THE SOUTH AFRICAN MEDICAL ASSOCIATION SUBMISSION TO:

The Parliamentary Portfolio Committee on Health

In respect of:

The National Health Insurance Bill
(Published 08 August 2019)

29 November 2019

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EXECUTIVE SUMMARY

The South African Medical Association welcomes the opportunity to submit comments on the NHI Bill on behalf of our membership of medical doctors working in public and private healthcare sectors in South Africa.

SAMA has been and remains supportive of the progressive realisation of Universal Health Coverage for people in South Africa.

SAMA can, unfortunately, not support the NHI Bill in the form that it has been ascended to Parliament. In 2018, in response to the Draft NHI Bill, SAMA raised many issues with the contents of the Bill, which have regrettably not been addressed in the 2019 Bill.

SAMA believes that the establishment of an office of the NHI is an important step forward in taking the vision for the NHI forward, but we are extremely concerned that other elements of the Bill, which will be signed into law as an Act, are premature and have not been based on good available evidence for acceptability or implementation.

Such considerations include proposed organisational structures for the health care sector, which have not been piloted anywhere, to our knowledge. Payment mechanisms have also not been designed with the best available evidence in mind, and we are concerned that there will be a substantial challenge should these not function adequately out once they have been signed into law.

SAMA has long highlighted the shortcomings in terms of quality of care addressed by the NHI Policy, NHI Draft Bill and now the 2019 Bill. We remain concerned that there are no definitions of quality of care to be delivered under an NHI-funded healthcare system.

The considerations of immigrants, although improved from the 2018 Bill, will unfortunately not address the concerns of our membership. Doctors at the service level do not discriminate based on citizenship or legal status on the need for health care services, and it is unethical for them to do so. The provisions relating to asylum seekers and illegal immigrants will be impossible for doctors to implement.

Human resources for healthcare are already strained in the South African context, and the current economic, social and political conditions in the country are resulting in an exodus of trained health professionals from the country. South Africa does not have the considered Human Resources for Health strategy, and previous attempts to develop one have been sadly lacking. SAMA's doctors in both the public and private sectors work long hours, and in many instances in the public sector are exposed to unsafe working conditions, poor management of their skills and time and gruelling expectations of clinical work, studies and teaching responsibilities.

SAMA membership has also voiced concerns about issues such as cover for medico-legal claims, which is currently afforded by the Provinces, but for which a place is unclear in the future envisaged system.

Additionally, employment arrangements and benefits are no longer clear, given that the Provinces will be marginalised in their role, and will no longer be the employers of health care workers.

Most of the reimbursement functions under the NHI are envisaged to function on the basis of reimbursement contracts to be signed between the National Health Insurance Fund and health care providers or between intermediate structures like the District Health management offices and some form of organisation of health care practitioners.

It is not clear, where the Fund contracts with hospitals, whether doctors will be employed by these hospitals, or whether they will be contract workers. It is also not clear what the expectations of contracts in primary care will be, nor how these will involve doctors in capitation arrangements. None of these contracting mechanisms have yet been tested, yet the government is on the brink of turning in them into the law of the land.

In order for practices to survive, they need a steady source of cash flow. In the Medical schemes environment, claims have to be paid within 30 days. However, there are no such requirements for the NHI Fund. We are aware of significantly long payment periods for suppliers in the public sector at present, which has in the past threatened the ability of suppliers to continue to supply services and goods to the public sector.

The Bill also proposes significant changes to other pieces of legislation which will, among other things:

- Remove the responsibility of employers to cover the healthcare costs of workers injured on duty. SAMA is concerned that this may take away some of the incentives to ensure a safe working environment.
- Fundamentally change the pricing regimen for medicines and medical devices and in-vitro diagnostics. The proposed changes effectively do away with the Single Exit Price, which operates in the private sector, and the tender prices which operate in the public sector. There is no clear replacement for these two systems.
- Make significant changes to the National Health Act, which will alter the delivery functions of healthcare, changing from the current provincial system to a District managed system. This without testing how well this could work in the country.

SAMA has made a number of recommendations, which we believe may address some of these challenges for the NHI Bill itself. We continue to engage with the policy proposals and envisioned improvements to the health system being pursued through various forums in the country.

INTRODUCTION

The South African Medical Association (SAMA) is pleased to submit its inputs to the Parliamentary Committee, on the National Health Insurance Bill which was gazetted on 08 August 2019.

SAMA recognises the huge potential of the policy of progressive realisation of Universal Health Coverage in influencing the delivery of equitable, quality, affordable and safe health care in this country.

We have participated in commentary and engagement throughout the stages of the development of the National Health Insurance Policy and legislation.

Substantive submissions were made to the National Department of Health in 2016, in response to the NHI White Paper, and again in 2018 in response to the Draft NHI Bill.

SAMA truly wishes to be part of the solution in progressively finding the way to Universal Health Coverage for the country.

The functions and role of the South African Medical Association

Role in the healthcare sector: The South African Medical Association NPC (SAMA) is a professional association for public and private sector medical practitioners. SAMA is a registered independent, non-profit company and a trade union for its public sector members. SAMA membership is voluntary, and the organisation is the largest representative body for doctors in South Africa, with a membership of ± 17,000 registered doctors practising in the public and private sectors.

Relationship with its members: SAMA acts as a voice for its members, represents the interest of doctors at local, regional and national levels, and ensures that the professional expertise and voice of the medical profession has an effective expression in national debates that shape healthcare in South Africa.

SAMA's role in Health Policy in South Africa: SAMA aims to unite doctors for the health of the nation and is a major player in influencing health policy in South Africa and beyond. SAMA supports legislative and policy measures aimed at protecting and promoting public health, and enhancing access to comprehensive, affordable, and quality healthcare in South Africa through both the public and private sectors.

Evidence-based medicine and decision-making

In our day-to-day work as a professional organisation, and throughout this submission, we endeavour to reflect and emphasize the principles of evidence-based decision-making.

SAMA's overall stance on the National Health Insurance

For some years now, SAMA has affirmed its support for the globally accelerating principle of universal, solidaristic, equitable, and responsive health systems.

However, our organisation recognises that the NHI proposals provide both opportunities and threats. The sweeping changes, if not properly planned, properly implemented and efficiently managed, could cause wide-scale harm to the delivery of healthcare.

The greatest opportunities can be found in the improvement of access to healthcare services for all, regardless of socioeconomic status.

In July 2007 the SAMA National Council adopted the following Resolution endorsing the principle of universal access:

"NOTING:

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

Therefore resolves:

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

b) *That SAMA funding be made available to enable such an initiative.*

c) *That SAMA interacts with all forums where funding of healthcare is being discussed to influence outcomes".*

This was followed by another SAMA National Council Resolution in August 2008:

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

1. *SAMA reaffirms its endorsement of a system of Universal Access to healthcare for all South Africans;*
2. *SAMA reaffirms the position that Public and Private sectors both add value and must continue to contribute synergistically to the achievement of this objective under the banner of an NHI;*
3. *SAMA continues to explore, prepare model(s), present, pilot and co-implement practical, viable ways to achieve these objectives;*
4. *Secretariat, BOD, EXCO and relevant Committees take all measures necessary in pursuance of the above;*
5. *Secretariat communicates this resolution and associated process to all SAMA structures to enable them to give feedback and participate meaningfully.*

The above SAMA Resolutions played an important role over the past decade in guiding the SAMA dialogue on healthcare financing reform in the country.

SAMA recognises that there have been significant developments and shifts in the national health financing reform over the past decade.

The NHI proposals were made substantially clearer by the NHI White Paper of 2016, and have provided a platform for engagement, interrogation of over-arching principles and proposals for the health system under a National Health Insurance.

SAMA internal consultation process

SAMA consists of a number of structures or committees namely: the Board of Directors at the top, regional SAMA Branches (20 branches), membership committees and professional affairs committees.

There are three membership Representative Committees, namely, the Committee for Public Sector Doctors (CPSD) representing the interests of all SAMA members employed in the public sector, the General Practitioners in Private Practice Committee (GPPPC) representing the interests of all SAMA General Practitioners, and the Specialists in Private Practice Committee (SPPC) representing the interests of all the specialists groupings in private practice amongst the SAMA membership.

Professional Affairs committees address specific areas in the medical practitioners' professional arena and include the Human Rights, Law and Ethics Committee (HRLE),

the Education Science and Technology Committee (EST) and the Health Policy Committee (HPC).

These committees are supported by corresponding internal departments based at the Head Office in Pretoria.

The main SAMA internal departments central to the NHI project include the Legal and Governance Department, the Knowledge Management, Research and Ethics Department (KMRED), the Private Sector Doctors Department (PPD), and the Employed Doctors' Department.

As SAMA is a membership-based organisation, the voice of members is of critical importance in policy matters.

Therefore, in compiling this official response on the NHI Bill, we consulted our members in their various categories highlighted above. SAMA's internal consultation and engagement around NHI has been effected through:

- Ongoing written correspondence and updates between SAMA Head Office and SAMA members
- Regular meetings of SAMA committees
- SAMA member dialogue at the annual SAMA Conference, August 2018 and August 2019,
- Frequent publication of articles on NHI in our *SAMA Insider* magazine,
- Roadshows and SAMA branch meetings on NHI, the Draft NHI Bill in 2018 and the NHI Bill in 2019.
- A physical NHI symposium for SAMA members on 14 and 15 September 2019.

Additionally, an open call was made to our membership to submit their comments and concerns related to the Bill and (presumably) the media coverage which has accompanied its release, to judge membership's understanding of the reforms and ensure that we adequately represent our doctors.

In November 2019, SAMA also conducted an online survey of the membership in order to confirm that the multiple comments and inputs received through the above processes were indeed the views of the majority of our membership.

