct			12	4
	Waiting periods		General waiting periods	15	13
			Pre-existing conditions	19	11
TECHNICAL / CLINICAL		NON-PMB	DSP	2	3
			Exclusion of condition	11	5
			Formulary	4	
			Incorrect coding	5	5
			Information Outstanding	2	2
			Protocol	14	9
			Provider irregular billing		1
			Sub-limits in options	4	8
			3rd party claim	3	4
			DSP	22	28
			Exclusion of condition	12	13
			Formulary	42	23
			Incorrect coding	19	21
			Information Outstanding	16	28
			Other	6	3
			Paid at scheme tariff	37	74
			Paid from savings account	16	16
			Protocol	64	74
			Provider irregular billing	4	1
			Non-payment	PMB	Sub-limits in options
		NON-PMB	Incorrect coding	1	
			Sub-limits in options		1
			3rd party claim		1
			DSP	2	
			Formulary	1	1
			Incorrect coding	1	
			Other	2	
			Reversal of claim	PMB	Sub-limits in options
		NON-PMB	DSP	8	1
			Exclusion of condition	2	1
			Formulary	1	
			Incorrect coding	10	4
			Information Outstanding	8	6
			Protocol	8	6
			Provider irregular billing		1
			Sub-limits in options	15	8
		PMB	DSP	149	134
			Exclusion of condition	2	1
			Formulary	24	15
			Incorrect coding	29	38

			Information Outstanding	10	28
			Other	4	1
			Paid at scheme tariff	259	422
			Paid from savings account	23	43
			Protocol	60	37
			Provider irregular billing	11	3
			Sub-limits in options	120	61
Grand Total				1869	1870



news

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CMS

Council for
Medical Schemes

What is troubling South Africa's healthcare system?

Editorial

The Department of Health is proposing ways to fundamentally change the workings of the country's entire health system, public and private. The policy proposal is captured in a Green Paper on the so-called National Health Insurance, more commonly known as the NHI, which was published for public comment in August 2011.

The Council for Medical Schemes (CMS) has always supported, and continues to support, the Department's efforts to strategically review South Africa's healthcare landscape; there is no doubt that change is needed. The CMS submitted its comments on the NHI policy paper

in January 2012; the document is available on its website (www.medicalschemes.com).

In exploring a concept as large and complex as NHI, the CMS decided to give external experts a chance to share their views on the proposed health reforms, and approached a wide variety of stakeholders, including the Department, to draft short articles for this edition of *CMS News*. The result is what you hold in your hands: a comprehensive collection of diverse views on what NHI is understood to be and how it could change the face of our country.

Editorial Committee

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Strategic health reform and “National Health Insurance”

South Africa is in desperate need of health reform. But is government doing enough?



While it is undeniable that South Africa is in desperate need of health reform, government appears consistently unable or unwilling to lay out a well-framed strategy sufficient to address areas of systemic non-performance.

The Green Paper on “National Health Insurance” (NHI), which should have served this function, instead offers a set of vague structural reforms of the public sector that lack any rational relationship to what is not working.

An important blind spot in the Green Paper, and in its various associated policy processes, is the failure to recognise that South Africa, as a developing country, has little option but to achieve universal coverage using multiple mechanisms rather than a single financing mechanism – with a lot riding on how the accountability framework applicable to each is framed.

Properly considered policy, by way of contrast, should aim to leverage opportunities for deepening coverage by drawing on the redistributive characteristics of each mechanism. No single mechanism is perfect, however.

Non-contributory tax-based health schemes are good at providing highly rationed services, but are generally unresponsive to communities and to the preferences of income earners, and are susceptible to systemic delivery inefficiencies and corruption. Contributory schemes, which are typically private or quasi-private, respond better to family and community preferences but structurally exclude the vulnerable and are susceptible to systemic cost increases.

Non-contributory schemes in all countries operate side-by-side with contributory schemes, with failures and successes in each impacting on the other. The concept of “universal coverage”, as adopted by the World Health Organisation (WHO), therefore speaks to the need to optimise the performance of both non-contributory and contributory schemes to achieve universal access to needed health services and to ensure adequate financial risk protection.

“South Africa, as a developing country, has little option but to achieve universal coverage using multiple mechanisms rather than a single financing mechanism – with a lot riding on how the accountability framework applicable to each is framed.”

South Africa has two large government-supported financing mechanisms for general healthcare which, at a strategic level, serve two goals: subsidising the care of those without adequate income, and regulating private contributory schemes of those able to finance their own healthcare. Together they ensure that the bulk of South Africa's residents face no or very limited point-of-service cost-related barriers to access for essential health coverage. However, what is considered essential health coverage is logically different in the two public schemes.

Continues on next page





The non-contributory scheme, which is funded through general taxes, provides services paid for and operated by public authorities. As the beneficiaries have no alternative service, government is obligated to fund and provide only those services which are needed by the served population at all levels of care. Understandably, therefore, general tax-funded services cannot be used to subsidise frivolous health demands. Consistent with international practice, service configurations attempt to prioritise the interventions that address health needs at the lowest levels of care to maximise the health outcomes achieved for the funds spent.

“The concept of ‘universal coverage’, as adopted by the World Health Organisation (WHO), (...) speaks to the need to optimise the performance of both non-contributory and contributory schemes to achieve universal access to needed health services and to ensure adequate financial risk protection.”

The contributory system, by way of contrast, has evolved from occupational health schemes into a private voluntary health insurance market now regulated as medical schemes. Consistent with the WHO objectives of universal coverage, it seeks primarily to offer financial risk protection against catastrophic health expenses.

Historically South African income earners have never had free access to public hospital services, a major catastrophic expense. Various forms of medical schemes consequently evolved to cover the health expenses associated with public hospital services and private professional fees and medicines. Tax subsidies were also provided to incentivise employers to provide income earners with medical scheme cover to compensate for their lack of coverage in the public hospital system.

During the 1980s, however, a private hospital system emerged as budget cuts impacted on the size of the public hospital system and its ability to employ specialists, increasing the cost of catastrophic coverage. During the 1990s and 2000s the public hospital system was further rationed to prioritise primary care. As medical schemes are private arrangements, with government

involvement limited to regulation (protecting the integrity of the risk-pooling mechanism) and a minimal subsidy, contributors are free to use their own funds to buy care in facilities selected by the beneficiaries.

The tax revenues used to fund the public sector derive substantially from the income groups excluded from free access to public hospital care. The overall health system therefore incorporates a strong form of income redistribution in the funding of the public system and the related tax subsidy (which is also funded by high-income earners), and risk-pooling (the redistribution from contributors to claimers) within medical schemes. In this way resources are mobilised for health coverage in excess of what can reasonably be raised through tax revenue.

Government policy has, however, failed to address many of the weaknesses in both the non-contributory and contributory systems, undermining the efficiency and quality of available coverage.

Decision-making in the public system has been centralised (within provinces) and politicised, internalising inefficiencies and dramatically increasing corruption. No mechanisms were introduced to regulate performance and deepen public accountability. What measures did exist were instead systematically undermined, removing any possibility of accountability to the served population.

“[G]overnment has failed to implement internationally recommended mechanisms to protect cost-effective access to medical scheme coverage – ostensibly due to successful private lobbies.”

There are consequently no independent regulators, no independent supervisory boards, and no impartial structures of any kind that can act on behalf of the served population as occur in, for instance, the National Health Service in the United Kingdom. This has resulted

in the widespread well-funded collapse of large parts of the public system from around 2000 to the present despite very substantial budget increases from 2004 onward, and is reflected in the appalling health outcomes achieved by the public system in contrast to country peers.

“The Green Paper on NHI (...) offers a set of vague structural reforms of the public sector that lack any rational relationship to what is not working.”

The financial management of eight out of the nine provinces (all but the Western Cape) is furthermore characterised by massive waste, improper procurement, non-payment of contractors, and salary increases way in excess of budget increases. South Africa pays far higher salaries to public sector health workers than any country at a comparable level of development, crowding out opportunities for improved resourcing. Even if South Africa were to improve its production of health professionals it is doubtful they could be employed at significantly higher ratios (to beds) with the present trajectory of salary increases. There is a structural accountability mismatch in the setting of conditions of employment for public sector health professionals between available funds (which is a provincial accountability) and staff cost decisions (which are a national function).

On the contributory front, government has failed to implement internationally recommended mechanisms to protect cost-effective access to medical scheme coverage – ostensibly due to successful private lobbies. Several crucial reforms identified by the 1995 NHI and 2002 Taylor Committee reports sought to maximise risk-pooling, eliminate risk-selection and risk-rating on essential catastrophic coverage, and contain medical cost increases, but have been ignored.

Recommended measures included: a risk-equalisation mechanism to counter risk-selection incentives and achieve system-wide risk-pooling; the regulation

of provider prices; the development of private beds in public hospitals to compete with private hospitals; the expansion and simplification of mandatory minimum medical scheme benefits; the removal of conflicts of interest between brokers and medical schemes to ensure members receive impartial advice; the restructuring of the tax subsidy to favour low-income groups; and the removal of conflicts of interest in the governance of medical schemes.

On the whole, therefore, the Green Paper on NHI avoids the issues of accountability and systemic reform, proposing instead that massive and plainly irresponsible tax increases be used to channel additional funds to an unreformed public health system.

No reforms of any consequence are consequently proposed for the non-contributory system, while no mention at all is made of the contributory system.

“[F]or the foreseeable future no systemic reform of the health system will materialise.”

Despite a burning platform, South Africa's health policy blind spot consequently raises the reasonable concern that for the foreseeable future no systemic reform of the health system will materialise.

As with the decade of the 2000s, South Africa faces the worrying and untenable prospect that for another consecutive decade it will breathe the dust of country peers that are evidently far more capable of making and implementing common sense social and economic policy for the protection and betterment of their people.

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First things first: what is NHI?

NHI, SHI, NHS, socialised medicine, universal cover, mandatory health insurance, single-payer systems, multi-payer systems ... and the list goes on. What does it all mean?

“What’s in a name? That which we call a rose by any other name would smell as sweet” (William Shakespeare).

