Comments on

National Health Insurance Bill

Submission by

Financial Intermediaries Association of Southern Africa

fia
Financial Intermediaries Association of Southern Africa

Building
A FUTURE IN FINANCIAL SERVICES

CONTENTS

EXECUTIVE SUMMARY

1. Health is an enabler for economic growth

The economic impact of ill health is severe and requires South Africa ("SA") to identify health as a national priority. Improved health is an enabler of economic growth.

2. The Healthcare system should be accountable to the community it serves

A desired healthcare system for SA should be decentralised, de-politicised and should put the people at the centre of the health delivery.

3. Ward based primary healthcare (PHC) can be a net contributor to job creation

PHC can be a net contributor to job creation whilst improving the health of the people at municipal ward level. All citizens should have access to the ward based primary care and the integrated school health programme and emergency care (whether rendered in the private or public sector). These services need not be provided by medical schemes and may be funded from general taxes.

Citizens should be incentivised for healthy lifestyles and penalized for poor lifestyles. The formula and criteria should be simple but should drive the correct behaviour.

4. Public sector must provide meaningful choice

The public health system should be improved in order to provide citizens with meaningful choice and a real alternative to the public sector.

5. Employers should be incentivised for health improvement

Employers should be incentivised with tax benefits for improving the health of their employees. Companies should be allowed a tax deduction for improvement of the health of their employees and an additional tax rebate where employer sponsored programmes also improve the health of the community they serve.

6. Barriers to leveraging Universal Health Care

South African Citizens below the means test do have access to healthcare at no cost at point of service. South African Citizens can also voluntarily belong to private medical schemes. Therefore, we have achieved Universal Healthcare for most citizens. The current healthcare system is equitable, but the public system needs to improve quality of delivery of healthcare, and exploitation in the private sector needs to be prevented with adequate regulation. The poor are protected against financial ruin by receiving free access to healthcare in the public sector. The employed can also make use of the public system but if they earn above certain levels they must contribute. Alternatively, they can choose to belong to a private medical scheme and protect themselves against financial ruin at point of service. Out of pocket payments ("OOP") are not excessive if compared to peer countries. However, OOP are primarily paid by people belonging to private medical schemes or those who choose not to make use of the public healthcare system.

7. Implementation of previously adopted policies

Various policy decisions were made regarding the strengthening of the healthcare system but not implemented. These include but are not limited to the decentralisation of the public sector, improved governance, compulsory membership, introduction of the Risk Equalisation Fund, introduction of a minimum benefit package, recruitment training and deployment of community health workers and incentives to employers for health promotion activities.

8. Improved healthcare is not dependant on more money

Efficiency needs to be improved:

- Public Health Establishments ("HE") must comply with Office of Health Standards Compliance ("OHSC") standards
- Private HE's must be assessed and comply with OHSC standards
- Increase in legal action and complaints is due to poor performance of public HE's
- Health outcomes are poor despite high spend on health compared with peer nations
- NHI pilot projects failures cast doubt on National Department of Health's ("NDoH") ability to manage a project of this magnitude

9. Private medical scheme market is a national asset

- Private sector adheres to social solidarity.
- Private healthcare is sustainable however HMI recommends improvements in terms of supply side and demand side of the market. Recommendations are primarily due to Regulators' inability to regulate properly and NDoH not fulfilling its mandate as the custodian of health policy and strategy.
- Private medical schemes should co-exist with the public sector to deliver UHC.

10. Introduce a minimum benefit package

- **Public sector:** This will include referral pathways starting with nurses, then GP's and then specialists. The integrated clinic will provide specific primary care and diagnosis, care and treatment for chronic conditions. Hospital treatment will be included. These services will be funded from general taxes.
- **Private Medical Schemes:** The same set of benefits with the same protocols and formularies and referral pathways will have to be provided by all medical schemes. These benefits will form part of the private medical scheme contributions. These benefits must form part of a risk equalisation fund. Contributions must still be community rated and open enrolment must still be enforced. Additional benefits outside the minimum benefit package can be provided. However, medical schemes will still be obliged to apply open enrolment and community rating and health insurers can only underwrite as per the current demarcation rules.