The results are summarised as Annexure 1 to this submission.

The views of our member doctors working in public and private healthcare sectors in South Africa were incorporated into the comments which follow.

SUBSTANTIVE COMMENTS

SAMA deeply regrets that it cannot endorse the enactment of the NHI Bill as it is written in 2019.

There are too many areas of ambiguity, which will potentially negatively impact on our member practitioners as well as their patients, for the Association to be able to support the envisaged massive changes to the health system.

There are significantly unclear provisions in all of these areas:

- Addressing the potential for corruption within the healthcare system under a single-payer system
- Governance issues within the Fund, and the significant powers afforded to the Minister of Health
- Proposals for the payment of health care service providers and contracting arrangements, which have not been tested;
- assessment and maintenance of the quality of care;
- Threats to the ethics of medical practitioners under the proposed structures
- Human Resources for health
- Issues regarding public procurement of health care services, medicines, health goods, and health-related products;
- the relegation of important aspects of implementation to regulations;
- the role of complementary cover by medical schemes and private health insurance and
- Proposed changes to other legislation which will have significant impacts

This lack of clarity has made it extremely difficult to take solid positions on proposals within the Bill.

Essentially what is being proposed is a complete overhaul of the health delivery and funding mechanisms, with little to no evidence-based policy inputs, and virtually no trialling or piloting of the proposed models and structures in the South African healthcare system.

Provisions are made, without evidence for their proposed impact, and a meaningful level of detail is still absent.

In addition, submissions from our members in both the public and private sectors demonstrate little faith in the National Health Department to get beyond stages of planning and strategizing and actually implement anything meaningful as far as change management and quality improvement go.

These concerns are generating significant anxiety amongst healthcare practitioners and serving to undermine positive engagement with the progressive achievement of reforms.

1. A Step in the right direction towards Universal Health Coverage

Achieving Universal Health Coverage (UHC) is a target set by the Sustainable Development Goals (SDGs), and SAMA is in support of the achievement of good quality universal health coverage for all.

According to the World Health Organisation, UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care[1].

SAMA has noted, however, that this extensive coverage is achieved progressively, with multiple interventions and improvements required within the health system to be able to make the offering a desirable one.

We recognise that enacting appropriate legislation to enable the mechanisms towards achieving UHC, is necessary within the South African environment operating within the rule of law.

However, we feel that the extent of the regulatory changes being attempted all at once, as well as the switching of multiple functions from different levels of government, has not been adequately addressed by the Bill.

Proposed changes to health delivery structures, shifting of funds from provinces and conditional grants and proposed changes to the way health services will be paid for, will involve significant change management to achieve. Management of implementation and change has not been a strong feature of the Health sector to date, so we are concerned that these massive changes are included in a proposed Act of Law, which leaves little room for fast adjustment in the case of failures.

We address the lack of proper research and evidence-based policy in section 4 to follow (evidence-based policy-making).

The details included in the Bill are incomplete in multiple respects, with many aspects of care neglected or completely left out, that we cannot support the additional details regarding health systems arrangements and functions included in the Bill.

There are too many unanswered questions, and assumptions made about the functioning of systems which we simply do not believe will play out (see section 2: Broken Trust).

The enactment of enabling legislation to enable to Fund to begin its work seems appropriate, but generally, we are concerned that the additional details in the Bill, if converted into an Act of Law, may serve to hinder rather than help the processes towards universal health coverage.

[1] World Health Organisation, 2019. Universal health coverage (UHC). Available at: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc). Accessed 15 September 2019.

2. Deep-seated broken trust

It is regrettable that the NHI proposals have been made during a period in which the mistrust of government has deepened significantly.

The 2019 Edelman Trust Barometer reveals that trust in South Africa has risen for all institutions (NGOs, business, government, media) with NGOs in the lead (60 percent) over business (58 percent) followed by media (40 percent) and government continues to be the least trusted institution (21 percent)[2]. South Africa's Corruption Perception Index continues to be below 50, with no improvement over several years[3].

While this growing mistrust is a global trend, the situation in South Africa has become chronic and entrenched and will take years to correct.

Many of the membership responses we have received regarding the NHI proposals reflect a sentiment that the Government simply will not implement its promises and doesn't actually care whether grand plans materialise to serve the population in reality.

Our public sector doctors are particularly scathing in their comments relating to cadre deployment at management levels, insufficiently qualified or even dedicated management and lack of accountability throughout the systems where they work.

They do not attribute the problems experienced to lack of money, but to governance, management and accountability failures, mixed with purely corrupt practices and patronage.

The public has also lost faith in the healthcare system[4], and its ability to care for them.

Many of SAMA's calls for clarity on issues poorly addressed in the Bill are met with responses from government officials which are essentially "trust us – of course, we will address it".

Unfortunately, these responses are no longer acceptable to the Association. Our membership has indicated that in the majority, their concerns regarding the impact of the NHI lie with the Governance and potential for corruption in the Fund (See Annexure 1).

Before we can fully support the Government in its endeavours, it needs to prove, through its policies, actions, and outcomes, that it really does have the interests of all South Africans at heart, and that the system really can become accountable to the users it serves.

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[2] Daniel J Edelman Holdings. 2019. The Edelman Trust Barometer, 2019. Available at: https://www.edelman.com/sites/g/files/aatuss191/files/2019-02/2019_Edelman_Trust_Barometer_Executive_Summary.pdf . Accessed 12/09/2019.

[3] Transparency International. 2018. Corruption Perceptions Index 2018. Available at https://www.transparency.org/cpi2018. Accessed 06/10/2019.

[4] Maphumulo, WT, Bhengu B. 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. Curationis 42(1), a1901. https://doi.org/10.4102/curationis.

3. Need to address corruption in the Health sector

"*The health sector in both the public and private sectors is most vulnerable to fraud and corruption because of vast and varied numbers of transactions on goods and services in terms of fraudulent orders, tender irregularities, fiscal dumping through non-governmental organisations, bribery, over-pricing, poor governance, transfer of liabilities to the state, and bogus and fraudulent qualifications"*[5].

SAMA was an active participant in the Presidential Health Summit and in the development of the recommendations which followed. SAMA welcomes the President's launch of the Health Sector Anti-Corruption Forum (HSACF) in response to the Presidential Summit findings and agrees that addressing all forms of corruption in the health sector is an important development in the pursuit of universal health coverage.

However, it is noteworthy that even some of the stakeholders who signed the terms of reference for the Forum on 1 October, namely the Council for Medical Schemes (CMS) and the Health Professions Council of South Africa (HPCSA), have been subject to investigations of corrupt practices by the Special Investigating Unit.

SAMA re-affirms its White Paper assertions that corruption is eating away our health system and poses a serious threat to the achievement of health outcomes.

Corruption is not just about money. Systemic corruption rampant in our health sector and the South African environment in general, takes many forms, including tender-preneurship, cronyism, kickbacks, theft of time (absenteeism), bribery, medical scheme fraud, and theft of medicine. Besides being severely costly to the system, corrupt behaviour is unacceptable and puts anyone who practices it, health workers included, at odds with ethical expectations of good professional practice.

SAMA also participated in the CMS Fraud, Waste and Abuse Summit in February 2019, although we did not sign the Fraud, Waste and Abuse Charter at the time. SAMA cautioned then against a simplistic narrative that is one-sided and fails to address the complexity of the beast.

We are on the starting line as far as addressing corruption in the health sector goes, and it is not prudent at this stage to introduce a structure that could lend itself to more corrupt practices.

The establishment of the NHI as a single monopolistic purchaser for healthcare opens its structures up to large-scale corruption.

[5] South African Government: Strengthening the South African health system towards an integrated and unified health system, Presidential Health Compact, 25 July 2019.

The potential for this is enhanced through the large amounts of money which the Fund will be managing, the removal of the Competitions Act from the operation of the NHI Fund and the introduction of a central procurement unit within the Fund.

While SAMA endorses the envisaged corruption-fighting Investigating Unit (Clause 20(2)e), it will be ineffective if the corruption develops within the NHI Fund itself, as the Unit will be unable to confront corruption from within.

The NHIF is a fund and it is not exempt from typical funder behaviour (namely conflict between budgetary constraints and health service delivery). Whilst it can be argued that NHIF is a state entity and access to services is central to its object, the Fund is not exempt from inefficiency and corruption.

SAMA recommends that the initiatives in their infancy in the public and private sector be carefully followed in terms of their impacts and outcomes, and the ability to actually deal with corrupt and fraudulent activities before the proposed centralised structures are signed into law.

4. Governance of the Fund

Related to our comments in section 2, SAMA notes that the NHI Fund will now become a Section 3A entity in terms of the Public Finance and Management Act (PFMA).

In terms of the 2019 Bill, all top-level decision-making functions are effectively appointed and report to the Minister of Health. This includes the Board of Directors, and the CEO of the Fund, as well as the various ministerial committees which will be set up to regulate prices, benefits, and other matters.

SAMA recognises that Ministerial control over these sorts of structures is not unusual, in the international context. Countries such as Thailand and the United Kingdom, which arguably have successful universal coverage systems, have these entrenched in laws that also provide their ministers or secretaries of health with similar powers.

As in Section 2, comments from our membership have quoted mistrust in the Department of Health and its senior staff and functions, as major reasons of concern relating to the envisaged powers afforded to the Minister of Health by the structures in the Bill, and the centralisation of the flow of funds through the National Health Insurance Fund.

SAMA strongly recommends that the Bill should not afford too much discretionary power to the Minister of Health in operational issues of the NHIF.

We also recommend the establishment of an oversight function (beyond the Auditor General) to monitor the activities and finances of the Fund.

