Sizani

Universal Healthcare for South Africa

Contents:

6 building blocks of a health system by WHO

1. Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources.

2. A well-performing **health workforce** is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).

3. A well-functioning **health information** system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.

4. A **well-functioning health system** ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.

5. A **good health financing system** raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.

6. Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition- building, regulation, attention to system-design and accountability.

1. Introduction:

The global trend in public health is to move towards providing universal healthcare. It is crucial that South Africa follows suit. In addition to the complexities of delivering public healthcare, is our country's history of segregation and subsequent legacy of inequalities.

This has meant that the millions of South Africans who make use of the **public health system form over 80%** of the country's population. This has also meant that those who have no choice but to surrender themselves to the public service are mostly poor and they are mostly black South Africans.

Public healthcare in this country has become a microcosm of South Africa's legacy of insiders and outsiders. The **deep inequalities** which exist in our country play themselves out painfully in the health system.

The majority of South Africans make use of public health facilities which are overly burdened; with crumbling infrastructure; often with critical medication stock-outs, long waiting times in queues and public healthcare professionals who are evidently over-stretched.

On the other hand, the **16% of South Africans who rely on the private health** system do so at increasingly high rates which lockout more people from medical schemes and lends itself to exploitative practices. This once again entrenches the notion of those who have access to quality healthcare and those who have been relegated to a lower-class system.

South Africa is one of the countries which spends the most on healthcare, with an **accumulative budget of over R222 billion** across all departments and its entities. A department with a budget this large should – at the very least – provide an adequate level of care. However, we know this not to be true.

The Democratic Alliance (DA) has devised a plan that would roll out universal healthcare to the people of South Africa. This would be done within the current budget envelope; without destroying the economy; without the increased opportunity for mass scale corruption and with the provision of quality healthcare.

Sizani Universal Healthcare (SUH) will ensure a comprehensive package of quality services within the public health system – free at the point of access to everyone while retaining and reforming the medical aid system.

For South Africans who **have no medical aid**, the reforms described below and in the full document will deliver improved service at clinics and hospitals, enhanced maternal and childcare provision and access to efficient – and free at the point of service – emergency services in urban and rural areas.

Those who **are on medical** aid will benefit from enhanced choice and greater access to more efficient – and free at the point of entry – service.

2. Basic idea

Sizani will see the implementation of a **national strategic resource allocation scheme** to operate within the first tier of government. This scheme would allocate a **universal subsidy** in respect of **every eligible person** in South Africa, **irrespective of whether or not they are covered by the public** or **private health systems**.

> The **value** of the subsidy would be set in **relation to an affordable and comprehensive package** of services available within the public health system.

Other points of the plan include:

- Within medical schemes, **benefits will be standardised for the main package**, whilst medical schemes will be allowed to offer top-up cover.
- Every person will be able to **choose whether to buy public or private sector cover with their subsidy** – with rules against opportunistic movement between the two.
- **Public services are free at the point of service for both** those who have medical aid membership and those who do not. **Medical schemes will increasingly pay for public services** used by their members as the quality thereof improves.
- An **Information and Information Technology Regulator** will provide data on which health services are available by cost and quality at every entity nationally.
- Incentivise **medical schemes to compete on the cost and quality** of the health services they fund.
- This will eliminate the funding gap for those who fail the means test but cannot afford medical aid, by **eliminating the means test itself**.
- To **prevent so-called stock-outs**, reform provincial logistics to enable incorporating their costs into tender prices and structure depots to run like businesses.

3. Additional resources

Additional resources will be allocated to crucial sectors. By bringing the medical aid tax credit on budget and allocating some of it to build better services in the public health sector, those South Africans with **medical aid are cross-subsidising** those without, a welcome act of health justice.

- Provide an additional **R1 billion per year towards the training** of medical, nursing and health professional staff.

- Provide an additional **R2 billion per year for expanded maternal and child health programmes** for which clinics and hospitals that qualify compete.

- Provide an additional **R1 billion for a single number national public-private emergency service** governed by an independent board.

- Provide for **expanded clinic-building programmes, especially for under-served areas** nationwide by devoting an additional **R2 billion** per year to building and staffing clinics.