11. Mandatory membership

Personal income taxpayers over the tax threshold will have to make a compulsory contribution to medical cover. However, these people can opt out of the public service cover. In this case they will have to provide proof of cover in the private sector. When taxpayers opt out of the public sector, they will be able to receive a tax rebate. However, a portion of the public contribution will not be rebated.

12. National Service & Public Private Partnerships

School leavers should complete community service. This will assist school leavers to gain workplace experience whilst gaining an appreciation for healthy lifestyles. School leavers can be used in the ward based primary care teams, at clinics and at hospitals. Their services can range from cleaning, administration and health promotion to name a few.

Employer based clinics must be allowed to form part of the Health system where services can also be rendered to the community surrounding the employer. Employers rendering these services must be able to either claim for the services rendered to the community or receive a tax incentive for rendering these services or both.

Public private partnerships must be established in terms of academic hospitals and nursing training facilities. Both spheres of the health system, public and private must be able to make use of these facilities in production of health personnel.

13. Governance

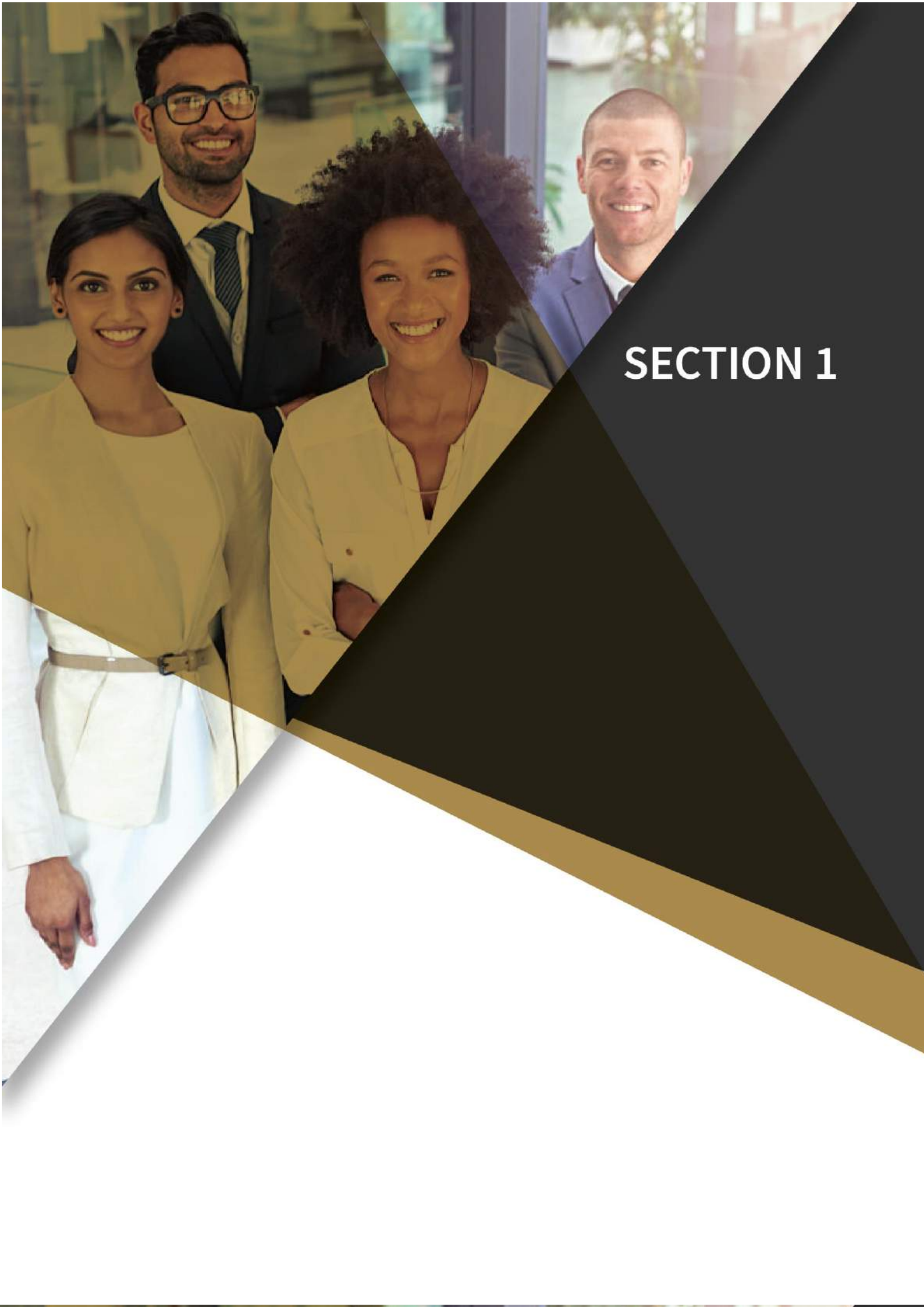
Governance requires rational policy decisions based on clear economic and financial impact studies and thorough research of alternatives. Governance also requires institutional and structural reform. Furthermore, governance requires implementation of previous decisions before new policy designs are considered, empowerment of providers to deliver quality healthcare and the development of a sustainable and equitable co-existing healthcare system that serves the healthcare needs of all South Africans.