Advisory Committees established by the Minister

SAMA notes the positive changes made to the selection and appointment of the key Advisory Committees within the fund, versus how these were to be established in the Draft 2018 NHI Bill.

In the 2018 Bill, **the Benefits Advisory Committee** had previously been "pre-selected" in terms of existing positions and representations specified for certain organisations, e.g. the provinces, universities, Hospital Association, Council for Medical Schemes. SAMA objected to the fact that clinicians were not represented, although this committee would deal with the specifics of clinical benefits.

SAMA is very gratified to see that in the 2019 Bill, the committee will be selected based on a set of skills, including medicine, public health, and epidemiology.

SAMA is also pleased that the **Stakeholder Advisory Committee**, which originally also excluded practitioners and their associations in the 2018 Bill, has now been made more inclusive by the specific addition of “associations of health professionals and providers” AND “patient advocacy groups” within the committee. These are positive developments.

However, the process of selection of the members of these committees has not been made clear in the new Bill and is, we believe, open to manipulation.

For example, in the appointment of the Board of the NHI, clause 13(3) states that “An ad hoc advisory panel appointed by the Minister must conduct public interviews of shortlisted candidates, and forward their recommendations to the Minister for approval. There are no transparent processes for the selection of such an ad-hoc committee, nor any requirements for how they will be selected, yet, they will be responsible for appointing the highest structure within the NHI.

SAMA has already seen the impact of the attempts at adhoc and disorganised processes to appoint key committee members and other senior officials to the structures for NHI, which we are certain would be considered inappropriate, if not illegal.

An example of why this is a challenge manifested on 13 September 2019, when the Department of Health issued a notice calling for nominations from Clinical Societies to serve on the Steering Committee for the Benefits Advisory Committee for the NHI. This call also gave stakeholders only two working days to respond (deadline of 17 September).

This steering committee was a completely new and un-gazetted structure for the NHI, and the notice resulted in confusion, both as to the process and the role of this committee. The Department was forced to withdraw the notice on 18 September.

SAMA recommends that the processes for the nomination and selection of the Board and committee members also be considered for publication, in the Bill or preferably as regulations, so that such confusion can be avoided in the future.

5. Evidence-based Policymaking

SAMA is fully in support of evidence-based policymaking, as well as the implementation of legal frameworks to support intended well-informed policy.

The South African Presidency also puts emphasis on evidence-based policymaking, defining it as "making decisions based on knowing with an estimated degree of certainty what works, at achieving which outcomes, for which groups of people, under what conditions, over what period, and at what costs.[6]"

We regret that many proposals in the NHI Bill lack an evidence base to be able to interrogate the most appropriate way forward.

It is additionally concerning that, should the Bill be approved, these policies will become enforceable by law.

A) Payment reform and proposed payment mechanisms

The NHI Bill proposes that certified and accredited healthcare services providers will be paid in multiple ways, including capitation for primary care, Diagnosis-related Groups (DRGs) for hospitalisation and per-case based payments for emergency cases.

These are all internationally acceptable payment mechanisms, each with its own positive and negative aspects.

None of these mechanisms have been used for payment of health services in South Africa before. Thus these changes are substantial in terms of reimbursement for services.

Existing "capitation" models in the private healthcare sector are actually not capitation as generally understood. A management company collects capitation fees and doctors still bill according to a fee-for-service model (as the HPCSA ethical rules allow). The HPCSA does not allow practitioners to charge for services not personally rendered by themselves, which is, in essence, what capitation requires.

The NHI Pilots which ran from 2012 to 2016 did not test capitation nor DRG models in the NHI setting, so it is difficult to predict what challenges might arise.

Other countries' experiences with capitation have led to changes in payment and reforms, according to the challenges experienced in pilots or in implementation.

Thailand's National Health Security Act of 2002, established the National Health Security Office and the structures associated with it but did not include all the details

[6] Department of Planning, Monitoring and Evaluation in the Presidency. 2014. What is Evidence-Based Policy-Making and Implementation? Available at: https://www.dpme.gov.za/keyfocusareas/evaluationsSite/Evaluations/What%20is%20EBPM%2014%2010%2013_mp.pdf. Accessed 05 November 2019.

of the operation of the reimbursement mechanisms for the Thai Universal Health Coverage Scheme[7].

Thailand implemented capitation for primary care and DRGs in hospital, in their Universal Health Coverage Scheme, but has had to make changes to this system[8].

These changes include introducing separate funding for certain high-cost services such as dialysis, and payments to hospitals for capital equipment replacement[3]. The National Health Security Office Thailand also covers medical litigation as a result of errors.

These types of payments and coverage are not addressed anywhere in the South Africa NHI Bill, so it remains uncertain where these are going to be covered in the health system.

If this Bill signed into law, it is not clear where the flexibility will come from to adjust where the proposed unprecedented payment mechanisms don't achieve the desired results or where gaps are determined.

DRG payments can have their own problems. Thailand pays hospitals on a DRG basis, but there is also a budget cap that applies, to ensure that the hospitals are cost-conscious. To calculate the price per relative weight, the system needs to know the total number of DRG relative weights being delivered over the period before it can calculate the amount to reimburse. This results in a delay of several months.

When providers are late submitting utilization statistics, the payment is further delayed. To address this situation, the National Health Security Office adopted a new system that disburses initial payments in the early phase of a fiscal year based on historical utilization statistics, so that the providers have some cash for operation. The final amount is rectified or adjusted in the last batch of financial transfers.

Once again, building the DRG and global budget mechanisms into the Act in South Africa will result in inflexibility in altering mechanisms where necessary, as an Act of Law would have to be changed to allow for different payment mechanisms.

This type of implementation evidence needs to be gathered in the South African context before laws made around reimbursement mechanisms.

Ghana too has had to learn from experiences with capitation. Ghana, having decided to introduce a capitation mechanism for its NHI, piloted this first in the country's Ashanti region[9]. There were a number of learnings as a result. It took significant efforts on the

[7] Thailand Ministry of Public Health. 2002. National Health Security Act BE 2545 (AD 2002). National Health Security Office. Available at https://www.nhso.go.th/eng/files/userfiles/file/2018/001/NHS%20ACT_book_revised%20Apr5.pdf. Accessed 16 September 2019.

[8] Hanvoravongchai, P. 2013. UNICO Study Series Health Financing Reform in Thailand: Toward Universal Coverage under Fiscal Constraints. The World Bank, Washington DC.

[9] Aboagye, AQQ. 2013. Capitation in Healthcare Financing in Ghana. East African Medical Journal Vol 90(5):156-163.

part of the NHI Fund and health authorities to educate practitioners and patients. In addition, getting patients on to capitation lists was a problem and patients were turned away from providers as they were uninformed that patients were on their list. There were also no significant cost savings noted when the Ashanti region under capitation was compared to the National figures, although this was the primary aim of introducing capitation payments.

Although the first batch of capitation payments reached providers in good time, subsequent payments were delayed, inconsistencies were identified in the lists of subscribers – to the extent that providers threatened to opt-out of the payment models.

SAMA recommends that the proposed payment mechanisms are adequately piloted before they are included in an Act of Law or any regulation.

B) Contracting issues

Contracting issues present one of the largest areas of uncertainty for healthcare professionals.

In terms of the proposed contracting mechanisms with public and private hospitals (via global budget or diagnosis related groupers), it seems that medical practitioners will be employed by hospitals and that hospitals will contract directly with the NHI Fund, for regional, tertiary and central hospitals.

SAMA categorically objects to contractual arrangements that would seek to make doctors the employees of private, profit-making hospitals.

The employment of doctors in this manner has been shown to result in a dual loyalty challenge, whereby doctors serve two masters – their patients and their employers. Ethically speaking this situation is truly undesirable.

The language used by hospital groups and medical administrators during the Health market Inquiry in the private sector is indicative that these entities would seek to "control" and "manage" medical practitioners, in a bid to save costs. SAMA has commented widely on these issues and is very against the potential to compromise the clinical autonomy of practitioners in this way[10].

SAMA emphasises that contracting for doctors' services should be with doctors and directly with other healthcare practitioners where these are contracted in. There are multiple ways in which direct contracts could be structured so that practitioners are able to practice appropriately and exercise their own professional judgement for the sake of patients, and which could be manageable at a local level.

At a Primary Health care level, there is also uncertainty expressed by our general practitioner members regarding the envisioned contracting arrangements.

SAMA has advocated for multidisciplinary teams that are doctor-led and nurse-driven in the primary health care service, but recognize the importance of all the elements of primary care, which can be delivered by occupational therapists, physiotherapists,

[10] South African Medical Association. 2018. Comments in response to the Provisional Competition Commission Health Market Inquiry Report, October 2018.

optometrists, dentists, podiatrists, emergency care practitioners, psychologists, and other registered health professionals.

The proposed Contracting Unit for Primary Health Care (CUP) is described as the "preferred" unit for contracting with the District Health Management Offices (as yet to be established). However, these remain nebulous, and the capitated arrangements have yet to be discussed for a CUP.

While we are aware that the National Treasury has been consulting regarding capitation models for general practitioner services, it must be recognised that it is not only general practitioners who would be involved in a primary care setting, which by definition offers a mix of preventative, curative and rehabilitative services, including palliative care[11].

It is not clear at what point this capitation and contracting capitation will operate.

In order for capitation to serve the purpose of effectively ensuring that practitioners carry the risks of their actions, it must be an all-encompassing fee, sufficient that practitioners can manage patients with multiple health issues, at the primary care level.

Additionally, the envisioned construct of CUPs holds a contradiction in that the parties which constitute a CUP will be healthcare practitioners, yet the CUP has the duty to identify, accredit and monitor provider contracts. It is not clear where accountability will be situated and where the outcomes and practices will be monitored.