4. Regulatory requirements

- **Reform the Council of Medical Schemes** (CMS) to have a board that is independent of the Minister of Health and the entities it (the CMS) regulates.

- **Reform the medical schemes** so that they compete on the **cost and quality** of the health services they cover, rather than on the risk groups they target.

- Introduce **autonomous public hospitals and district health authorities governed by independent boards** and with wide operational discretion allocated to executive heads to carry out their mandates.

- Insists on having **clinically trained chief executives of hospitals** and managers of health facilities.

- Extend nationally, the **Western Cape's reliance on inter-sectoral collaboration with non-governmental organisations (NGOs), private companies** (Clicks), pharmacists, private physiotherapists, general practitioners (GPs) and complementary medicine and allied healthcare professionals.

- Extend nationally, the Western Cape's system of **having three service streams** (1) home and community-based services provided by community healthcare workers; (2) intermediate care and (3) primary health clinics, community health centres and day centres.

- Introduce a **Quality of Care Regulator** to replace the weak Office of Health Standards Compliance (OHSC). This Regulator will define and review the 'standard package' funded by the universal subsidy and oversee and audit the actual quality of care provided by all public and private health facilities.

5. Compared to NHI

We believe access to healthcare should be determined by an individual's need, not their financial status. The **DA unequivocally support universal healthcare**, but the National Health Insurance (NHI) model proposed by the ANC will not truly achieve this.

Having studied the available NHI Bill, the DA is left with many concerns, including:

- questions over financial viability;
- the risk of a medical skills drain;
- the massive potential for institutionalised corruption;
- the absence of a plan to address the already failing public healthcare service; and
- the lack of adequate public participation in decision-making, especially within the National Health Council. The provinces are the implementing arms of healthcare.

Indeed, the proposed creation of a single National Health Insurance Fund is **little more than the creation of another enormous state-owned entity (SOE).** This is very concerning considering the government's dismal performance in managing SOEs and its equally dismal performance in providing healthcare.

Institutionalised corruption is already a feature of public healthcare in South Africa. With the NHI proposing to make the state the sole purchaser and financier of health services in the country, the potential for corruption is boundless and terrifying.

It has become clear that government is incapable of exercising any control over the wanton maladministration that is rife in the South African public healthcare. If the NHI is implemented and the budget increased by hundreds of billions of rands, institutionalised corruption is sure to spread to the entire South African health system.

The proposed legislation will **effectively lead to the nationalisation of health services** if doctors and other providers are forced to contract to the NHI. The draft NHI Bill in its original form and more so in this revised form will **do nothing to address the collapsing healthcare system**. It is a **blatant attempt to nationalise the private healthcare** system and to **remove funding and functions from provincial departments**.

The failing of the **multibillion-rand NHI pilot** projects is exposed in a report from the health department. Government has spent R4.3 billion between 2012/13 and 2016/17 on 10 NHI pilot sites with no clear monitoring and evaluation framework – making it almost impossible to gauge its effect.

The key differences between the DA's plan for universal healthcare and NHI are outlined below:

	National Health Insurance	*Sizani*
Core	Setting up a **central fund** to buy health-care services for South Africa's entire population. Beyond the obvious issues with managing such a complex fund, which government has failed to do in other cases, it provides a giant pot for looting.	Allocate a **universal subsidy** to every South African citizen and legal resident, irrespective of whether or not they are covered by the public or private health systems. The value of the subsidy would be set in relation to an affordable and comprehensive package of services available within the public health system.
Funding model	Financed by **yet-to-be-determined** mandatory payments from those who can afford to pay as well as scrapping medical scheme tax credits. In the past, National Treasury said it was considering hiking payroll taxes or a new surcharge on personal income tax.	The universal subsidy would be funded from a combination of **existing budget allocations** for public services together with a re-allocation of the **off-budget tax credits** presently allocated to medical scheme members via the tax system.
How long will it take to implement?	10-15 years	5-8 years
How are healthcare service costs determined?	Prices are set by a **ministerial advisory committee** and bought by central government from accredited public and private sector providers.	Provide for an information system that makes transparent the nature, quality and price of every service provided by health facilities in the public and private sectors nationwide. **Costs are kept down as public sector and private sector becomes more competitive**.
System governance	More **centralised control by Minister** – vulnerable to state capture.	Implementation of **localised accountability systems** to hospitals and district health authorities, as well as