LIST OF ACRONYMS

AI	Artificial Intelligence
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral drugs
CCMDD	Centralised Chronic Medicine Dispensing and Distribution
CEO	Chief Executive Officer
CMS	Council for Medical Schemes
COID	Compensation of Occupational Injuries and Diseases
COIDA	Compensation of Occupational Injuries and Diseases Act
CPIX	Consumer Price Index excluding mortgage costs
DCST	District Clinic Specialist Team
DHS	District Health System
DTP	Diagnostic Treatment Pairs
EHR	Electronic Health Records
FAIS	Financial Advisory and Intermediary Services
FIA	Financial Intermediaries Association of Southern Africa
FSCA	Financial Sector Conduct Authority
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GP	General Practitioner
HE	Health Establishments
HIV	Human Immunodeficiency Virus
HMI	Health Market Inquiry
HPRS	Health Patient Registration System
ICRM	Ideal Clinic Realisation and Maintenance

LIST OF ACRONYMS

IHME	Institute for Health Metrics and Evaluation, University of Washington
ILO	International Labour Organisation
IPTP	Intermittent preventative therapy for malaria during pregnancy
ISHP	Integrated School Health Program
LIMS	Low Income Medical Scheme
MDR-TB	Multidrug-resistant TB
MEC	Member of the Executive Council (“Provincial ministers”)
NDoH	National Department of Health
NDP	National Development Plan
NHI	National Health Insurance
OHSC	Office of Health Standards Compliance
OOP	Out-of-pocket
PMB	Prescribed Minimum Benefits
PRASA	Passenger Rail Agency of South Africa
PHC	Primary Health Care
RAF	Road Accident Fund
REF	Risk Equalisation Fund
RFID	Radio-Frequency Identification
SHI	Social Health Insurance
SOE	State Owned Entities
UHC	Universal Healthcare
WBPHCOT	Ward-based Primary Health Care Outreach Team
WHO	World Health Organisation



SECTION 1

Introduction

The Financial Intermediaries Association of Southern Africa (FIA) is a trade association for insurance broker and financial advisor practices within the financial services sector. The FIA represents more than 1 800 financial services providers (FSP's) that collectively employ more than 45 000 people. FIA members are licensed by the Financial Sector Conduct Authority (FSCA) and all advisors employed are qualified and licensed as Key Individuals and or Representatives by the FSCA. The members of the FIA are made up of multi-national, large, medium, small enterprises as well as sole proprietors with the majority being small to medium.