SAMA recommends:

The proposed payment mechanisms are adequately piloted before they are included in an Act of Law or any regulation.

6. Quality of Care

Regrettably, the Department of Health is trying to implement the NHI in an environment still impaired by severe, chronic, quality shortcomings in both the existing public and private health sectors.

In 2018, the President of the Republic conceded that there is "a crisis" in the public health system, and convened a Presidential Summit, with the objective of bringing all stakeholders together to identify challenges and propose solutions to the many problems in the system. The report from this summit was published in July 2019[12].

SAMA welcomes the elements of the Bill which seek to improve quality of care, for example, certification and accreditation of health care providers and development of service and performance profiles.

[11] WHO. 2019. Primary Health Care. World Health Organisation, Geneva, Switzerland. Available at: https://www.who.int/news-room/fact-sheets/detail/primary-health-care. Accessed 16/09/2019.
[12] South African Government. 2019. Strengthening the South African health system towards an integrated and unified health system, Presidential Health Summit Compact, 25 July 2019.

However, the lack of emphasis on quality care, given how important it is to the success of the NHI is concerning.

We are pleased by the addition of mention of a Quality Improvement Programme in the Memorandum On The Objects Of The National Health Insurance Bill, 2019; as well as the fact the funding is to be made available for this programme.

However, we note with concern that the statement with regard to funding (Memorandum section 8) reads: "*The War-room is of the view that a new funding component is required to accelerate quality initiatives, to support a stronger response post-OHSC audit and also to support progressive accreditation of facilities for Fund. Amounts of R75 million, R125 million and R175 million will* ***be considered for potential reprioritisation*** *as part of the budget process."*

This is hardly a strong commitment to the prioritisation of funds for a quality improvement programme.

The World Health Organisation recognises the urgent need to place quality healthcare at the centre of country, regional and global action and notes that "the success and value of Universal Health Coverage depends on the ability to provide quality services to all people"[13].

In April 2019, The Lancet Health Commission on High-Quality Health Systems delivered its report on the state of quality of care in South Africa[14]. Major quality concerns were identified, including

- Gaps in ethical leadership, management, and governance
- Poor quality of care
- Malpractice cases and medical litigation threats
- A human resources for health (HRH) crisis
- Health information system gaps
- Fragmentation and limited impact of the quality of care initiatives.

The recent report of outcomes of the **NHI pilot programme** shows that many pilot facilities fell short on a range of issues, typifying the deep cutting challenges in the wider public healthcare system[15]. The first phase of NHI did not involve developing new funding arrangements for health care in South Africa but rather piloted various health system strengthening interventions focused at the primary health care (PHC) level.

[13] WHO. Quality of Care in the Context of Universal Health Coverage. Available at: https://www.who.int/maternal_child_adolescent/topics/quality-of-care/quality-of-care-brief-uhc.pdf?ua=1 . Accessed 12/09/2019

[14] South African Lancet National Commission. Confronting the right to ethical and accountable quality health care in South Africa: A consensus report. Pretoria: National Department of Health, 2019.

[15] Genesys Analytics. 2019. Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa, Evaluation Report, Final. NDOH10/2017-2018

Overall, the implementation of the pilot interventions had mixed success across the pilot districts. Where successful, there were identified a few common factors: strong political will, adequate human and financial resources for implementation, good coordination and communication, and good monitoring systems put in place at the time of implementation. However, the interventions also faced a number of challenges, and, to varying degrees, these factors hindered their success: inadequate planning, lack of resources, inconsistent communication, and a lack of coordination where necessary and insufficient mechanisms to monitor progress to ensure course correction.

In view of the above, SAMA strongly questions the wisdom of proceeding with implementing NHI when the public health system is in crisis, and without necessary governance and accountable structures, particularly on the quality of care received by citizens.

Government interventions to improve the state of public health system have clearly not been sufficient to bring about the required change, and it is difficult to realistically envision – given the current pace of progress as well as level of the economy – that the government will be able to put in place the infrastructure required for an effective NHI within the proposed time-frames.

7. Threats to the ethics of medical practitioners within the proposed NHI coverage

Literature attests that one critical avenue to address the progressive realization of access to healthcare is to engage ethical principles and human rights arguments[16].

SAMA acknowledges the significant ethical underpinnings inherent in the philosophy and prescriptions and the NHI Bill, including social solidarity and reference to Section 27 rights, among others.

SAMA's members are medical doctors, and ethically do not discriminate on factors such as citizenship, or ethnicity.

While SAMA is pleased to see that refugees have now been included within the groups that qualify for health benefits, we note that asylum seekers and illegal foreigners are only entitled to emergency services and services for notifiable conditions.

This exclusion of asylum seekers and illegal foreigners put doctors in an ethical and legal dilemma. Medical doctors, by virtue of their training and ethical codes, prioritise biomedical and social considerations for their patients above any legal status at the Department of Home Affairs.

[16] Meyer ED. Access to health care in South Africa: an ethical and human rights obligation. University of Witwatersrand, 2010. Available from: http://wiredspace.wits.ac.za/bitstream/handle/10539/8832/Thesis%20Jan%202010%20-%20ED%20Meyer.pdf?sequence=1&isAllowed=y [Accessed 20 August 2018]

SAMA also draws attention to some ethical issues that have not been taken into consideration. These are **priority setting, rationing, and trade-offs**.

These central issues are necessary for allocating a limited pool of resources in a population, towards achieving justice and efficiency[17,18].

The World Health Organization highlights the importance of rationing as a prerequisite to universal health coverage[19]. '**Priority setting' and 'rationing'** were well defined in the NHI White Paper, but, for unknown reasons, these twin issues have been omitted in the NHI Bill's definitions.

SAMA recommends that definitions of these be included in the Bill, and moreover, priority setting and rationing mechanisms must be practically implemented to help ensure equity in the distribution of healthcare resources in the NHI.

Members have raised concerns that in the private sector, primary care has already fallen victim to poor priority-setting mechanisms, which has led to benefit packages which are purely based on cost savings, and completely neglect the quality of care.

Distributive and procedural justice issues are involved in the financing and distribution of healthcare under a universal health coverage system such as the NHI.

As such, SAMA strongly advises the appointment of bioethicists to provide expertise towards decision making in the NHI. We are convinced that there is a sufficient number of these ethicists in the country; at least one such ethicist should be appointed to serve on the following the key NHI structures envisaged by the Bill, namely:

- The Board of the NHIF
- The Benefits Advisory Committee
- The Benefits Pricing Committee

Doctors have an ethical obligation to put their patients first.

SAMA notes with concern that some of the protocols to be developed in the NHI may put doctors into dual loyalty conflicts.

SAMA sees challenges with existing guidelines and protocols on a regular basis. The Council for Medical Schemes Prescribed Minimum Benefits should have been reviewed and updated every two years, in terms of the Medical Schemes Act. However, the algorithms published in 2003, for implementation, have never been updated, with the result that patients are subject to regulations promoting highly outdated treatment and care.

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[17] Sabik LM and Lie RK. Priority setting in health care: Lessons from the experiences of eight countries. Int J Equity Health. 2008; 7: 4. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2248188/ [Accessed 22 August 2018]

[18] Dhai A. Healthcare reform in South Africa: A step in the direction of social justice. South African Journal of Bioethics and Law. 2011; 4 (2)

[19] World Health Organization. Health Systems Financing: The Path to Universal Coverage: World Health Organization; 2010.

SAMA has been pleased to contribute to the improving Essential Medicines List processes since 2016, but these are also slow, requiring review over about two years before a whole level of medicines list can be updated. Where conflicts arise in practice with the existing guidelines, these are not easily remedied timeously.

8. Human Resources for Health

The supply of HRH is essential for UHC and for the successful implementation of NHI. The last publicly available health workforce projections for South Africa's public sector needs were generated in 2011[20].

Modelling the need for and cost of adequate Human Resources for Health (HRH) is of paramount importance in South Africa because HRH makes up almost two-thirds of total public health expenditure[21].

HRH information systems remain underdeveloped and under-utilised. Data exclude information on environmental health officers, nurses, doctors and other categories of health workers employed by municipalities[22].

Even health professional council databases have limited information on the numbers of practising health professionals. Many health professionals maintain their registration even though they may have emigrated or no longer practice their profession.

Updated and accurate information is also lacking on the maldistribution of healthcare personnel between urban and rural areas, between the public and private healthcare sectors, and within provinces.

The National Department of Health has been developing and implementing health workforce staffing norms and standards for health facilities, using the Workload Indicators of Staffing Need (WISN) method. This method was developed by the World Health Organization (WHO) and is based on a health worker's workload, with activity (time) standards applied for each workload component. The tool determines the number of each category of health workers needed to cope with the facility workload.

SAMA understands that the NDOH has completed the exercise for primary care, and in 2017 it reported that the activity standards for district hospitals had been completed.

[20] South African National Department of Health: South Africa. Human Resources for Health South Africa 2030: HR Strategy for the Health Sector, 2012/13–2016/17. Pretoria; 2012.
[21] Blecher M, Daven J, Kollipara A, Maharaj Y, Mansvelder A, Gaarekwe O. Health spending at a time of low economic growth and fiscal constraint. In: Padarath A, Barron P, editors. South African Health Review, 2017. Durban: Health System Trust; 2017.
[22] Rispel LC, Blaauw D, Ditlopo P, White J. Human resources for health and universal health coverage: progress, complexities and contestations. Rispel LC, Padarath A, editors. South African Health Review, 2018. Durban: Health Systems Trust; 2018. URL: http://www.hst.org.za/publications/Pages/SAHR2018 . Accessed 17/09/2019.