For many South Africans who are members of medical schemes, the term “National Health Insurance” or “NHI” conjures up the image of a single, large, state-run fund which operates along similar lines as medical schemes. It might therefore be appropriate to pause for a moment and consider the meaning of the term.

After all, this is South Africa, where we call health insurance “medical schemes”, where *eish* does not mean “ice”, *ag shame* has got nothing to do with disgrace, and stiff upper lip Brits blow on *vuvuzelas* during FIFA World Cup matches.

Similarly, the terms “social health insurance” (SHI) and “socialised medicine” have taken on a specific meaning in the USA context, where health financing reforms are underway. In their context, SHI seems to denote community rating and income-rated contributions while socialised medicine seems to mean publicly provided healthcare (Uwe E. Reinhardt. 2012. *Where “Socialized Medicine” Has a U.S. Foothold*) similar to the UK’s publicly provided (and publicly funded) National Health Service (NHS).

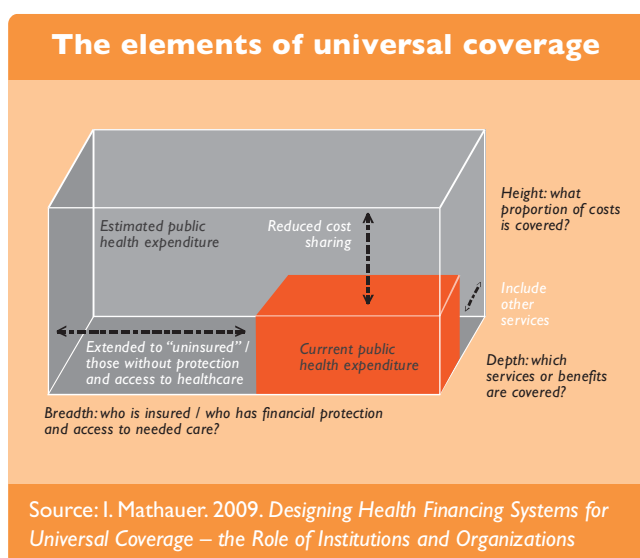
In her article entitled “National Health Insurance: providing a vocabulary for public engagement” published in the *South African Health Review* in 2010, D. McIntyre explains the meaning of NHI in the context of the current reforms: “[T]he term ‘insurance’ in essence refers to the policy objective of providing financial protection against the very uncertain and potentially high costs of healthcare, rather than a specific policy instrument, i.e. an insurance scheme. ‘Insurance’ – in the sense of providing financial protection against healthcare costs for the population – can be achieved through a range of policy instruments, including tax revenue and insurance schemes.”

Understanding the terms SHI and NHI requires the definition of two additional underlying terms, namely “universal cover” and “mandatory health insurance”.

Mandatory health insurance describes systems where there is a legal requirement for the full population or certain population groups (such as the formally employed) to be members of an insurance scheme (D. McIntyre & A. Van den Heever. 2007. “Social or National Health Insurance”. *South African Health Review*) as opposed to the current medical schemes environment where membership is not mandated by law and therefore considered voluntary.

Universal coverage is a term which describes the breadth of cover (who is covered?), the depth of cover (which services and interventions are included in the cover?), and the height of cover (which portion of the costs is borne by the insurer or; conversely, how large are the co-payments?).

The figure illustrates the three elements of universal coverage.



In developed countries there are three main types of systems (National Planning Commission. 2011. *National Development Plan: Vision for 2030*) providing universal coverage. One of them is a National Health Service (NHS) such as those in the UK, Spain, and Sweden. NHS systems are predominantly publicly funded and publicly provided.

Another type of universal cover system in developed countries is NHI where financing is predominantly public but provision is typically a public-private mix. Australia

and Canada have single-payer systems while countries such as the Netherlands and Germany have developed multi-payer systems which were built on occupational health insurance vehicles.

The variant of voluntary Private Health Insurance such as in the US is considered very expensive and inefficient.

The matrix presented in the table below provides an alternative typology to serve as an adjunct to the former naming conventions.

Alternatives for funding and providing healthcare			
		Provision	
		Public	Private
Finance	Public	1	2
	Private	3	4
	1 Public finance & public provision	3 Private finance & public provision	
	2 Public finance & private provision	4 Private finance & private provision	

Source: C. Donaldson & K. Gerard. 1993. "Alternatives for funding healthcare." *Economics of healthcare financing: the visible hand*

“The context within which NHI is stated as an important strategy in South Africa must not be ignored when the meaning of this term is considered.”

In exploring the meaning of NHI in the South African context, it must be considered in relation to the strategic 10-point Plan of the Department of Health, as contained in its Strategic Plan for 2009/10-2011/12, namely:

1. Strategic leadership and social compact for better health outcomes
2. Implementation of NHI
3. Quality of services
4. Overhauling the system and its management
5. Improved Human Resources planning
6. Revitalisation of infrastructure
7. Accelerated implementation of communicable diseases management

8. Mass mobilisation for better health
9. Drug policy
10. Research and development

"In exploring the meaning of NHI in the South African context, it must be considered in relation to the strategic 10-point Plan of the Department of Health."

The context within which NHI is stated as an important strategy in South Africa must not be ignored when the meaning of this term is considered.

The term may furthermore be open to misinterpretations since the proposed reform will not result in a typical insurance system.

Instead, NHI will initially be publicly provided and funded mainly through general tax revenues (National Planning Commission. 2011. *National Development Plan: Vision for 2030*).

Considering the typologies discussed above, NHI as proposed in the Department of Health's draft policy can be described as a mixed system which is largely publicly funded and mostly publicly provided with some private provision.

The system will also introduce a purchaser-provider split in a much-strengthened public provisioning system.

Medical schemes will continue to exist, but their role might change from their current substitutive to a supplementary nature.

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Primary healthcare in an NHI system

Successful provision of primary healthcare is paramount to the success of any healthcare system in serving its full population. The NHI Green Paper acknowledges this.

Introduction: modern reengineering needed

Successful provision of primary healthcare is paramount to the success of any healthcare system in serving its full population.

The challenge to the National Health Insurance (NHI) system in South Africa is clear: we need to deliver good quality services to more people within the existing resources.

Currently, we spend far too much on hospitals treating patients with problems which could have been managed in a lower-cost setting or which could have been prevented with good primary healthcare.

The need to make primary healthcare services central to our system (including but not only by redistribute funding) has long been recognised but has not happened. Most recently, a public health system strategy document entitled *PHC Reengineering* helps to create a renewed impetus to provide effective primary healthcare services.

However, arguably, it is partially because of a lack of belief by policymakers, managers, and clinicians that these primary healthcare services could competently absorb this load. The current performance of primary healthcare services in the public and private system does not easily permit such a conclusion, since they simply do not take proactive responsibility for the clinical management of their populations; nor do they successfully “triage” clinical demand to appropriate levels of the supply of services.

We propose that it is both possible and critical to “reengineer” the health sector to achieve these goals.

But this cannot occur within the current or historical paradigm, even if it were possible to fill all the posts. Instead, it requires a new approach: using incentivised teams, modern measurement, and IT tools. Organisations need to be geared for evidence-based healthcare

and continuous knowledge management, learning, and improvement. The patients' voice is important both as a client and as stakeholder in the successful management of facilities and systems.

How should primary healthcare fit into a reformed healthcare system?

The NHI Green Paper acknowledges the importance of primary healthcare as a component of fundamental system reform, aiming to reach into the community providing preventative, curative, and rehabilitation services in the healthcare package.

Measurement, planning, and management

Primary healthcare cannot be planned or provided in isolation. Maximising the health of communities with effective and efficient primary healthcare is paramount to fulfilling the role as coordinator and gatekeeper to more resource-intensive services at secondary and tertiary level. Planning and delivery of effective and efficient care in any healthcare setting is only possible if the specific healthcare needs of the local population are known and monitored. Understanding the burden of disease and the ability to segment the need for care of the population ensures appropriate resource use and reduction of waste.

Regional planning for primary healthcare services should include the need of communities according to their urban status, income, and their interaction with the quadruple burden of disease (1. trauma, 2. HIV/AIDS, 3. other communicable diseases, and 4. non-communicable diseases). For example, communities with a youthful demographic profile need greater provision of maternal, trauma, and HIV/AIDS services, whereas older communities need more focus on chronic diseases.

The literature on reforming delivery systems is mostly about effective systems and only secondarily about revenue, technology, and skills. Providing the right service at the right time in the right care setting to the right person by the right level of expertise is key to delivering more care to more people within resource constraints.



Workforce

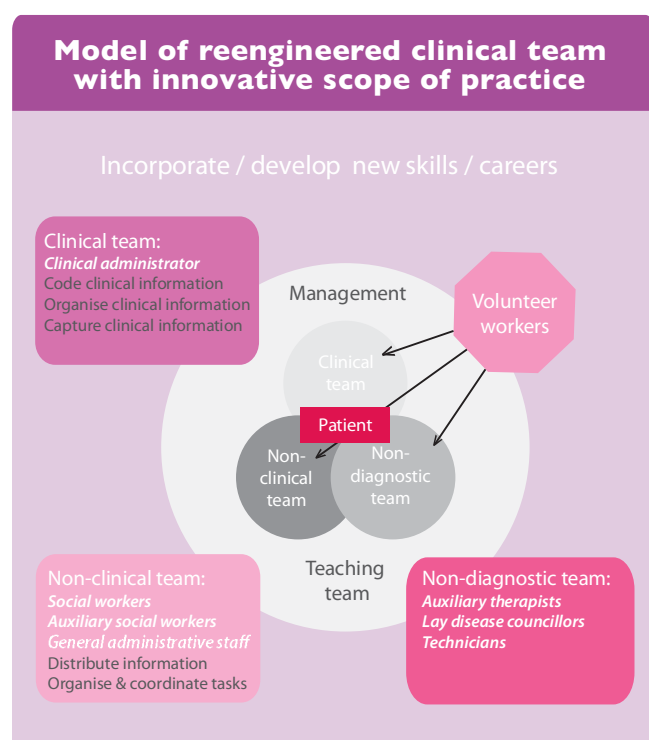
Significant creative reengineering of primary healthcare services is also required because of the profound shortage of healthcare workers. There is international acknowledgement that reengineering the processes of healthcare services is needed to improve quality and maximise resources. In South Africa we face these same challenges, and more.