		decentralises decision-making and appointment processes
Who chooses where you can get healthcare?	**Central government** from accredited public and private sector providers.	Every person will be **able to choose** whether to buy public or private sector cover with their subsidy – with rules against opportunistic movement between the two.
Fees at point of service?	Everyone will be registered with the fund, and no-one who is a citizen/permanent resident will pay at the point of care. Patients will have to follow correct "referral pathways" and can't go directly to a specialist.	Public services are **free at point of service** for both those who have medical aid membership and those who do not. Medical schemes will increasingly pay for public services used by their members as the quality thereof improves.
Does it work in practice?	**NHI pilot projects have failed** across the country with late (perhaps even non-payment) of doctors; financial problems; non-renewal of contacts; under-expenditure of conditional grants; rise in unemployment; staff shortages; shortage of equipment and medicine; and infrastructure problems	**Aspects of our plan have been implemented in the Western Cape** where mortality rates are lower – half of any other province, it has attracted the highest number of South African doctors and has the highest number of specialists per capita. Hospitals and clinics are better maintained and have far better resources.
How will the current public-sector healthcare be improved?	The NHI **isn't designed to fix a health-care system** that has already collapsed under government stewardship. It diverts attention from issues that should be dealt with now.	The Western Cape has proven within its current budget to run the best healthcare system in South Africa. This model, if applied nationwide and accountability is decentralised, is **set to improve healthcare facilities**.

6. Financing

Achieving universal health coverage requires institutional/structural reforms rather than additional financing.

Sizani will strategically reform the system **within its current resource envelope** and strengthen our constitutionally ordained and provincially organised public healthcare delivery system. The total accumulative budget of over **R222 billion** across all departments and its entities, is enough to ensure universal healthcare.

These reforms hold out the opportunity for substantial efficiency gains in both the public and private systems. However, bringing the medical aid tax credit on budget adds **R27 billion** (*Budget Review 2019*: Table B3) in revenue to the national budget (*Table A*).

In the DA's Sizani plan (see table A) we nominally set aside from this amount an additional indicative R2 billion to Maternal and Child Health, R2 billion for the Primary Health Care clinic programme, R1 billion for Emergency Services and R1 billion towards the Health Education and Training platform. The balance of R11 billion is paid over to medical aid schemes, R2 billion of which is used to finance their members' use of public health facilities and R9 billion to subsidise members' medical aid fund monthly contributions.

Because the R27 billion belongs to medical aid members, the R6 billion devoted to improving public health will be a cross-subsidy from those who have medical aid to those who do not, an act of health justice. Lastly, R10 billion will be transferred to the national strategic resource allocation scheme.

As mentioned before, an Information and Information Technology Regulator will provide data on **which health services are available by cost** and quality at every entity nationally. The value of the subsidy would be set in relation to an affordable and comprehensive package of services available within the public health system.

Once the value of this has been established, the current budget envelope will be redistributed. Funds that will *immediately* be moved from the national Health Department budget (*Table b*) to the national strategic resource allocation scheme will free up an **additional R3.3 billion**.

6. Conclusion

Universal healthcare is non-negotiable in an unequal society such as our own, but South Africa is currently at a cross-road: We can either adopt NHI with dire consequences or we can **stop playing political games** with people's lives and adopt *Sizani*.

The **DA unequivocally supports universal healthcare**, but not the NHI, which will wreck our economy, lead to a brain drain and destroy the private sector.

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24 July 2019

Table A: Bringing medical tax credits unto main budget

Additional resources to improve public sector	**R6 billion**
Training of medical staff	R1 billion
Expanded maternal and child health	R2 billion
National public-private emergency service	R1 billion
Expanded clinic-building programme	R2 billion
Medical aid members using public facilities	**R2 billion**
Medical aid members using private facilities	**R9 billion**
Transferred to national strategic resource allocation scheme	**R10 billion**
TOTAL	**R27 billion**

Table B: Initial Funds moved from National Health Budget

Programme 2: National Health Insurance	R2.7 billion
Consultants: Bussiness and Advisory	R668 million
TOTAL	**R3.3 billion**