However, our attempts to engage with the NDoH on these issues have been shrugged off, and we have not been able to establish what if any activity has been undertaken to ensure that staffing norms are upheld.

In general, our members' experiences are that facilities remain under-resourced and chronically understaffed.

It remains unclear how the NHI proposals will serve to address this situation.

While SAMA is pleased that 2019 saw the largest group of graduates to date graduate under the Nelson Mandela Fidel Castro Medical Collaboration (NMFCMC), the impacts of these doctors have yet to be publicised, and reports are scarce.

SAMA has also contributed to the recent discussions on the new Human Resources for Health Strategy to 2030. This is nearing finalisation, but we are aware that there are still significant challenges in qualifying such key areas as needs and costs.

The plans envisioned in the NHI Bill will not be implementable without a sufficient number of trained health care practitioners in all areas, including nursing, rehabilitative services, psychology, pharmacy, emergency services, and many other disciplines.

The safety of Health Care workers remains a concern. This issue, although raised as a crisis, may not have been adequately addressed by the Presidential Health Summit. Although the document spoke to the wellbeing of healthcare practitioners, in terms of morale and issues such as depression and burn out, nothing was said about the physical safety of professionals in their working environment.

In recent months, with attacks on medical personnel, SAMA has raised significant concerns about this issue.

The health system deserves a solid analysis of personnel need, gaps, maldistribution, costs and modelled potential implications for all of these aspects under a reformed system if there is to be any realistic consideration of changes to the status quo.

Our own SAMA survey has indicated a significant portion of respondents considering emigration as a direct response to NHI (See Annexure 1). Other surveys have shown similar trends of professionals leaving the country, although this has not necessarily been related to the NHI proposals.

SAMA is concerned by these findings and they should also be extremely concerning to the Department of Health and parliament.

9. Health care benefits to be provided

One of the basic tenets of a health insurance structure is cover for certain benefits.

The Sustainable Development Goals 3.8.1, related to UHC is: "*Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn, and child health, infectious*

diseases, non-communicable diseases, and service capacity and access, among the general and the most disadvantaged population).”[23]

This definition acknowledges that countries provide a wide range of services for health promotion, prevention, treatment, and care, including rehabilitation and palliation.

Currently, the benefits to be offered by the NHI are unknown and are yet to be determined by the envisioned “Benefits Advisory Committee” as described in Section 25 of the Bill.

It is thus extremely difficult for health practitioners to support the NHI reforms, not knowing what will be available to patients, or under what conditions.

Considerably more detail would be necessary relating to the clinical protocols and guidelines. The emerging patient encountered by the primary healthcare system often has multi- or co-morbidities, which cannot easily be addressed by a simple disease protocol.

While the NDOH has repeatedly assured us that benefits will “not be less than what is currently available”, this has several challenges.

1. **Patent gaps in the benefits as described by the payment mechanisms**

The NHI Bill concerns itself with reimbursement for primary care services, hospital services, and emergency care, which we understand to be the structure of benefits under the Fund.

Yet, there are no mechanisms to reimburse or contract for specialist ambulatory services, which do not require hospitalisation, but which are more complex than a primary health level of care.

Mental health is one of these areas. Community-based mental health services are considered highly desirable. Ideally, at a district level, mental health professionals should be available to users, as specialist services to which a Primary healthcare team can refer. This is not addressed in the NHI Benefits.

Many other specialist services can also be delivered in an ambulatory setting. Examples include rheumatology, dermatology, ophthalmology, paediatrics, gynaecology, and many more specialist services, which are not a primary level of care, but which do not need hospital-based management.

Radiology and pathology funding are also very poorly addressed through the proposed funding mechanisms.

If these specialist services are to be hospital-based, they will remain difficult to access.

[23] Inter-Agency and Expert Group on SDG Indicators. 2017. Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (E/CN.3/2017/2), Annex III. Available at https://unstats.un.org/sdgs/indicators/Official%20Revised%20List%20of%20global%20SDG%20indicators.pdf

If payment mechanisms are described for primary care and hospital-based care in the Bill, these should also be described for these ambulatory services. Failing to do so will effectively mean the exclusion of these services from the benefits package.

2. **What should be in place is actually not available to patients in many settings**

Comments received from our members working in the public sector have highlighted the lack of essential services.

There are apparently no functional rehabilitation facilities in the country, and SAMA members have highlighted the lack of basic supplies and equipment in their hospitals and facilities to provide anything from the point of care testing, through to specialist oncology care.

Benefits which currently exist in the Standard Treatment Guidelines (primary care and hospital level) are simply not always available, because of the aforementioned staffing and resource issues.

Medicines shortages and stock-outs are currently commonplace in the public sector, and doctors express frustration about these situations all the time. Yet essential medicines are supposed to be available to patients in the public sector at all times.

3. **The clarity of what will be considered "covered" by the NHI, will be necessary for medical schemes to decide their benefits – and this is not clear either**

Where benefits are not covered by the NHI, the Bill has left room for these benefits to be covered by private funds, through medical schemes.

However, this is ambiguous in the Bill from the outset.

The definition of Complementary cover in the Bill is: "third party payment for personal health care service benefits not **reimbursed** by the Fund, including any top-up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund".

However, later in Section 33, which speaks to medical schemes, the Bill states:

"33. Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services **not reimbursable** by the Fund."

What is reimbursed, and what is reimbursable may be quite different.

Given that we can expect there National health Insurance services to have waiting periods for procedures such as tests and surgeries, it is likely that these may be unacceptable to some. In the case where a patient chooses not to follow the referral pathways of the fund, his choice would render his treatment "not reimbursable" – meaning that it would not be covered by the fund although the service is reimbursed under other circumstances.

SAMA thus believes that even on the issue of complementary cover, the Bill remains unclear.

10. The role of Medical Schemes

Clause 33 of the Bill provides that "Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund."

Clause 6(o) provides that users have the right: "to purchase health care services that are not covered by the Fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act, any other private health insurance scheme or out of pocket payments, as the case may be".

Application of this clause would mean that if for example, NHI benefits include hip replacements and hospitals cannot offer the service timeously, patients should have a choice to attend private sector facilities.

SAMA argues that, while the user's right to use non-NHI service is being respected, a user seeking care from non-NHI providers should not be compelled by an incomprehensive basic NHI package, or poor quality of the package, including interrupted service and goods supply, especially in the public sector.

Otherwise, users forced to use complementary services are not protected against financial risk.

Moreover, compelling users to seek expensive non-NHI services, because of the poor public supply of a comprehensive package could constitute an unjustifiable infringement of the section 27(1) (a) right to access to healthcare, albeit healthcare paid for by one's own contributions.

The right to life (section 11 of the Constitution), freedom, and security of the person (section 12 of the Constitution) could also be threatened.

SAMA believes that the rights of users to the full range of services are at stake especially in view of a related provision (Section 27) of the Medical Schemes Amendment Bill 2018, which limits what complementary can include by providing that:

"The Registrar may restrict [our emphasis] the extent of benefits offered by medical schemes, having regards to the benefit and services covered under the Fund, thereby eliminating duplicative costs for the same benefit".

To the extent that the Bill restricts the benefits that patients may purchase from medical aids, such limitation must have a rational purpose.

Rationality is a constitutional principle. It is not clear what rational purpose, if any, is served by the restriction to access to private healthcare and no explanatory note was provided along with the draft Bill in this regard.

The government will have to provide a rational basis for this requirement in court in the event that the partial limitation on private health insurance is challenged. The government will have to demonstrate and properly communicate to the public that the partial limitation on private insurance is rationally connected to a legitimate governmental purpose, for example, the preservation of the public insurance system.

11. Significant changes to other legislation

SAMA has been at pains to try to examine the implications of the significant changes proposed to several other pieces of legislation by the Bill.

We believe that each of these proposed amendments deserves to be viewed individually such that the merits and potential threats can be properly assessed. There are multiple implications as a result of the many amendments, which are not immediately apparent.

The National Health Act, derived from the Constitution, lays down the responsibilities, rights, and duties of multiple participants in the delivery of health services in the country, including provincial departments. The NHI Bill seeks to introduce new structures and functions, without clarifying the roles of existing structures. For example, the Bill will take many functions from provincial administrations, but yet the role of the provinces is not clarified and will supposedly be modified at a later date.

Change management is difficult enough while knowing where changes are to be implemented. Without this, SAMA feels changes are doomed to fail.

Proposed amendments to the **Occupational Diseases in Mines and Works Act**, as well as the **Compensation for Occupational Injuries and Disease Act**, could see the responsibility of employers to financially assist employees who are injured in the workplace, removed.

SAMA believes this could reduce the level of accountability of workplaces to ensure a safe environment for their workers, and contribute negatively to the levels of workplace injuries our country experiences.

Changes to the **Medicines and Related Substances Act,** may also have a significant knock-on effect in the country. The proposals essentially are that the prices at which health products are procured by the NHI will be the price to be supplied to the whole country. This is an extension of a single exit price to the whole country.

While it can be argued that some elements of single exit pricing and the accompanying legislation on perverse incentives and bonuses have served the country well, applying a single price across the country will prove problematic, we believe. This specifically if the price has been forced very low by the buying power of the NHIF and if it results in alternative suppliers exiting the market. Competition and quality of supply may well be harmed, with few choices remaining for alternative purchase.

Given that the NHI will be a single monopsonistic purchaser for healthcare in the country and given that it will be engaging in the procurement of health products, SAMA also questions the wisdom of completely removing the operation of the Competitions

Act from the NHI Bill, as well as the proposed amendment to the **Competitions Act** such that it does not apply in its entirety to the NHI.