Thinking around teamwork, development of mid-level workers, and extension of new career opportunities will unlock unprecedented resources and quality of care. This will require a new look at regulatory constraints and requirements. It will require unpacking of roles, tasks, and skills.

Training new cadres of healthcare workers (and some retraining of existing staff), is required. These include technically proficient non-professionals or *technicos* (as in Mozambique) who can perform a Caesarean Section, assistant surgeons who can perform a laparotomy (as in Zambia), clinical and anaesthetic assistants, and disease coordinators and educators.

Historical professional assumptions about clinical scope will be challenged, and we will all need to be flexible.

In addition to a team-based clinical role, some clinicians will need to take on leadership and management responsibilities too.



How could things change for South African patients under NHI?

The current model of providing primary healthcare in South Africa is insufficient. Currently the public gets access to budget-funded, publically run facilities while access to the private sector is via private medical insurance arrangements or cash.

The intention of NHI is to improve the value that the population gets for their investment. This includes permitting new arrangements to emerge, namely purchasing access for public dependants to private facilities with public funds. For this to happen, such services must be of high quality and low cost based on good efficiency.

Clearly, the current single-GP practice model lacks the "economies of scale" to be able to provide this. Instead we will need multidisciplinary staff models based on population-based remuneration contracts and much strategic investment in appropriate clinical management system technologies. The effect of such private primary healthcare models will improve access to care. In some small and rural communities, combining existing private and public healthcare under one roof can achieve economies of scale, including by the shared efforts of the small number of healthcare professionals.

The entire system can benefit from such initiatives.

Conclusion

New systems of delivering primary healthcare are required in South Africa. Clinicians will need to take on new ways of working; they will need to adopt new technologies as well as leadership and management roles. Patients will become clients with rights and voices. Conceptual constraints which prevent innovation and the pursuit of efficiencies and quality will need to be challenged and overcome.

Clinical data about patients and their care is a critical component of this exciting new journey, and in doing this we must build on the work that has been done by the Council for Medical Schemes over the past decade.

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How do private doctors fit into an NHI system?

Doctors must be recognised as the foundation of the healthcare system. They must be treated as equal partners in the NHI planning process, and remunerated commensurate to their level of expertise.



The South African Medical Association (SAMA) represents the largest proportion of the total national medical workforce, with a membership of more than 17 000 doctors both in private practice and state employ, and is therefore the most representative body for doctors in South Africa.

The views expressed in this article, however, are restricted to what SAMA envisages as the role of private practitioners within the proposed National Health Insurance (NHI) system.

Doctors play the central role in the provision of health to the nation, not only in the prevention of disease and in the management of acute and chronic conditions, but in administering the entire healthcare system.

It is for these reasons that SAMA's declared intention is to be engaged at every stage of the NHI process.

The NHI Green Paper states that accredited "providers" will be contracted and reimbursed on the basis of payment levels yet to be determined by the NHI system. Since there is still no clarity as to what those payment levels should be, SAMA would like to request that the Department of Health consider the following crucial facts:

- + All doctors have the right to make a decent living.
- + Any payment level should take into consideration the costs of rendering a service and must include

a reasonable return on investment.

- + Price control under the guise of cost containment will not be acceptable.
- + No patient must be penalised for using the services of a non-accredited service provider, especially in an emergency.

Failure to address the above issues will result in the non-participation of doctors, and may even force them to leave the profession.

SAMA believes that the fairest way of calculating a salary is to compare the total career earning potential of a doctor with that of another profession which requires a similar investment in time for its training. The comparison must then be made by calculating *opportunity cost* and the *time value of money* to compensate for the length of time it takes for doctors to complete their studies. Only then can apples be compared with apples.

"It is economic suicide for doctors to treat NHI patients at a lower rate than other patients."

It must be remembered that doctors start working harder than other students from Grade 1 at school because they have to maintain high marks throughout their scholastic careers in order to meet the exceedingly strict qualification criteria required to be accepted to

study medicine. It can be argued that these criteria could be relaxed, but this is an extremely short-sighted view since the country still needs dedicated and studious individuals to become doctors because of the fact that the profession deals with real life or death situations requiring the most intelligent and most ethical professional intervention.

Doctors study for six years and do two years of internship and a year's community service before being allowed to register as a private general practitioner. This means that GPs only start practising their profession and building a nest egg nine years after beginning their studies. It is not unfair to expect that the earning potential lost in those years needs to be compensated for.

“All doctors have the right to make a decent living.”

If doctors decide to specialise, they have to work as a medical officer for an average of two years and then specialise in their chosen field for an average of five years. Super-specialists study for up to eight years, which means that most specialists only start practising their profession 16 years after beginning their university studies – on average 10 years after other professions.

When calculating the opportunity cost of this delay, one has to determine not only what other professionals will have earned by the time a GP or specialist qualifies, but also how much they were earning while doctors were studying. This is because any salaried individual functions in a zero overhead cost environment and also has the opportunity to start investing their money much earlier. The economic phenomenon of compound interest allows them to build a larger retirement nest egg by virtue of them having spent a longer time contributing towards their retirement. Any insurance company will confirm that retirement funding is more sensitive to time than to value. This means that due to the delay in starting their careers, doctors need to earn more money than other professionals once they start working because they have a shorter window in which to prepare for retirement.

“Doctors play the central role in the provision of health to the nation, not only in the prevention of disease and in the management of acute and chronic conditions, but in administering the entire healthcare system.”

The final fact that has to be considered is that doctors can only sell time, meaning that while private practitioners are treating NHI patients, they cannot treat other cash-paying or insured patients. Furthermore, they will be expected to spend a considerable portion of their time performing administrative duties since they will function as the foundation of the NHI system. At present it appears that this will be done free of charge, as there is no mention of an administration allowance in the NHI Green Paper.

In this scenario it is economic suicide for doctors to treat NHI patients at a lower rate than other patients.

Unfortunately it would appear that the Department of Health showed its hand in the ill-considered 2012 Tariff Guideline published by the Health Professions Council of South Africa (HPCSA) and gazetted in September 2012 for public comment. Herein the Department proposed to pay doctors 5% less than what SAMA determined doctors should have earned in 2003. To put this in perspective, the Consumer Price Index (CPI) inflation and therefore the cost of living has increased by 55% and medical schemes contribution inflation has increased by 119% since then. At this unacceptably low rate it would be impossible for private doctors to contribute to NHI.

In conclusion SAMA wants to reiterate that we are willing to contribute towards making NHI a success, but only if doctors are:

- + recognised as the foundation of the healthcare system;
- + treated as equal partners in the planning process; and
- + remunerated commensurate to our level of expertise.

Anything short of this is unacceptable.

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The role of private specialists in an NHI system

South Africa has an undersupply of specialists, and those currently working in the private sector will need to be harnessed to serve the NHI need nationally.



In the context of the Green Paper, National Health Insurance (NHI) refers to a system of universal access to healthcare in which a state-operated single-purchaser system is funded predominantly by taxation.

“Private sector services are currently undervalued, and to ensure sustainability will need as much as a three-fold increase in some disciplines.”

It is important to recognise that South Africa currently has in place a system of universal access to healthcare, albeit a dysfunctional one.

The current two-tier system of healthcare, in which the state services the needs of the indigent majority, and the employed minority provide for their own

healthcare needs via a pre-funded medical scheme or through out-of-pocket payments, is such a system.

Furthermore it should be acknowledged that the tax-paying minority, who are fortunate enough to be able to finance their own private healthcare at no or minimal cost to the state, also contribute, through their taxes, the majority of the funds that support the public health services.

Under the proposed NHI, this admittedly uneven system of universal access will be replaced by a unitary system, funded by all in formal employment, in which services currently provided in the public sector will be purchased through this central fund from either the state or private sector. Fee-for-service will not be allowed, the Green Paper referring instead to the use of capitation in the case of GPs, and case mix reimbursement or diagnosis-related group (DRG) models for specialists.

"The rate paid by the central fund will need to be sufficient to enable specialists to cover their overhead expenses and earn a reasonable salary, or they will be lost to the service."

South Africa has an undersupply of specialists, and those currently working in the private sector will need to be harnessed to serve the NHI need nationally.

The central fund will therefore have to purchase services from private specialists by some mechanism other than fee-for-service. Capitation is unsuitable for purchasing specialist services, and private hospitals do not currently employ specialists who operate as independent contractors, so case mix and DRG models do not easily fit the need.

The Green Paper on NHI has little to say about specialist services generally, but what is clear is that any improvements in primary care will also increase the requirement for specialist services.

"The Green Paper on NHI has little to say about specialist services generally, but what is clear is that any improvements in primary care will also increase the requirement for specialist services."

A considerable portion of private specialist work occurs outside hospital, where consultations take place and special investigations, such as laboratory tests and radiological examinations, are undertaken prior to entry to hospital for either further investigation or definitive treatment.

Indeed many patients never enter hospital but are managed exclusively as out-patients.

In the absence of fee-for-service it is unclear how these services are to be remunerated, but certainly the case mix / DRG / hospital model will not work easily in this scenario.

Current organisational constraints will also need to be addressed if private specialist services are to be readily accessed by state patients. Most private specialists work in solo practices and are already overburdened with their case load, limiting their ability to supply additional services to the state. The evolution of large single specialty or multi-specialty group practices will clearly facilitate the provision of private sector services to the state, but regulatory changes will be required first.

The value of the Rand Conversion Factor, used to calculate the price of private services purchased by the state, is the cause of much controversy.

"South Africa currently has in place a system of universal access to healthcare, albeit a dysfunctional one."

The original NHI estimates of cost done by Calikoglu and Bond for COSATU in 2008 were based on an assumption that the central purchaser model would drive down private services purchase costs by a third, but this assumption ignored the findings of the cost studies mandated by the Reference Price List process. These studies clearly showed that private sector services are currently undervalued, and to ensure sustainability will need as much as a three-fold increase in some disciplines.