Focus areas of the FIA include the sustainability and relevance of the intermediary (through ongoing education, training and transformation of business models and people). We also focus, foster and support small business development within the intermediary market. This of course not being at the exclusion of promoting development within the middle to large sized firms where there is more resource and infrastructure in which to create employment and skills development.

As an industry sector, the FIA stands fully behind the objectives articulated by the legislators and regulators with regards to ensuring South Africa maintains its high global standing as possessing a professional well-managed financial services sector. We are committed to facing and addressing financial inclusivity and transformation with due recognition for the significant headwinds that face our country, including the uncertain socio-political environment, economic stagnation, skills shortages, disintermediation through the deployment of new technologies and changing regulation that seeks to significantly reshape our industry.

The recent publication of the National Health Insurance ('NHI') Bill in South Africa has provoked vigorous debate. We commonly refer to the health crisis in South Africa as two-fold; namely a public system that renders poor quality of healthcare and a private sector that is becoming unaffordable. This oversimplification of the healthcare crisis in South Africa forces commentators either to criticise or defend the proposals at all cost. However, what is often misunderstood is the devastating impact that ill health has on every person, family, community and the economy. In arresting this crisis every stakeholder in the healthcare value chain should be guided by their sense of humanity, and their sense of UBUNTU should drive them to ask what will a South Africa look like where every citizen is healthy and where citizens spend more years being healthy than their peers in other countries. Only when our focus changes from protecting the existing position or dogmatically supporting a proposed solution, to real care for the health of our nation will sustainable solutions unfold. Only when business cares about the health of the whole population, and puts this caring into action, will economic growth become a reality. This thinking informs this submission of the FIA.

SECTION 2

Desired Healthcare system

The current healthcare system in South Africa can best be described as a system that is well funded, consists of adequate healthcare professionals and an adequate number of healthcare facilities but healthcare outcomes are very poor[1]. However, objectively and subjectively assessed, health outcomes in the private sector are substantially better than those of the public sector. The HMI report highlighted the inefficiencies, over servicing and lack of value in the private sector. The healthcare system needs to deliver quality care to all citizens with the current levels of funding, resources and personnel. Basically, we need to improve the health of the nation with the resources available.

To achieve a desired transformed healthcare system, the following areas need to be simultaneously addressed:

- We need to ensure that South Africans make healthy choices regarding their lifestyle.
- Living standards must be conducive to good health.
- Health workers must be skilled, motivated and have the resources to provide quality care, and be accountable to the community they serve. This requires a strong governance structure.

Strong primary healthcare, ward-based healthcare an instrument to healthy choices

Primary Health Care ('PHC') can be described as a globally endorsed healthcare model that supports the following values; universal access, equity, participation and integrated care. Critical for an effective PHC system is improved access to, and use of, first-contact care, patient-focused and home-based care (rather than disease-focused). Therefore, PHC is a district and ward health system that embodies a decentralised approach to health care, responsive to the healthcare needs of the people in a specific area. PHC also supports an equitable approach to healthcare benefits and funding. The National Development Plan ('NDP') proposes that PHC is delivered via district-based clinical specialist support teams, school-based primary health care services, and municipal ward-based primary health care agents.

Through this, South Africa can rapidly increase the poor's real (and not only nominal) access to healthcare, and this can result in improved health outcomes, especially if the ratio of community health workers to population increases to ensure that all households are regularly visited, and health problems detected early. The NDP suggests a team of 6 health workers per ward. The NDP proposes that community health workers should undertake a range of activities, spanning the full breadth of rehabilitative/palliative care, treatment, preventive and promotive interventions. This means that whilst health is actively improved at ward level, an estimated 700 000 jobs (according to the National Development Plan) can be created which will substantially contribute to reducing poverty. Some of the countries that have benefitted from PHC are Bangladesh, Brazil, Ethiopia, Iran, Rwanda, Thailand and Nepal to name a few.