Particularly entrenching some of the proposed reforms in an Act of Parliament is, we believe unwise, given the difficulty in changing Acts once they are in place and the difficulties in addressing the unintended consequences of these reforms.

12. SAMA Recommendations

SAMA recommends that:

- The enactment of any NHI Bill is delayed as the country moves forward with the proposals from initiatives such as the Presidential Health Summit, Lancet Quality Commission and Competition Commission Health Market Inquiry.
- If a Bill has to be enacted towards the achievement of universal health coverage, that the many poorly considered and non-evidence-based details are removed from the Law until these have been properly developed and tested.
- Before we can fully support the Government in its endeavours, it needs to prove, through its policies, actions, and outcomes, that it really does have the interests of all South Africans at heart, and that the system really can become accountable to the users it serves.
- Corruption initiatives which are in their infancy in the public and private sector be carefully followed in terms of their impacts and outcomes, and ability to actually deal with corrupt and fraudulent activities, before the proposed centralised structures are signed into law.
- The NHI Bill should not afford too much discretionary power to the Minister of Health in operational issues of the NHI Fund.
- An oversight function (beyond the Auditor General) be established to monitor the activities and finances of the Fund.
- The proposed payment and contracting mechanisms are adequately piloted before they are included in an Act of Law or any regulation.
- The pursuit of NHI is reviewed, given that the public health system is in crisis, and without necessary governance and accountable structures, particularly on the quality of care received by citizens.
- Bioethicists are appointed to provide expertise towards decision-making, given that the NHI Fund will be making critical decisions in terms of rationing, prioritisation, and trade-offs, the appointment of bioethicists to provide expertise towards decision making in the NHI.
- An alternative solution is clarified for asylum seekers and illegal immigrants under the proposed system.
- The health system deserves a solid analysis of personnel need, gaps, maldistribution, costs and modelled potential implications for all of these aspects under a reformed system if there is to be any realistic consideration of changes to the status quo.
- Proposed healthcare benefits should be clarified before any support can be offered for the NHI and the Bill.
- Medical Schemes should be allowed to continue to offer the same benefits cover as the NHI Fund.

- The multiple proposed amendments to other legislation are carefully considered, before receiving a blanket approval through the implementation of this Bill.

13. Conclusions

SAMA is committed to the cause of Universal Health Coverage in South Africa.

We have actively engaged in discussions and projects improvement of the conditions for patients in both the public and private sectors, quality initiatives, policy discussions and advocated where crises have manifested in service delivery to the country.

We are committed to serving the patients of this country and improving the levels of quality of care patients receive.

We do not believe that the proposals in the NHI Bill will achieve the stated aims of the Bill and the proposed purpose of the reforms.

Many of the proposed reforms, new structures and changes in governance and accountability have not been tested or explained in a policy document. This has led to guesswork as to the reasons for the reforms and the expected impacts that they are to have.

We, therefore, cannot support the NHI Bill in its entirety, nor the multiple structural and functional reforms and new entities, units and agencies which are proposed.

Dr A Coetzee
SAMA Chairperson
29 November 2019

ANNEXURE 1: SELECTED RESPONSES TO THE SAMA NATIONAL HEALTH INSURANCE MEMBERSHIP PERCEPTION SURVEY

Background

The South African Medical Association conducted a survey to gauge our membership's attitudes and perceptions of the National Health Insurance Bill 2019.

The survey took place online, and links to the survey were sent to all SAMA members via Med-email and SMS with all members encouraged to participate.

A summary of the NHI Bill and proposals accompanied the survey communications for members to familiarise themselves with proposals if they were not already familiar.

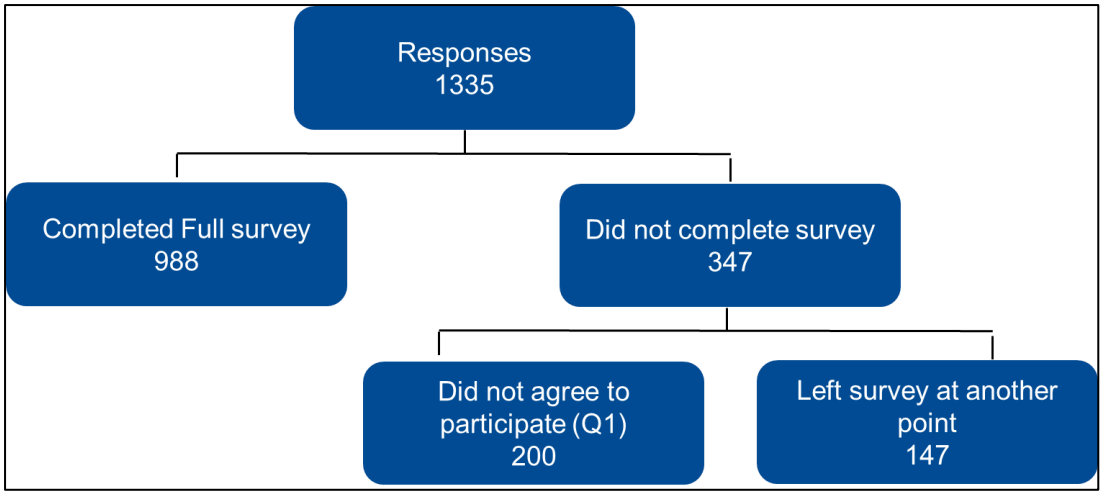
The survey ran from 12 to 25 November 2019.

Responses

We received over 1000 responses to the survey (approximately 8%) of the membership of the organisation.

Given responses to previous surveys, we consider this a reasonably good response rate.

Not all respondents completed the full survey, and the results to follow are based on the respondents which completed the full survey (988).



Demographics

Respondents were majority Male (68%), Figure 1.

Most of the respondents were young or mid-career practitioners, actively participating in the provision of medical services in the country (72%), Figure 2.

IN line with the current distribution of medical doctors across the country, the largest group of respondents were from Gauteng (38%), followed by the Western Cape (20%) and KwaZulu Natal (15%). We also received a substantive response from doctors in the Eastern Cape (10%), Figure 3.

There was a relatively even split between specialist/registrar and general practitioner/ medical officer respondents (40% and 41% respectively). Other respondents were community service doctors (5%), interns (7%), and retirees (5%). Figure 4.

There was also a fairly even response from our doctors practising in public (37%) and private sector (42%) exclusively, and colleagues who practice in both sectors (21%). Figure 5.