Contracting specialists will not be allowed to charge co-payments to NHI patients, therefore the rate paid by the central fund will need to be sufficient to enable specialists to cover their overhead expenses and earn a reasonable salary, or they will be lost to the service.

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The role of the private hospital sector in universal access to healthcare

The private hospital sector is a valuable national asset and should be leveraged to extend access to quality care to more South Africans.



South Africa prides itself as a constitutional democracy with a Bill of Rights (Constitution of the Republic of South Africa, 1996) that enshrines “the rights to food, water, healthcare and social assistance, which the state must progressively realise within the limits of its resources”. The National Health Act goes on to reaffirm, in its preamble, these obligations imposed by the Constitution and sets out a framework for a structured uniform health system. These two interlinking pieces of legislation form the basis of government’s current healthcare reform, as stated by Minister of Health, Dr Aaron Motsoaledi, on various public platforms.

While there is need for greater clarity on the architecture of the proposed government reform, the underlying goal of “universal access to quality healthcare services” is well-stated in the National Health Insurance (NHI) Green Paper of 2011.

“The big challenge is finding the best path that must be traversed along this [health] reform journey.”

The Hospital Association of South Africa (HASA), which represents over 85% of private hospital beds, can significantly contribute to the achievement of universal coverage in South Africa. Within an NHI dispensation, a key contribution of private hospitals could be the provision of hospital services under state financing.

However, HASA has identified the following critical issues which need to be addressed in order to realise the objective of expanding access to quality healthcare. These also have implications for the effectiveness of the private hospital sector’s contributions to achieving the stated objectives of health reform:

1. the need for significant increases in the human resources deployed in the South African health sector;
2. the need to leverage all health assets, private and public, in public health service delivery; and
3. the role of governance and contracting to effect sustainable change.

Human resources

The Department of Health’s Human Resource (HR) Strategy document indicates a shortfall of 82 962 healthcare workers in South Africa. This includes approximated shortages of health professionals such as nurses (48 000+), medical professionals (4 000+), and medical specialists (7 000+). The stated aim of this HR policy is to reduce the backlog of healthcare workers to 17 475 by 2020 and to have a surplus of 8 500 by 2025. This is clearly a significant task given the capacity constraints in education facilities and clinical facilitators. HASA is committed to working with the Department of Health in addressing resource constraints.

Nurses

The private sector nursing education institutions are already training their own specialist nurses and many are willing to make such training available to public sector hospitals. The theory could be provided with a mixed group of public and private nurses, and the public nurses

would be able to return to their units in public hospitals for the clinical practice. These students would also be free to circulate through some of the private units for exposure to certain technology if it were not available at their resident hospital. This type of joint initiative will bolster the number of specialised nurses on the South African Nursing Council registers.

There is, however, a key obstacle: it is not well-known, but there is a cap on the number of nurse students that can enrol in private nurse colleges. This cap is determined by the number of hospital beds associated with the training facility. Many of the largest private providers of nursing colleges feel this is an unnecessary hurdle as there is capacity to increase student intake.

There is also no shortage of demand to study nursing. Some private colleges get student applications which are 10 times over the available seats. In light of South Africa's hurdles in education, employment, and health access, this is an obvious avenue to address many of the structural problems in our country.

Doctors

With only 55 doctors per 100 000 people, South Africa needs to take dramatic steps to prevent a skills crisis.

International comparative healthcare ratios, 2008	
	Doctors per 100 000 population
High-income countries*	280
Middle-income countries*	180
Low-income countries*	50
South Africa	55
Brazil	185
Mexico	198
USA	256
Greece	500
UK	230
Australia	247

Source: Econex calculations and World Health Organisation, 2008

A country with a similar population base to South Africa is Columbia. While South African regulation does not

allow the creation of private medical schools, Columbia does. They boast 35 medical schools while South Africa has eight.

Even if the regulatory barriers to private medical schools are not lifted, one should still leverage the pool of talented specialists and current medical technology in the private sector by allowing registrar training in private hospitals. Current regulation caps the time registrars may spend in private facilities to 30 days.

The leadership of private hospitals fully appreciates the risks of a depleting specialist pool and encourages the relaxation of this regulation in the interest of health access.

Another critical area of need as the country strives to strengthen public health delivery includes the training and education of administrative and general management in district health management teams, and the private hospital sector has the capacity to contribute significantly to this task.

Broadening the service delivery platform

Strategic thinking is required to overcome service delivery constraints. Private Public Partnerships (PPPs) in healthcare have been somewhat limited in South Africa and have not extended into the physical delivery of healthcare. PPPs which focus on “Build, Operate, and Transfer” models around physical infrastructure are insufficient in and of themselves to make a structural contribution to health access.

More and more countries are purchasing elements of public health delivery from the private sector. This is very much a function of the economic climate since 2007 which has resulted in public sector budget cuts. It is often cheaper to purchase services from the private sector than it is to build the additional capacity in the public sector. Brazil has a long tradition of public financing of private facilities (Forgia, GM & Couttolence, BF. 2008. *Hospital performance in Brazil*, World Bank), with the majority of the country's hospitalisation accessed in private facilities.

The UK Department of Health has over the last decade focused on extending patient choice, enhancing quality of care through increased competition in public health



delivery, and reducing waiting lists for clinical services through several considered programmes. These programmes were initially launched as National Health Service (NHS) tenders with specified volumes and time frames. The lessons of these various programmes have culminated in the current *Any Qualified Provider* (AQP) programme (<http://healthandcare.dh.gov.uk/any-qualified-provider-2/>) which gives the population the option of using a public hospital or a private hospital of their choice.

The AQP programme has had the effect of reducing public sector waiting lists and rendering them more sustainable on a longer-term basis. It has also had the impact of significant improvements in public sector efficiency and service delivery as they have needed to compete to attract patients and funds in an environment where the money follows the patient. By way of example, South African hospital group Netcare has 64 hospitals in the UK where over 25% of patients are public sector patients.

The role of governance, deepening of contracting skills, and a sustainable payment mechanism

Health reform in the last decade in the UK shows the extent to which health reform needs to be an iterative process. Considered functions and skills need to be in place before one scales up health reform. Contracting has played a critical role, as has public price determination and quality measurement.

“Governance structures which determine the roles, responsibilities, and powers (authority), and hold the responsible players accountable for delivery, are [...] critical to the success of health reform.”

Furthermore, governance structures which determine the roles, responsibilities, and powers (authority), and hold the responsible players accountable for delivery, are also critical to the success of health reform.

“Strategic thinking is required to overcome service delivery constraints.”

These are all areas where the private hospital sector can inform the debate and share experience garnered in operations in other parts of the world.

Conclusion

The vision of universal access to quality care as an end goal is one that has found resonance with players in the health sector across many divides, including the public-private divide.

The big challenge is finding the best path that must be traversed along this reform journey. Herein lies the complexity which tends to polarise thought leaders. Instead, we need to find common ground; now more than ever it is necessary for leaders across the entire healthcare spectrum to find solutions for a population that is looking for overall improvement in quality and access.

The South African private hospital sector is a valuable national asset, both intellectual and physical, and should be leveraged to extend access to quality care to more South Africans.

Private hospitals have both the desire and the capacity to offer services to the state.

The private health sector also wishes to contribute to policy formulation and other meaningful plans aimed at exploring and establishing such working agreements with the public sector.

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The role of the private healthcare funding sector in the proposed NHI for South Africa

The current two-tier system should be reviewed in order to bring about greater efficiencies in healthcare. The need to reform and improve service provision is paramount to promoting equity and efficiency.



The Board of Healthcare Funders of Southern Africa (BHF) and its members support the implementation of a system of universal access for all South African citizens to appropriate, efficient, and quality health services. The need to reform and improve service provision is paramount to promoting equity and efficiency.

“[The BHF] emphasises the importance for South Africa of the successful implementation of an NHI system.”

The BHF acknowledges that the current two-tier system should be reviewed in order to bring about greater efficiencies in healthcare.

South Africa already spends 8.5% of its Gross Domestic Product (GDP)

on health and still has poor health outcomes when compared to similar middle-income countries. It is evident that South Africa needs to more efficiently use the money it already spends on healthcare.

In its submission on the National Health Insurance (NHI) Green Paper, the BHF stresses that the private funding sector is a national asset, rich in expertise and experience in governing and administering healthcare systems, which could be made available to government as it implements NHI. The BHF believes that, once fully implemented, the model could be similar to the Gautrain model where the private sector was contracted by government to fulfil the function of building the entire system while the Gautrain Management Agency, under the Provincial Government, manages the running of the Gautrain. This model creates flexibility and establishes an appropriate platform to attract, retain, contract, and remunerate the required skills

and expertise adequately. To have a well-functioning NHI system will certainly require such a model.

Included in the BHF submission is an offering from the sector to provide expertise in a number of areas necessary for the successful development and implementation of an NHI system. Many of these areas relate directly to the National Department of Health's 10-point plan for health, as once these have been achieved, universal access to health will have been realised.

These areas are:

- + designing and costing the NHI package of benefits. The BHF has structured an Essential Benefit Package in line with national health policy, recommendations of the World Health Organisation (WHO), and the stated objectives contained in the Green Paper on NHI.
- + developing coding structures for the reimbursing of healthcare providers. Clinical coding is important and its use allows for the improvement of efficiency of healthcare service delivery through appropriate and standardised recording of diagnosis, analyses of patient care information, research, quality assessment, use of performance improvement tools (profiling), healthcare planning, and facility management. It also enables the development of fair reimbursement for healthcare services provided. The systematic collection of morbidity and mortality data assists with the identification of health needs and therefore the content of benefits to be provided.