However, given the failure to date to effectively implement a high standard of primary care services, despite significant budget improvements, the NDoH still has much to do.

Competition and choice

The current South African healthcare system can be best described as a systemic monopoly with no choice to those who make use of either of the two healthcare systems. Those who can afford it purchase private medical scheme membership, fearing to land up in the public healthcare system. They do so because of fear and not because they have a real alternative or choice. Those who can't afford private medical scheme cover have no choice but to make use of the public healthcare system. This reality merely results in polarising the

[1] According to Econnex, Discovery Health Data, College of Medicine of South Africa and Persal Data 77% of nurses are employed in public hospitals, 73% of health practitioners (medical, nursing allied and clinical staff) are employed in the public sector. According to the Health Systems Trust 74% of hospital beds are in the Public Sector.

two healthcare systems. The transformed healthcare state should rather consist of a strong quality driven public healthcare system where quality healthcare can be provided at affordable rates. In this environment the public healthcare system offers a real alternative to those who belong to private medical schemes. Private medical schemes will have to compete with the public sector on quality and price. The purchasing decision of private healthcare now moves away from fear to a value-based choice.

Workplace programmes

The engagement of employers and employees in workplace wellness programmes contributes to health improvement and the national health promotion agenda. Employers are assisted by financial planners who utilise different communication models to reach employees and support a change in lifestyle.

The green paper, white paper and the NDP rely heavily on a preventative and primary healthcare delivery model to bend the cost curve of healthcare. The current South African healthcare model provides little legislative or tax relief for employers that embark on workplace programmes. The current community rated medical scheme environment makes it less viable for employers to implement workplace programmes focusing on improved health of the workforce. In stark contrast, employers that employ good safety practices stand to benefit in terms of COID discounts. The FIA is of the opinion that discounts for good health and improved health of workforce communities will not contradict the principles for community rating. This tax relief is also supported by the NDP.

Living standards and other aspects that impact health

There are other non-behavioural factors that affect the health of a community. Curative healthcare is estimated to contribute only 20% to the health of a community. Access to quality non-polluted water, proper sanitation and safe and adequate housing are regarded as major contributors to the health of a community. Furthermore, the environment in which people are born, and work in can impact their health. Societal determinants such as violence, lifestyle choices and risk exposures also contribute to the health of the society. Therefore, solutions to improve the health of the society are more complex than a mere healthcare system.

Organisation of healthcare

Healthcare systems globally will be challenged by how they organise healthcare. The key drivers are an ageing population, lifestyle behaviours that drive changes in the burden of disease, technological advances, artificial intelligence, big data, cloud computing and robotic process automation, to name a few. Governments worldwide struggle to find the right balance between social provision and market forces. In South Africa, the proposed NHI and the release of the final HMI report are testimony of the challenge our healthcare system faces.

We have become accustomed to online renewal of drivers' licences. This same technology can be adapted to support the WBPHCOT's to book and manage regular and mandatory check-ups and access to health providers.

The South African burden of disease requires a very different type of healthcare than the healthcare model we applied 20, 30, or 40 years ago. Our unique burden of disease requires that we deal with more acute illnesses such as having an accident, having a major infection, having a heart attack. This different set of diseases needs a continuum of care. They need care that focuses on the patient's lifestyle and health behaviours. Furthermore, the healthcare system needs to focus on the patient's broader well-being. The healthcare system we require needs to move from a curative system to a pro-active preventative community-based healthcare system.