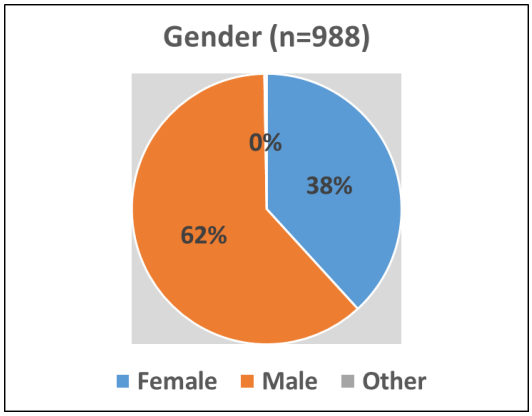


Figure 1: Gender

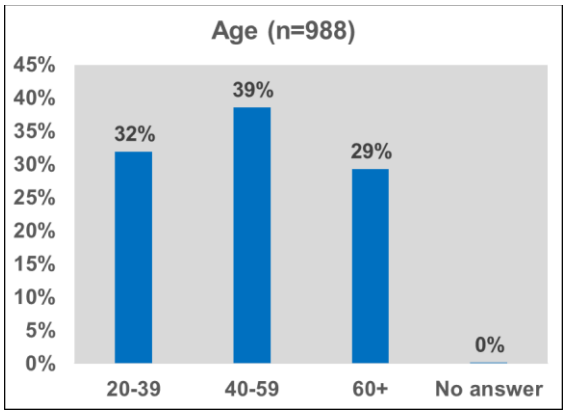


Figure 2: Age

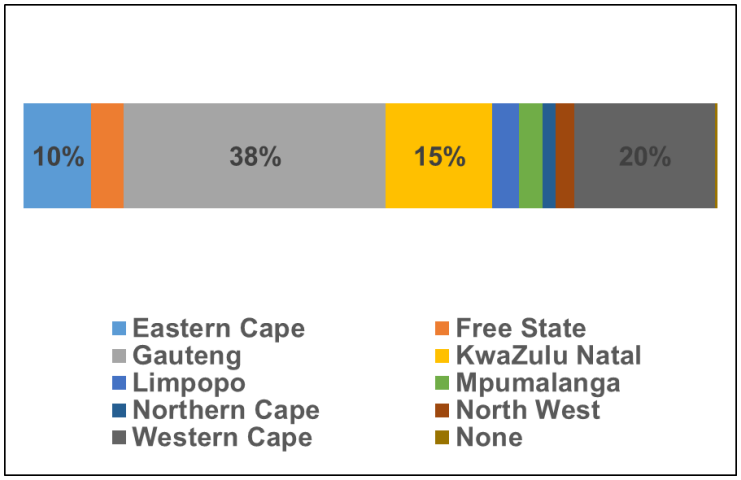


Figure 3: Province where respondent practises most of the time

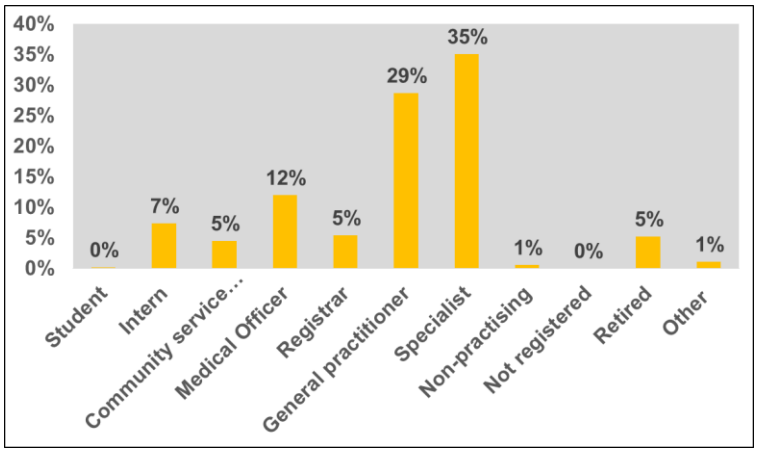


Figure 4: Registration status of respondents

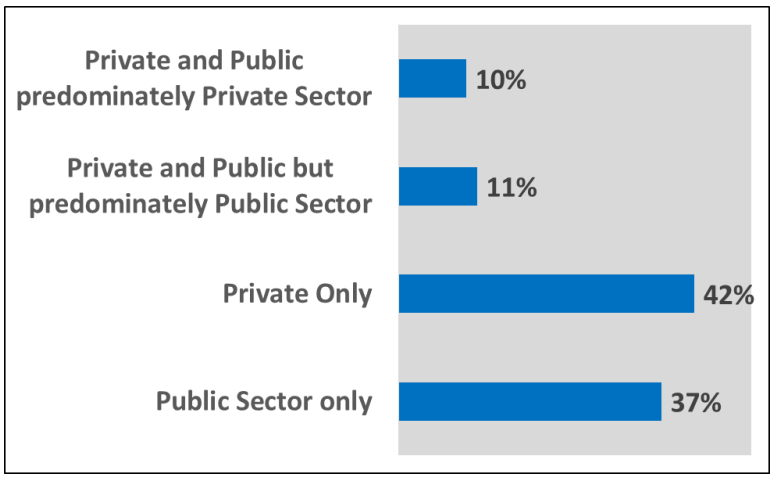
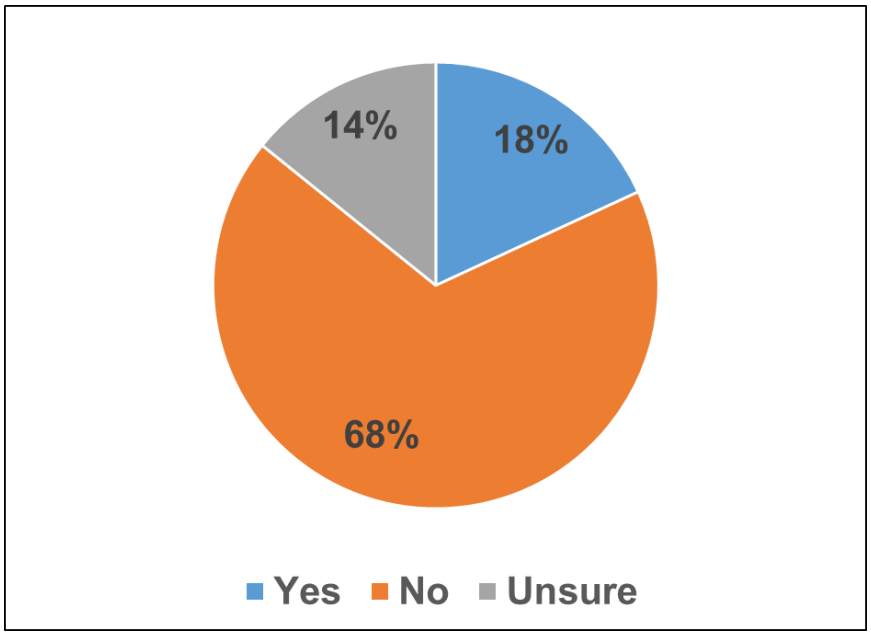


Figure 5: Sector where respondents practice (public versus private)

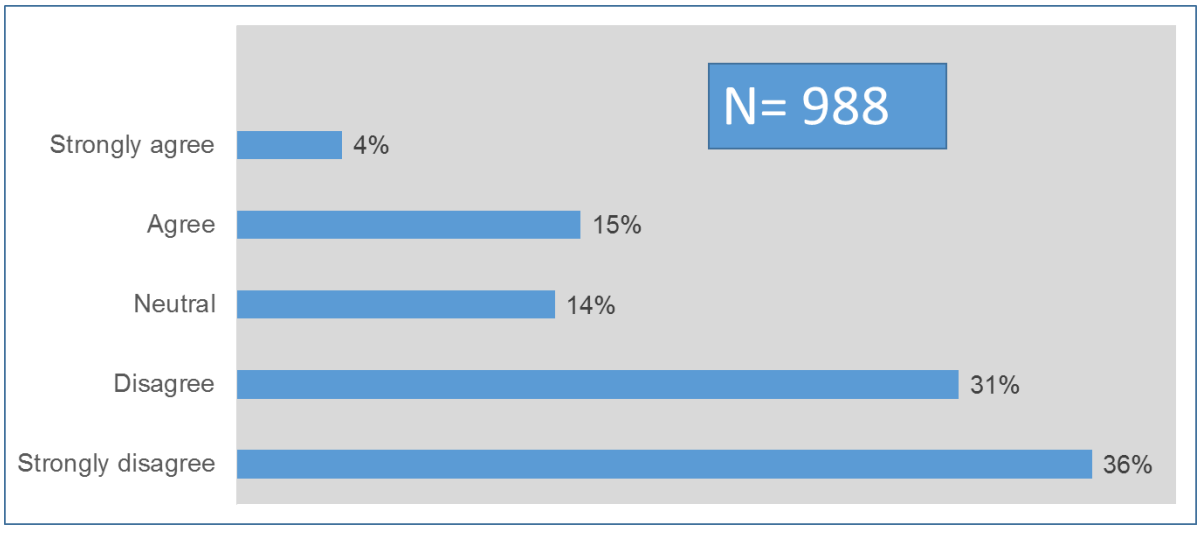
Perceptions and Attitudes to NHI Proposals

Question 1: Do you believe a single fund is an appropriate mechanism to achieve equitable UHC?



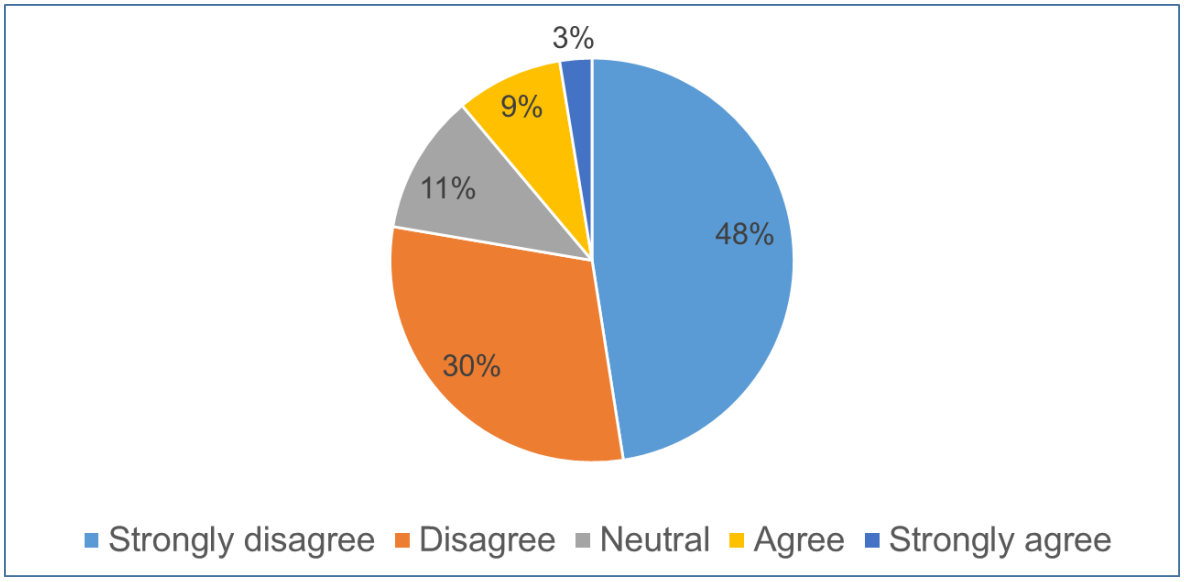
68% of the respondents do not believe that a single fund is an appropriate mechanism to achieve universal health coverage.

Question 2: The National Health Insurance Proposals will improve access to healthcare in the country



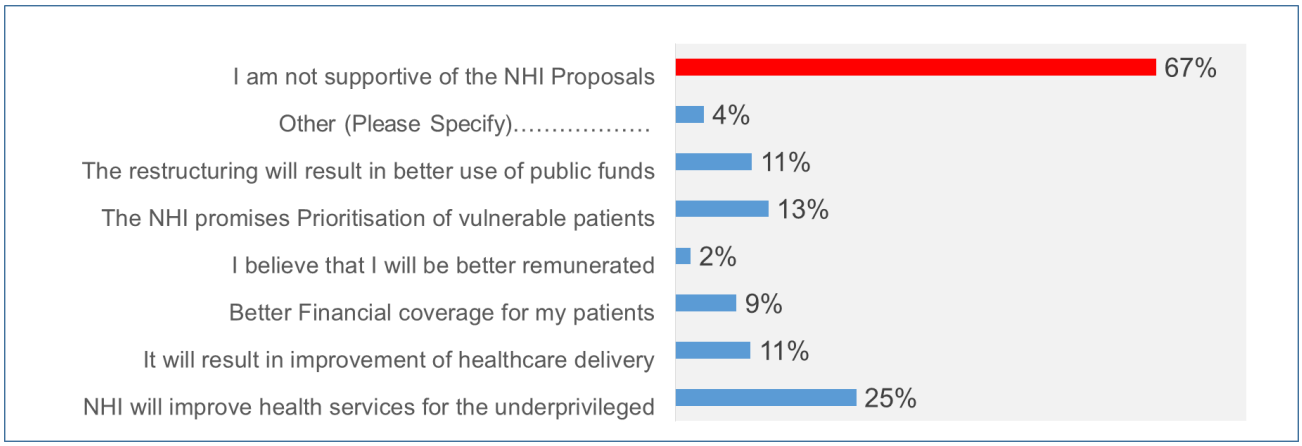
67% of the respondents disagreed or strongly disagreed that the NHI proposals will improve access to healthcare in the country.