- + developing healthcare tariffs, and payment and provider reimbursement models. The BHF believes that the prevailing fee-for-service model is problematic, further exacerbated by the third-party payment system. The private funding industry has extensive experience in contracting with private practice providers, and the BHF could play an important facilitation role in rolling out alternative reimbursement models in preparation for the NHI.
- + measuring healthcare quality and other outcomes. Measurement of clinical quality indicators from the outset is recommended to enable the proper and appropriate measurement of clinical outcomes. Much expertise exists within the private funding sector in developing quality measurement standards in clinical quality codes, utilisation statistics, morbidity and mortality figures, as well as quality standards within the practice settings, and hospital and clinic environments.
- + fraud management interventions. Due to the high level of fraud within the private sector, sophisticated fraud management interventions have been developed which could be utilised in a NHI environment. Already the BHF coordinates and manages the Healthcare Forensic Management Unit with the support and participation of the majority of industry players.
- + accrediting providers and facilities, and provider contracting. The BHF believes that healthcare providers should have the option to participate in the NHI on an "able and willing" basis, and that the system of accreditation should be as inclusive as possible. The private healthcare system, including managed care organisations and administrators, has experience in contracting with providers, and such healthcare providers could easily assist the NHI initiative to put in place the required service agreements.
- + communication and education to the general population and providers of service. The BHF submission stresses the need for effective communication to all constituencies affected

by the NHI, both during the build-up to the NHI and during its implementation. The BHF and its members offer communication expertise and established communication channels that can fulfil the required communication and education needs.

- + provider network management. Managed care organisations and provider groups have organised themselves into risk-bearing entities with the ability to take capitation risk and to perform the required network management functions to ensure the proper functioning of provider services within a national framework. Such organisations could be invaluable with the requirement of providing services under an NHI model, and could ensure that administration functions required in terms of provider network management and recruitment of additional providers within selected areas are performed. The BHF, with the support of its members, can facilitate the utilisation of these networks in a way that will service the NHI.

“The private funding sector is a national asset, rich in expertise and experience in governing and administering healthcare systems.”

- + peer review and profiling. The BHF has a long and successful history of working with provider groupings and academics in the development of peer review and provider profiling systems. These systems can be adapted and extended for use within the NHI contracting environment.
- + administration, claims and information systems, and managed care services. In order for the NHI to be effective, administration services and customer support services will be essential. Current administrator and managed care organisations have the infrastructure, systems, and experience to provide a valuable service under an NHI dispensation. These include the

"Healthcare providers should have the option to participate in the NHI on an 'able and willing' basis, and [...] the system of accreditation should be as inclusive as possible."

collection of key health data to monitor health system performance, the provision of accredited managed healthcare services based on identified needs including disease management for priority health problems, the provision of switching house services to the NHI Agency, and the management of provider contracting arrangements.

- + call centre support services. The importance of call centres to support members and providers is essential to provide quality service. These services should be easily accessible with the correct level of skills, service levels, and capacity to deal with queries and questions. The current medical schemes industry provides a highly competent call centre environment which could easily be extended to be utilised by the NHI system.

The BHF submission on the Green Paper also stresses the urgent need for reform of the private sector in the build-up to NHI in order to align this sector with current and future national health policy and to ensure a seamless integration of the 8.5 million medical scheme members into the NHI.

The reform must include the following areas:

- + the prescribed minimum benefits (PMBs). These are hospi-centric and curative-focused and are a major contributor to the high cost of private sector costs. The benefits package underlying the PMBs must be restructured to focus on essential healthcare, which would bring them in line with national health policy and what is stated in the Green Paper on NHI. The legislation must be reviewed

in order to alter the focus to primary and preventative care. This would enable resources to be directed to primary and preventative healthcare.

- + the establishment of a Pricing Commission. This would act as the precursor to the single-purchaser function (which is a cornerstone of the NHI), bring an end to the runaway costs experienced by consumers in the private sector; and enable medical schemes to further the social solidarity objectives under which they are governed. The proposed NHI single-purchaser model will inevitably include regulated prices for the NHI benefits package. Therefore, in order to prepare both providers and funders for NHI, we urge the Minister of Health to introduce the proposed pricing negotiating commission.
- + regulatory and professional bodies. Reform of the current regulatory and professional statutory bodies will be required to bring these bodies in line with the requirements of an NHI model.
- + The services to be delivered should be identified together with the service providers responsible for the delivery of the services. Healthcare services should be distinguished in terms of the level of expertise required and type of discipline required, including the differentiation between primary care, secondary care, tertiary care, and quaternary care or the academic hospital environment. Access to specialist care should be following consultation with a primary care provider; with appropriate referral procedures in place.

The BHF's submission on the NHI Green Paper applauds the Minister of Health and his team for providing a framework for consultation and emphasises the importance for South Africa of the successful implementation of an NHI system.

Heidi Kruger

Head of Corporate Communications

Board of Healthcare Funders of Southern Africa (BHF)

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Health insurance in an NHI system

Health insurance products are inconsistent with the principles of access and equity. They have the potential to undermine the policy objectives underpinning NHI.



A National Health Insurance system

For most governments, a National Health Insurance (NHI) system seeks to promote equity and efficiency in resource allocation and distribution. The ultimate objective is to address disproportionate distribution and access to healthcare services for the entire population in order to improve access to affordable, quality healthcare services regardless of the person's socio-economic status.

For South Africa, NHI is intended to “ensure that all South African citizens and legal residents will benefit from healthcare financing on an equitable sustainable basis [...]. NHI will provide coverage to the whole population and minimise the burden of paying directly out of pocket for healthcare services” (NHI Green Paper).

“[I]t is not fair for individuals to assume all the risk associated with their healthcare.”

The key components of this health financing mechanism include:

- + mandatory participation;
- + universal access to healthcare;

- + pooling of resources (which includes refinement of the revenue mobilisation strategy);
- + risk-pooling (to ensure that there is appropriate financial risk protection for the entire population);
- + alignment of health benefit packages (i.e. a “minimum healthcare package”); and
- + refinement of provider payment mechanisms.

These key components outlined above are in contradiction with the philosophy underpinning health insurance products. These products are inconsistent with the principles of equity and access. Furthermore, benefit design within these products encourages risk-rating and premiums are risk-related. Such premiums can be unaffordable, especially when combined with other costs related to a health event, such as transport, accommodation, and lost income (all of which can result in significant out-of-pocket expenditure).

Health insurance products

Health insurance products such as gap cover and hospital cash plans often sold by both life and short-term insurance companies tend to provide non-indemnity cover for major surgical and hospitalisation costs and shortfall payments for specialist costs. The insurer pays a predetermined amount of money on claims for clearly specified contingencies rather than reimbursing the actual medical expenses incurred. The policy holder pays monthly premium determined by his/her age, health status, and/or income. The Short-term Insurance Act 53 of 1998 and Long-term Insurance Act 52 of 1998 preside over these products.

Regulatory intervention, such as the establishment of NHI and a pricing authority, is required to protect the risk pool of medical schemes since health insurance products contravene the Medical Schemes Act 131 of 1998. The Council for Medical Schemes (CMS) considers such products to be unlawful given that they erode the principle of risk cross-subsidisation by cream-skimming or cherry-picking younger and healthier members who are encouraged to select cheaper benefit options and “top up” with health insurance products for more comprehensive cover. Furthermore, a number of these health insurance products are currently being subjected to judicial scrutiny.

“[Health insurance] products are inconsistent with the principles of equity and access [to healthcare].”

Given this context, close collaboration exists between the Department of Health, National Treasury, the Financial Services Board (FSB), and the CMS. This collaboration has resulted in the development of Regulations under the Insurance Acts. The objective of these Regulations is to address demarcation between medical schemes and health insurance products. Demarcation is required to preserve and strengthen the social solidarity principle that underpins medical schemes by pooling healthier and sicker individuals together to enable cross-subsidisation.

Health insurance products in an NHI system

Risk-pooling within an NHI system ensures that the risk related to financing health interventions is borne by all the members of the pool. But, as mentioned above, with health insurance products each individual is risk-rated and pays a risk-related premium. Equity arguments in support of risk-pooling reflect the view that it is not fair for individuals to assume all the risk associated with their healthcare. Therefore, risk-pooling reduces the uncertainty associated with healthcare expenditure for individuals.

Health insurance products undermine risk-pooling in a number of ways. They:

- + attract people with a lower-than-average expected risk of ill health and deter those with a higher-than-average expected risk of being or falling sick;
- + encourage healthier members to buy down to less comprehensive benefit options and to purchase comparatively lower-priced gap cover policies to fund shortfalls;
- + undermine cross-subsidisation within a risk pool;
- + cause the insured risk pool to become less healthy, leading to increased premiums and member movement;
- + attract the young and healthy by their benefit design; and
- + provide significantly low benefit levels with payouts unrelated to the cost of care.

“Demarcation is required to preserve and strengthen the social solidarity principle that underpins medical schemes by pooling healthier and sicker individuals together to enable cross-subsidisation.”

Conclusion

Health insurance products have the potential to undermine the policy objectives underpinning NHI. Unless addressed, these products might hamper the achievement of equity and efficiency within a national health system.

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NHI and human rights

NHI has the potential to bring the healthcare services closer to fulfilling the constitutional obligations of the state, but much will depend on the framing of the policy and, most importantly, its implementation.



The right to quality healthcare

The Constitution of South Africa seeks to build a democratic state founded on the values of “human dignity, the achievement of equality, and the advancement of human rights and freedoms”.

It is in pursuit of this aim that the Bill of Rights includes both civil and political rights, such as the right to vote and to assemble, and socio-economic rights.

Section 27 of the Constitution provides that everyone has the right to have access to healthcare services, sufficient food and water, and social security.

The formulation of the right to access healthcare services in the Constitution is a reflection of international law. The Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the African Charter on Human and People's Rights all provide a right of access to healthcare services.

The granting of the right to “everyone” further reflects international law in its inclusion of non-citizens.

While the quality of healthcare services required is not specified in the Constitution, to meet its constitutional obligation the state must ensure that the healthcare services provided are of sufficient quality to protect and promote the dignity and equality of all in South Africa, in line with the values on which the Constitution is based.

The present state of healthcare in South Africa clearly does not fulfill the constitutional promise.

“To meet its constitutional obligation the state must ensure that the healthcare services provided are of sufficient quality to protect and promote the dignity and equality of all in South Africa.”