Question 3: The National Health Insurance Proposals will improve the <u>quality</u> of healthcare in the country



78% of respondents strongly disagreed or disagreed that the NHI proposals will improve the quality of healthcare in the country.

Question 4: I am supportive of the National Health Insurance Proposals for the following reasons:

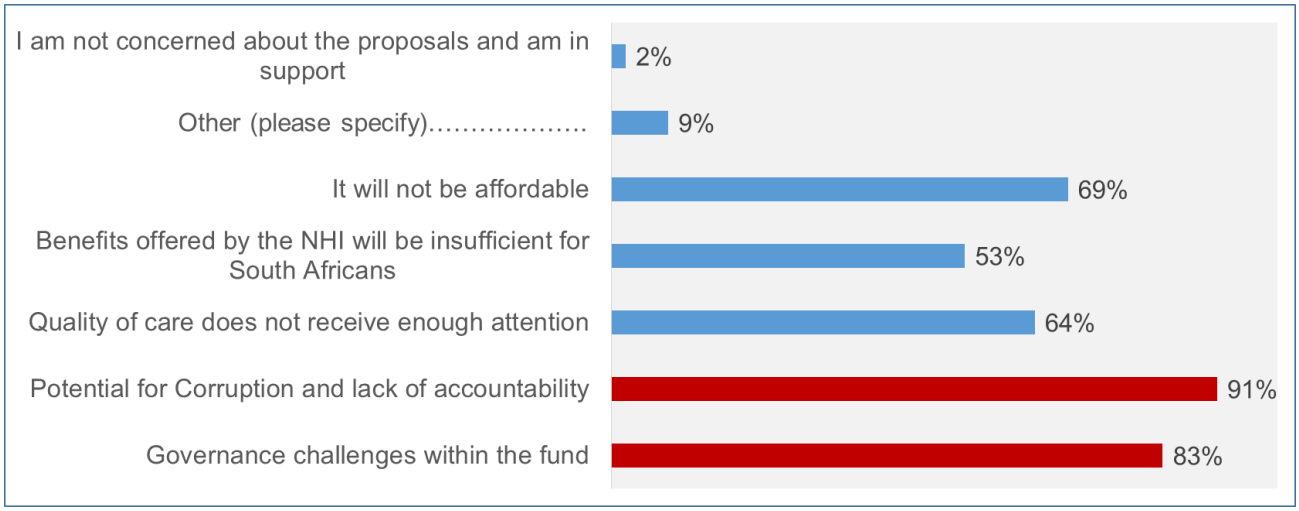


67% of our respondents indicated that they did not support the NHI proposals when given the opportunity to indicate why they would support the NHI.

Only 25% believe that the NHI will improve health services for the underprivileged, and only 11% believed it will result in better use of public funds and result in the improvement of healthcare delivery.

Only 9% perceived that NHI holds the promise of better financial coverage for their patients.

Question 5: I am concerned about the NHI proposals for the following reasons:



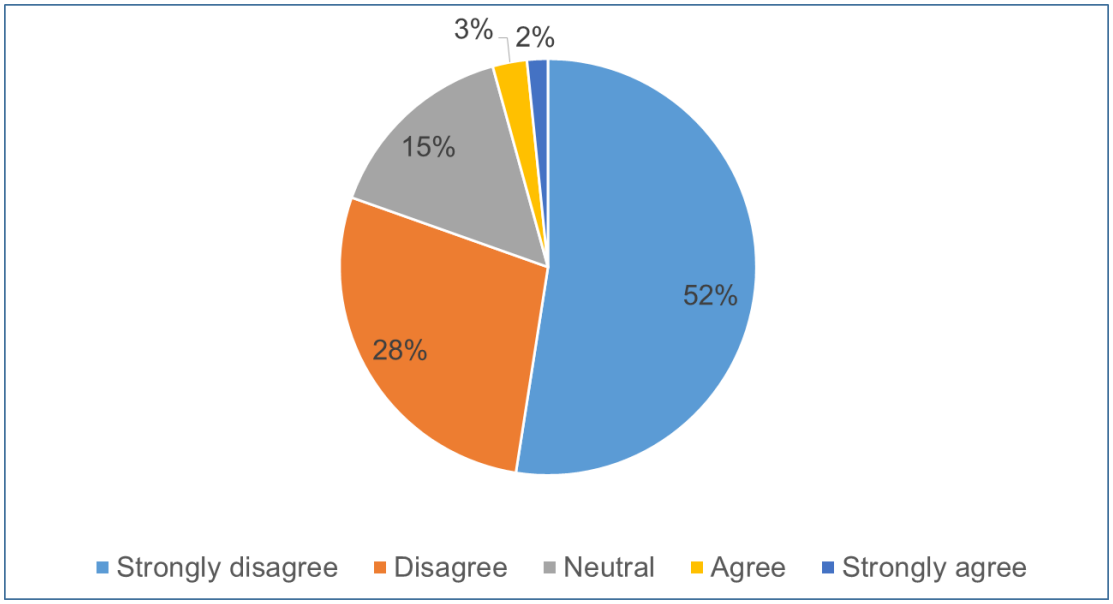
When faced with potential challenges, 91% expressed concerns regarding corruption and lack of accountability, and 83% were concerned about governance within the Fund.

69% believe the NHI will not be affordable and 64% believe that quality of care does not receive enough attention.

There were multiple comments received in response to “Other” concerns. The most frequently raised concerns were mistrust in the ability of the Government to implement the proposed changes, as well as concerns around the many details still missing from the proposals.

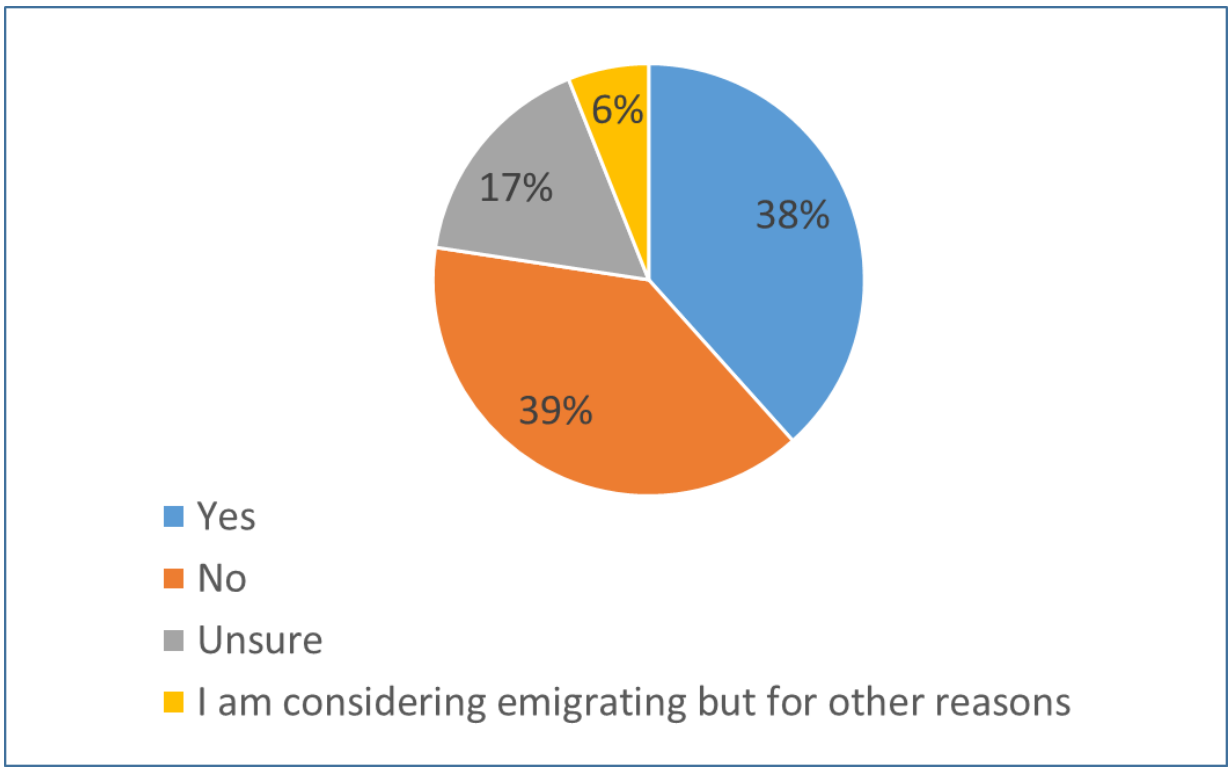
Many gaps were identified in the proposed service delivery platforms and reimbursement mechanisms.

Question 6: From the NHI proposals it is clear to me how I will be remunerated in the future



80% of our respondents do not believe that it is clear how they will be remunerated for their work under the proposed system.

Question 7: Are you considering emigrating because of NHI?



38% of respondents confirmed they are considering emigrating because of NHI, whereas 39% indicated they are not.