Access to healthcare is highly unequal, with the wealthy being able to access quality services (at substantial cost) while the majority is left to use a failing public healthcare system about which there are weekly reports of medicine shortages, electricity blackouts, and absent staff.

It is in the light of the constitutional impetus to provide quality healthcare services to all and the challenges in both the private and the public healthcare systems that the idea of National Health Insurance (NHI) was born.

How would the healthcare rights of people in South Africa be affected by NHI?

NHI aims to provide to all in South Africa access to healthcare services.

The idea is that everyone be provided with financial protection from the costs of healthcare and with access to healthcare which is of a quality that meets constitutional requirements. This requires income and risk cross-subsidisation and an improvement in the quality of healthcare available throughout the country. The social solidarity foundation for healthcare differs substantially from the current model of healthcare.

The intention is that NHI would grant to everyone equal, high-quality healthcare at a price that they can afford.

“NHI has the potential to bring the healthcare services available to everyone in South Africa closer to fulfilling the constitutional obligations of the state. This is to be applauded.”

NHI would affect the healthcare rights and experiences of different people in different ways.

Medical scheme members would be able to remain members of schemes if they wished, but would find themselves paying not just for medical aid but also for NHI, most likely through increased taxes.

Those not currently on medical aid would no longer face high medical bills when attending a private facility and, at least in theory, the quality of care at public facilities would improve, securing the realisation of the

constitutional right to access healthcare. They would have to pay for medical care through taxes, although the type of taxation involved is not yet clear.

“As always [...], much will depend on the framing of the policy and, most importantly, its implementation.”

Non-South Africans, including refugees, asylum-seekers, and undocumented inhabitants, would be granted access to healthcare services exceeding what is currently available to them, albeit in some circumstances the scope of services would be more limited than that available to citizens. This is a progressive step aimed at expanding quality healthcare services to everyone, as required by the Constitution.

NHI has the potential to bring the healthcare services available to everyone in South Africa closer to fulfilling the constitutional obligations of the state. This is to be applauded.

As always, however, much will depend on the framing of the policy and, most importantly, its implementation.

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SECTION27

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NHI and human rights

NHI must be implemented with a meaningful public engagement process, access to information, and cognisance of the rights of all people: users of the public and private healthcare facilities and marginalised groups of people.

The right to healthcare

The right to healthcare is generally referred to as fundamental to the physical and mental well-being of all individuals, and as a necessary condition for the exercise of other human rights, including the pursuit of an adequate standard of living.

National obligations

The right of access to healthcare services is one of the indivisible and interdependent rights entrenched in Section 27 of the South African Constitution (Act 108 of 1996), which states inter alia that everyone has the right to have access to healthcare services, including reproductive healthcare. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights, and no one may be refused emergency medical treatment. In addition, the Constitution entrenches that:

- + everyone has the right to bodily and psychological integrity through informed decision-making and consent (Section 12.2);
- + everyone has the right to an environment that is conducive to health and well-being (Section 24a);
- + every child is entitled, through Section 28, to basic healthcare services; and
- + detainees have the right to access adequate medical treatment (Section 35).

In addition to the constitutional provisions, South Africa has promulgated a plethora of legislation to ensure the right of access to healthcare. This includes:

- + Choice of Termination of Pregnancy Act 92 of 1996
- + White Paper on the Transformation of the Health Care System in South Africa (1997)
- + Medical Schemes Act 131 of 1998
- + Mental Health Care Act 17 of 2002
- + National Health Act 61 of 2003
- + Traditional Health Practitioners Act 22 of 2007

The White Paper on the Transformation of the Health Care System in South Africa provides a vision for the

country's healthcare system, particularly on the plans for a unified healthcare system capable of realising the right to quality healthcare for all. The paper also notes the important role of increasing access to primary healthcare.

The realisation of the right to health is enhanced by the National Health Act which, apart from those rights entrenched in the Constitution,

emphasises the right to free healthcare for specific groups (namely all except members of medical schemes and those receiving compensation for occupational diseases, especially pregnant and lactating women, children under the age of six, and all those seeking termination of pregnancy services) and the right to hold the healthcare system to account in cases where healthcare services have not satisfied a person's needs adequately.

The Constitution and court judgements unpack the responsibilities of government further by ensuring that the state must "move as expeditiously as possible towards the full realisation of the right" and take immediate steps to provide minimum core entitlements. The Constitutional Court defined the parameters of what constitutes "reasonable measures" by questioning the reasonableness of a programme that excludes a significant segment of society. The Court stated that "[i]t may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right ... [I]f the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test" (Government of the Republic of South Africa and Others v Grootboom and Others (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000)).

International obligations

The Constitution sets the benchmark for determining the role of international law domestically. Section 39(1)

"The right of access to healthcare services is one of the indivisible and interdependent rights entrenched in Section 27 of the South African Constitution."



of the Constitution states that “when interpreting the Bill of Rights, a court tribunal or forum must consider international law, and may consider foreign law”. The individual’s right to health is recognised by the Universal Declaration on Human Rights, which states that “everyone has the right to an adequate standard of living for the health and well-being of himself and of his family ... including medical care” (G. A. res. 217A (III), U.N. Doc A/810 at 71 (1948)).

National Health Insurance

The National Health Insurance (NHI) programme is a state initiative to improve the constitutional prerogative of egalitarian, universal healthcare. Although a degree of healthcare is broadly available, most national health institutions battle to realise the right to healthcare, particularly if one considers that this right must be realised progressively. While quantitative access to healthcare has been achieved, the public health sector is plagued by poor management, a lack of capacity and resources, long waiting times for patients, and poor access for vulnerable and marginalised people.

“[M]ost national health institutions battle to realise the right to healthcare, particularly if one considers that this right must be realised progressively.”

Currently, the private health sector consumes a disproportionate portion of the country’s resources compared with the number of people that it services. According to the South African Human Rights Commission (SAHRC) 2009 Health Report, findings showed that in 2003-2004 medical schemes spent approximately R8 800 per beneficiary per month while in the public sector the figure was approximately R1 050 for persons who were members of medical schemes. According to the latest figures, the state spends some R33.2 billion on healthcare for approximately 38 million people while the private sector spends some R43 billion on healthcare for about 7 million people (Public Inquiry: Access into Health Care Services (2009), South African Human Rights Commission).

The recent National Development Plan (NDP) released by the National Planning Commission of the Presidency lists the NHI as one amongst several urgent initiatives to address national inequality. The NDP clearly recognises the scale and challenges of implementing the NHI, and

suggests that it could take between 15 and 25 years to incrementally roll out this ambitious plan (*National Development Plan 2030: Our future – make it work*; www.info.gov.za/view/DynamicAction?pageid=623&myID=348761). The primary health aims of the NDP health plan include increasing the national life expectancy to 70 years, reducing infant mortality rates, reducing the national burden of disease, and ensuring that the present under-20-years generation remains HIV-free.

For the NHI scheme to be successful, it must be accompanied by strong management and optimal budget allocation. Before its implementation, proposals on the NHI scheme must be circulated widely for public comment, and this process must include the participation of those which it seeks to assist (i.e. the poorest and most marginalised). If implemented with a constitutional and human rights basis in mind, the NHI scheme has the potential to benefit all South Africans in many ways, including:

- + the provision of universal access to healthcare for all South Africans;
- + an increase in the realisation of the right to dignity and life for more South Africans;
- + an increase in equitable access to healthcare, reducing disparities in equality of access to healthcare;
- + a decrease in maternal, infant, and child mortality rates; and
- + a better functioning primary healthcare system.

Conclusion

The NHI will be of great benefit to the general population and for the advancement of human rights. It must, however, be implemented with a meaningful public engagement process, access to information, and cognisance of the rights of all people – both users of the public and private healthcare facilities and marginalised groups of people. Only then will it bring out the positive qualities of the private and public sectors and meaningfully increase the right to access healthcare for all.

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The NHI Green Paper

The levels of uncertainty about the status and content of the NHI are high. It is not clear that the Green Paper correctly diagnoses the problems. One cannot therefore be sure that the correct solution is being suggested.



The National Health Insurance (NHI) Green Paper was released by the Department of Health on 12 August 2011. Over a year later, and after much talk, it is still not exactly clear what is meant by “NHI”. Is it a funding mechanism, or will it replace the entire health system?

Our Minister of Health often describes the NHI to mean that every citizen will have access to good quality healthcare. It is obvious that this is desirable, but how precisely this will be achieved by the proposals set out in the Green Paper is unclear. With the lack of a clear definition of NHI, no White Paper in sight, and the National Treasury’s discussion document promised for April 2012 now only expected before the 2013 budget, the levels of uncertainty about the status and content of the NHI are high. Nevertheless, with the so-called implementation of NHI pilot projects, it seems as though South Africa is still rapidly moving towards this elusive reform.

“South Africa as a country cannot afford to embark on the wrong type of reform.”

With the publication of the Green Paper it appears that the Department of Health is serious about health reform. However, the lack of detail and many statements unsupported by references or evidence is worrying.

It is not clear that the Green Paper correctly diagnoses the problems. One cannot therefore be sure that the correct solution is being suggested. The challenge facing public healthcare is not the two-tiered health system and inequalities between public and private healthcare, as suggested by the Green Paper. The real problems in public healthcare are systemic and relate to lack of accountability and governance, poor management, and a failure to implement existing policies. In private healthcare, problems relate to lack of appropriate regulation, market inefficiencies, and lack of price competition.

As a result of the misdiagnosis, the Green Paper suggests that a single-tier health system should be implemented (although “single-tier” is not defined). It is also not clear why the goal is to eliminate the current tiered system.

A more appropriate goal would be to provide quality healthcare for all citizens which could be done using a number of health system configurations.

What is being proposed?

This is a good question. Unfortunately there is no easy answer.

The Green Paper explains that this single-tiered health system will be administered by a single fund which we assume will be a single purchaser of healthcare for the country. A clear omission is clarity on the relationship between the "NHI" and the current health system, which includes the public and private health sectors.

The Minister insists that NHI will not be possible until the quality in public healthcare is improved. This recognition is an important qualifier. It may thus be worth viewing the Green Paper as a first step in bringing together stakeholders to engage in a dialogue about the best way forward for our health system. The more engagement – with experts, stakeholders, civil society protectors of the public interest, and patients – the better.

Why is it being proposed?

Even a cursory glance at the newspapers suggests that serious action needs to be taken to address the poorly functioning public healthcare in the country. South Africa spends more on healthcare than our peer countries and yet our health outcomes are far worse. This sends a signal that throwing money at the problem is unlikely to yield the desired results. In this light, a proposal to increase spending on healthcare is ill-conceived. A better option would be to focus on management, governance, and accountability in public healthcare while improving efficiency and cost containment in private healthcare.

Some have contended that "NHI" is more of a political tool than an initiative for embarking on real health reform. But it appears that the Minister of Health does realise the importance and urgency of fixing up the health system. We may find that given the opaqueness that characterises the NHI Green Paper, "NHI" will come to mean any health reform-related intervention. From the point of view of developing a coherent policy aimed at strategic health reform, this is unsatisfactory.

Are we on the right track?

With strong industry lobbies and – given South Africa's poor record in the corruption department – the threat of capture of any centralised fund, we need to proceed with caution, but not slowly! Any proposed reform, especially one as potentially dramatic as "NHI", needs to be well-supported by evidence and must be shown

to fit into our rights-based constitutional framework. We need to ensure that we have correctly identified the real causes of poor quality and inefficiency in public healthcare so that our solutions are appropriate.

"We may find that given the opaqueness that characterises the NHI Green Paper, 'NHI' will come to mean any health reform-related intervention. From the point of view of developing a coherent policy aimed at strategic health reform, this is unsatisfactory."

Conclusion

Given the complexity of health systems and the vital part they play in delivering the right of access to healthcare, South Africa as a country cannot afford to embark on the wrong type of reform. It is a tricky balance between carefully and systematically deciding on the correct reforms while making progress on improving the quality in the public health system and continuing to ensure that the social protection mechanisms enshrined in the Medical Schemes Act are upheld.

For more detail on the Green Paper and for references to the claims made above, please take a look at the Helen Suzman Foundation's submission to the Department of Health: <http://www.hsf.org.za/projects/health-reform/national-health-insurance-project-developments/hsf-national-health-insurance-submissions>.

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Helen Suzman Foundation (HSF)

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Malpractice indemnity in an NHI system

If after the introduction of NHI state patients receive care in the private sector, it will be important that there is clarity as to where liability for negligent treatment lies.



The existing arrangements for malpractice indemnity differ depending on whether care is delivered in the private or state sector:

At present healthcare professionals working in the private sector are responsible for ensuring that they have their own professional indemnity arrangements in place. In the event that a healthcare professional provides negligent care, the patient would pursue that practitioner under the law of delict for financial compensation. The practitioner is personally liable.

The patient's access to compensation may be put at risk if the practitioner fails to put adequate and appropriate indemnity arrangements in place.

Patients treated in the state sector would bring any claim for compensation for negligent treatment against the state.

Treasury regulations accept that the state is vicariously liable for the acts or omissions of state employees, thus the state would be responsible for the payment of compensation due to the patient.

Patients treated privately are compensated by the private practitioner who has their own indemnity arrangements in place.

Patients treated in state (i.e. provincial) hospitals and clinics are compensated by the province.

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

“[D]ecisions about no-fault compensation need to be made through a robust and independent process and in a timely way.”

There would appear to be two options. Either the state takes responsibility for indemnifying the patient regardless of the sector in which the state patient receives treatment. Or, the state requires the private provider to have their own indemnity arrangements in place.

No-fault compensation

No-fault compensation schemes – where the patient does not have to sue the provider to secure compensation – operate in several countries and are frequently discussed in many others.

With no-fault compensation schemes patients do not need to prove fault although other qualifying criteria, such as the “avoidability” test, may be applied. There is still a requirement to prove that the harm was caused by the act or omission of the provider.

“Undoubtedly a system of accountability and learning would need to be carefully considered if the introduction of no-fault compensation were to be seriously contemplated.”

There are clear benefits to no-fault schemes but there are also significant drawbacks.

More people would obtain compensation because of the removal of the requirement to prove fault. However, this may mean a higher overall cost even with the potential reduction in legal fees, and despite the fact that financial compensation or entitlements in the existing schemes are usually set lower than those in successful clinical negligence claims brought under delict-based systems.

To be effective, decisions about no-fault compensation need to be made through a robust and independent process and in a timely way. It must be simple to access and people who use the scheme must feel that they have been treated equitably. Compensation could be awarded much more quickly, because the award could be made by administrative means or a tribunal rather

than following an adversarial process. A no-fault scheme also has the potential to integrate issues such as rehabilitation with financial compensation.

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

Critics of no-fault compensation will often cite the lack of accountability and lack of a patient safety incentive. There are concerns that by removing the element of fault-finding, doctors are no longer held to account for the mistakes they make and the opportunity to learn and improve is diminished.

Undoubtedly a system of accountability and learning would need to be carefully considered if the introduction of no-fault compensation were to be seriously contemplated. So too would the cost.

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The Registrar's Office, where it all comes together

The Office of the Registrar of Medical Schemes is headed by the Chief Executive of the Council for Medical Schemes (CMS) supported by an Executive Assistant. The Office encompasses the Complaints Adjudication Unit and the Clinical Unit housed within the Strategy Office, both headed by the Strategist.



Dr Monwabisi Gantsho
Chief Executive & Registrar

Dr Gantsho has been at the helm of the CMS since June 2010. Equipped with a medical qualification, experience as a medical doctor, and a number of qualifications in the fields of management, economics, politics, and leadership from respected local and international alma maters, Dr Gantsho has taken the wheel of the CMS with a steady hand.

The Chief Executive and Registrar describes himself as easy-going but very serious about his work. It is impossible not to notice his passion for providing the best healthcare for all South Africans and his clear vision for the CMS. "I am committed to ensuring that the CMS continues its role in the protection of beneficiaries, supporting the industry, and assisting the Department of Health wherever it may be deemed necessary."

The medical schemes industry is a complex industry and with the proposed National Health Insurance (NHI) fast approaching, nobody is more aware of the unique position that the CMS holds than the Registrar.

"Currently in the industry we are grappling with the issues of value-add by schemes, high healthcare costs,

and increasing quality healthcare in South Africa. But it is not all doom and gloom. I am confident that my Office is steadily increasing the culture of healthcare activism in this country. The future is busy for the CMS, with the biggest challenge being to form an indispensable hub of excellence and efficiencies in the NHI implementation."

Dr Gantsho has a large extended family and in spite of his many work commitments he tries to spend as much time as he can with his wife Moloko and their three children: Sanelisiwe, Lerato, and Luvuyo.

And what does one of the busiest men in the industry do to unwind? "I enjoy reading biographies and books on management and leadership, and playing the odd round of golf."

Dr Boshoff Steenekamp
Strategist

Dr Steenekamp has been with the CMS for seven years. He heads up the Complaints Adjudication Unit and the Office of the Strategist, which houses the Clinical Unit.

"My key role as Strategist is to develop and maintain the CMS's Strategic Plan and to develop a performance measurement mechanism to ensure that we discharge our mandate effectively."

A medical doctor by profession, Dr Steenekamp enjoys getting his medical feet wet with his work in the Clinical Unit, whose main aim is to provide clinical support to the CMS.

Dr Steenekamp attributes his ability to execute his duties to his quantitative and qualitative analytic skills and his numerous qualifications in the medical field.

He is also a keen biker: "The prospect of a biking weekend somewhere in the near future is my caffeine."

“The medical schemes industry is a complex industry and with the proposed National Health Insurance (NHI) fast approaching, nobody is more aware of the unique position that the CMS holds than the Registrar.”



Nthabiseng Sephadi
Executive Assistant

Being the Executive Assistant to any Chief Executive is a very challenging job but it is also a wonderful opportunity to learn the ins and outs of an organisation and an industry. Nthabiseng Sephadi is the Executive Assistant to the Chief Executive of the CMS and Registrar of Medical Schemes.

Having joined the CMS just over two years ago, the Human Resources Management graduate credits her ability to do her job to the skills she has acquired all throughout her working life and during her studies.

“I have to manage myself and my time carefully, while also planning, organising, and taking initiative. I love dealing with people so this job fits my personality.”

Nthabiseng is raising her two children, Mzwandile and Naledi, together with her husband of seven years. She describes herself as friendly and kind, and even though she manages a very hectic office, she always seems to have a smile on her face.

To unwind Nthabiseng spends time with her family playing games or taking a walk.



Thembekile Phaswane
Senior Manager: Complaints Adjudication

The Complaints Adjudication Unit at the CMS deals with complaints against medical schemes, administrators, managed care organisations, and healthcare brokers. As the Senior Manager at the helm of the Unit, Thembi is responsible for leading the team that makes sure that members' rights are protected and medical schemes meet their obligations.

Thembi has been at the CMS since the very beginning (2000). She has risen through the ranks after being hired as a Complaints Analyst. She is passionate about her job. “It is very comforting to know that I am in charge of a team that is just as hard-working, supportive, and reliable.”

Thembi's team consists of five Legal Adjudication Officers, one Senior Legal Adjudication Officer, and an Administrator.

Gugulethu Blose
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The NHI and South African legal frameworks

The Green Paper on NHI envisages numerous legal reforms, many of which would require legislative changes to ensure effective implementation.

The Green Paper on National Health Insurance (NHI) envisages numerous legal reforms, many of which would require legislative changes to ensure effective implementation. An NHI system would also require consideration of existing policies and legislation in order to prevent overlapping and/or conflicting legislative provisions. Some legislative changes have already been initiated; this article discusses some of the potential legislative changes and their implications.

Compliance with the Constitution

The NHI is proposed as one of the measures adopted by the state to give effect to Section 27 of the Constitution. Section 27 therefore sets the criteria (reasonableness, progressive realisation etc.) which would have to apply to all the legislative interventions aimed at giving effect to the NHI.

The legislation and policies giving effect to the NHI must comply with the interpretations of Section 27 as set by various cases on Section 27, such as that the specific law or policy (programme) must: be “reasonable”, clearly allocate responsibilities and tasks, ensure resource allocation that enables appropriate implementation, and cater for the most vulnerable.

New legislation is not constitutionally required to be the best or most favourable measure.

Apart from Section 27, the constitutional powers awarded to provinces may also be impacted by the move towards an NHI. The Constitution awards to provinces the power to make legislation on “health services” as a so-called concurrent legislative functional area (Schedule 4).

does not speak to each other. Basically Section 146 states that national legislation prevails over provincial legislation if it deals with, amongst others:

- + a matter that cannot be regulated effectively by individual provinces;
- + a matter that requires uniformity across the nation (i.e. one that establishes norms and standards, frameworks and/or national policies); and/or
- + the promotion of equal opportunity or equal access to government services.

Section 146 also states that “national legislation prevails over provincial legislation if the national legislation is aimed at preventing unreasonable action by a province that is prejudicial to the economic, health, or security interests of another province or the country as a whole”.

The move to an NHI would therefore entail a review of existing provincial health legislation for potential conflicts and may require amendments or realignment based on the NHI policy and legislation, once finalised.

A last constitutional consideration relates to the matter of “Money Bills”. The Constitution states that “a Bill is a money Bill if it (a) appropriates money; (b) imposes national taxes, levies, duties or surcharges; (c) abolishes or reduces, or grants exemptions from, any provincial taxes, levies, duties or surcharges; or (d) authorises direct charges against the National Revenue Fund”. The NHI Fund legislation would be a Money Bill.

Legislation to frame the NHI

Specific legislation would be required to establish the NHI system, likely one Act relating to the NHI Fund and another relating to an NHI Authority and its powers, which would need to create a legislative framework or link to legislation such as the National Health Act 61 of 2003 for the implementation of NHI aspects such as formularies and other mechanisms aimed at establishing uniformity as is required by Section 146 of the Constitution.

“The NHI Green Paper makes it clear that medical schemes can continue to exist.”

Section 146 of the Constitution provides for a conflict-resolution mechanism if provincial and national legislation (such as that relating to the NHI)



“It is not yet clear how the NHI would interact with other pieces of social security regulation.”

Financial and taxation legislation

The Green Paper envisages the payment of contributions in the form of a tax, or more than one tax, into an NHI Fund. The Income Tax Act 58 of 1962 would need amendment to facilitate the collection of NHI taxes.

The rules of the NHI Fund, as contained in its empowering legislation, would have to take into consideration financial legislation. The provincial equitable share is set according to the constitutionally mandated formula determined by the Financial and Fiscal Commission. The NHI Fund legislation may affect the existing allocations to provinces made under Section 214 of the Constitution, but has to consider the factors listed in the Constitution.

“The NHI may require a revisit of ethical rules and the recognition that has been given to patient choice, which might be limited within the NHI setting.”

The NHI Fund legislation would be subject to provisions of Section 216 of the Constitution (National Treasury Control) and legislation such as the Public Finance Management Act 1 of 1999 (PFMA) and its Regulations. In terms of the PFMA, the NHI Fund and Authority would be Schedule 2 public entities, and the Preferential Procurement Regulations would become applicable to all procurement undertaken by the NHI.

Coexistence of medical schemes

The NHI Green Paper makes it clear that medical schemes can continue to exist. However, the exact form of this coexistence is not yet clear and may necessitate changes to legislation.

Amendments to the National Health Act

A key NHI-envisaged amendment to the National Health Act is on provisions relating to the establishment, powers, and functions of an Office of Health Standards Compliance. This amendment went through Parliament in 2012 and will be brought into effect in 2013.

It is perhaps the first formal NHI-prompted legislative change that has taken place.

The structures through which decisions are made, advice is provided, and services are delivered, as outlined in sections of the National Health Act relating to the national, provincial, and district levels, may require revision.

Implications for other social security legislation

It is not yet clear how the NHI would interact with other pieces of social security regulation, such as the Compensation for Occupational Injuries and Diseases Act 130 of 1993 and the Road Accident Fund Act 56 of 1996. However, it is likely that some mechanism of excluding services rendered and paid for under these systems will be created under the NHI, or that some mechanism of transfer will be arranged from one fund to the other.

The Mines Health and Safety Act 29 of 1996 may require amendments or some inter-fund agreement.

In any event, patients should be clear under which circumstances they would be utilising occupational health services, when they would be utilising NHI services, and when they would be utilising employer-funded health services which are not occupational health services.

Labour law implications

Should the NHI require the transfer of operational and/or administrative staff from the provinces to the NHI Fund and/or Authority (e.g. in instances of centralised procurement or where staff fulfil certain administrative functions that would fall under the NHI), the provisions of Section 197 of the Labour Relations Act 66 of 1995 would have to be adhered to, i.e. all staff would have to be taken over as a “going concern”. Such staff transfers would be influenced by the agreements in the sector, as concluded under the Public Health and Social Development Sectoral Bargaining Council.

There are labour law implications for NHI contributors and beneficiaries where the NHI legislation may require payroll deductions if, in cases of medical scheme contributions, they were part of employee benefits.



“Specific legislation would be required to establish the NHI system, likely one Act relating to the NHI Fund and another relating to an NHI Authority and its powers.”



The exemption of certain categories of employees from payroll deductions may have implications under employment equity legislation.

Healthcare professional legislation

Currently healthcare professional legislation contains various restrictions on who can employ whom and who can own shares in what type of health facility. For example, pharmacists and nurses may not be shareholders in doctors' practices. They are also not permitted to work together as equals or, in some cases, as employees. Under an NHI it may be necessary to revisit these legislative prohibitions in the interest of efficient, larger-scale service delivery centres. It may also be necessary to establish more categories of independent practitioners, e.g. private sector nurse practitioners.

The NHI may require a revisit of ethical rules and the recognition that has been given to patient choice, which might be limited within the NHI setting. Increased commercial influence is a possibility should practice structures and cooperation between practices change. Billing rules would be affected if practitioners were paid according to DRGs and capitated fees, which may influence treatment choices and require dispute-resolution mechanisms.

Medicines and pricing legislation

If more patients move from the private sector and the medical schemes sector into the NHI sector, the system of medicines pricing in the private sector might require revision. Depending on the size of the “remaining” private sector market, price regulation may not be necessary. If private pharmacies become suppliers of NHI medicines, the current dispensing fee and keeping NHI stock separate from “private” stock might also require investigation and possible amendments to legislative requirements currently in place (both in terms of the Medicines and Related Substances Act 101 of 1965 as well as the Pharmacy Act 53 of 1974).

The system of procuring medicines and medical devices under an NHI may require formalisation subject

to provisions of the PFMA and preferential procurement systems.

Privacy, access to information, and data protections

Unless the NHI legislation makes specific provision for it, the whole NHI system will be subject to privacy and general access to information legislation such as the Promotion of Access to Information Act 2 of 2000 and the Protection of Personal Information Act (still a Bill at the time of writing this article). Some health-specific protections are included in the current National Health Act, but the more sophisticated and comprehensive the NHI patient database and records, the greater the protections and permissions required under it. Access permissions and restrictions would have to be regulated.

Consumer protection

Unless exempted from it, the Consumer Protection Act 68 of 2008 would apply to the goods and services rendered under the NHI.

Given Section 46 of the National Health Act that only private providers are required to have sufficient professional indemnity cover, this section may require amendment to also ensure protection for NHI patients where services are rendered by NHI-employed or contracted professionals and facilities.

Conclusion

The proposed NHI system has numerous implications for legislation. Most of the above are conceivable legislative changes, but there may be more, or different, approaches to what is explored here. In the end, the requisite changes will depend on the final NHI plans and the details which accompany those plans. And on this, only time will tell!

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... or write to us
... or come see us in person

In 2012, we continued to publish various documents on our website, including:

- + our Annual Report 2011-2012, which includes trends and detailed statistics on South Africa's medical schemes industry
- + 69 judgements of the Appeals Committee and the Appeal Board
- + 48 Circulars
- + 17 press releases
- + 15 documents on ITAP (Industry Technical Advisory Panel)
- + 8 issues of CMScript, our e-newsletter on medical scheme members' rights to prescribed minimum benefits (PMBs)
- + 7 guidelines and manuals
- + quarterly reports on the financial performance of medical schemes
- + discussion papers

Visit www.medicalschemes.com for more information and to subscribe to our publications.

Use our website to:

- + Find out more about your rights and responsibilities as a member of a medical scheme.
- + Get answers to the most frequently asked questions about medical schemes and how they work.
- + Do your research on the medical schemes industry in South Africa.
- + See whether your medical scheme is registered.
- + See which administrators and managed care organisations are accredited.
- + Check if your healthcare broker is accredited.
- + Get the rulings in complaints and appeals, up to the Constitutional Court.
- + Get the contact details of all the major role players in the industry.
- + Find all kinds of useful information, including forms, discussion documents, statistics, research papers, and the Medical Schemes Act.

How to avoid disputes

- + Understand the rules of your medical scheme.
- + Read all correspondence.
- + Study your benefits guide.
- + Familiarise yourself with the terms and conditions of the benefit option you have chosen.
- + Pay your contributions in full and on time every month.

How to resolve disputes

- + Speak with your medical scheme first. The law requires all schemes to establish dispute resolution committees. Give full details of your complaint and include any supporting documents.
- + If you are not satisfied with the outcome of your complaint to the scheme, lodge a written complaint to the Registrar of Medical Schemes at the Council for Medical Schemes (CMS). There are a number of ways in which you can contact us. All the contact details can be found in this newsletter.
- + If you feel aggrieved by the decision of the Registrar, appeal his/her decision to the Appeals Committee of the Council.
- + If you feel aggrieved by the decision of the Appeals Committee, appeal to the Appeal Board.
- + Rulings of the Appeal Board can be appealed in the High Court.



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*We are moving
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