The South African healthcare system should utilise technology to enable efficient healthcare delivery. However, in doing so quality of healthcare must improve and costs must be reduced. Technology must not be applied in such a way that it just becomes a new cost layer on top of an already expensive healthcare system. Technology should be used in such a way that the fixed cost to render healthcare and the cost to access healthcare should be reduced. Technology should also be used in such a manner that the asymmetry of information assists patients to determine the most appropriate, transparent, safe and cost-efficient provider. Technology does have the ability to create an ecosystem that is intuitive, personalised, and available to the patient, the healthcare provider and the funder system. The reason technology is not adopted to its full extent does not lie in the ability of the technology, but rather the patient bias towards existing providers and protection of the status quo by all stakeholders in the healthcare value chain.

Electronic health record (EHR) requirements will be more than merely an electronic storage of clinical data. EHR's must be patient-centric, longitudinal, and a complete data set versus institution-centric silo data recording. This requires a bespoke regulatory construct to ensure the power that is locked up in the EHR is moved away from the industry to the consumer. This empowers the consumer to channel care to an appropriate provider when needed. Artificial intelligence (AI), if applied correctly, enables the South African healthcare system to look at health data and predict what the interventions may be. Some of the interventions may not be clinical at all. It may relate to the patient's lifestyle and living conditions.

A transformed healthcare system in South Africa will have to answer the following questions, to name only a few:

- Do we need to staff every health facility with the same level of expertise and competence? Is this feasible in the short-medium or even longer term? Can technology be used to have less competent staff supported by a team of experts?
- Can we learn from the airlines where a staff intensive booking and boarding system was automated? Can this be used in the healthcare system to create efficiencies?
- Can our tech-enabled environment assist us to track vital signs applying radio-frequency identification (RFID)? How will this technology impact human resources and quality of healthcare? Is a nurse coming around taking blood pressure the most efficient way of monitoring vital signs today? Our tech-enabled environment should assist us to continuously check more vital signs than blood pressure and heartrate. The measurement of the quality of a patient's sleep in the healing of a patient is just one additional enhancement that can be made possible with RFID.
- Can we leverage our tech-enabled environment, AI and predictive analytics to spot problems and deploy healthcare resources in time to better manage health delivery?
- Can RFID devices assist in monitoring and enabling lifestyle behaviour changes? Can RFID assist community health workers to correctly determine lifestyle behaviours without relying self-reporting which may be false.
- How will our transformed healthcare system enable healthcare providers to spend more time on care? If we can achieve a situation where the physician can be unhurried, and the nurse can spend more time not trying to read 15 monitors but instead helping the patient with empathy-based care, will the healthcare outcomes and the patient's experience of the care not improve?
- What structural changes will be required to move our professional healthcare staff away from being paid for and being measured on sick care, to a system where they are measured on the health outcomes of the society they serve? What measurements will we use? How will we capacitate and resource this new healthcare system?

Strong governance

Healthcare as a private good, demands a governance structure that, like our Constitution, be recognised as an example for the world to follow. The required governance structure should go beyond the envisaged accreditation and auditing functions as proposed in the green paper. The FIA proposes a governance structure that is aligned to the King IV proposals and we specifically propose the following:

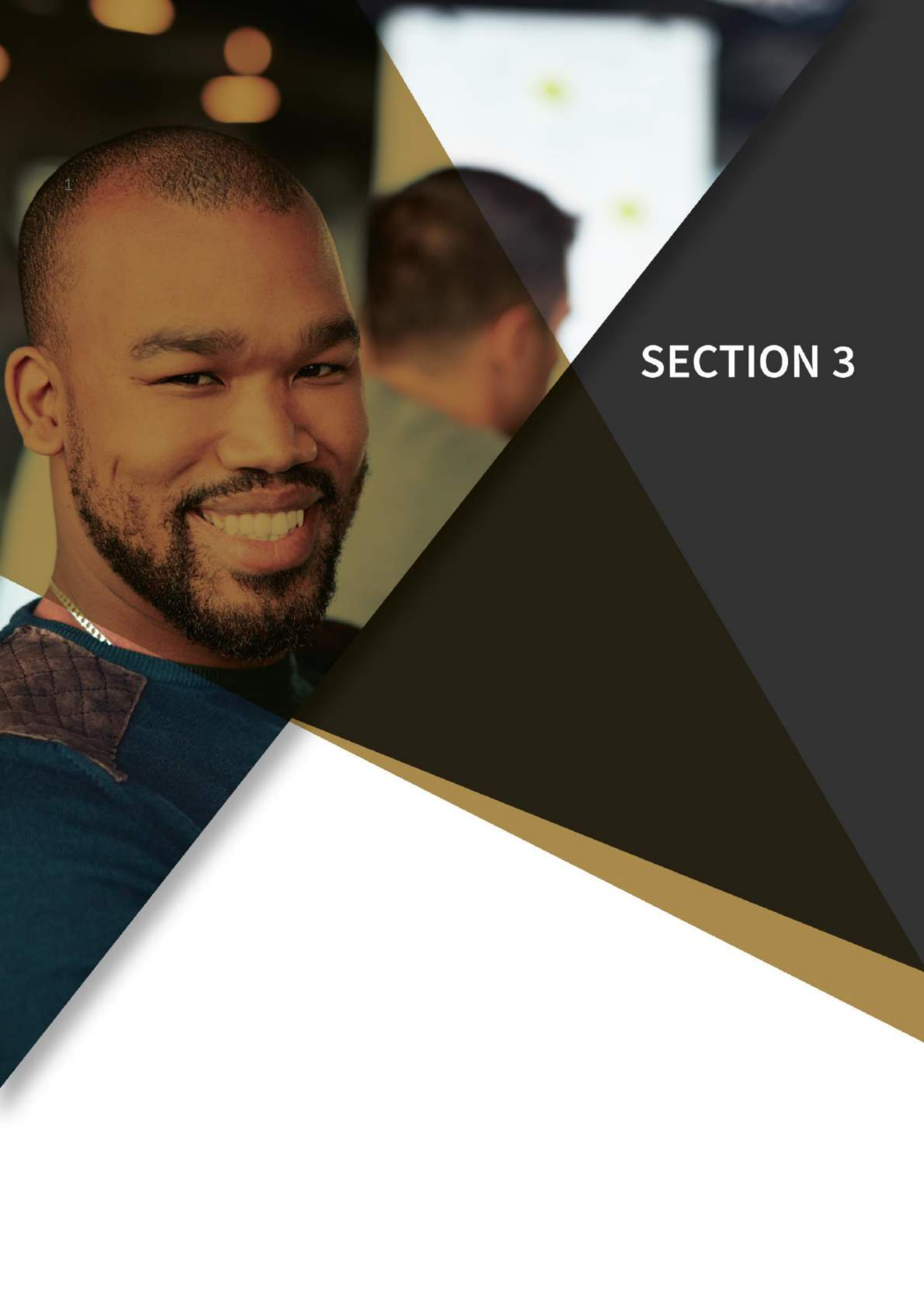
- A governance structure should retain the stewardship of the health of the Nation with the Government.
- A decentralised district health system with de-politicised governance and accountability structures to the community they serve. District health authorities should be established with the authority to appoint the CEO and all other health executives that serve in the district health system, hospital and clinics.
- Autonomous public hospitals with independent de-politicised governance and accountability structures to the community they serve. Public hospitals should remain an asset of the local health authority.
- Appropriate cooling off periods for any person in a position to influence a regulatory decision on healthcare. This governance proposal is more extensive than a mere recusal from decisions as proposed in the NHI Bill.
- The governance structure should also include the following stakeholders, Organised Labour, Employers (Business) and Civil Society.

Consumer protection

In a transformed healthcare system, consumers will have strong enforceable rights. The rights currently enshrined in the Medical Schemes Act in terms of prescribed minimum benefits, evidence-based medicine and compulsory substitution where formulary protocols are ineffective, cause or would cause harm, are some examples of what will be extended to every person engaging with the healthcare system. Furthermore, consumers will have progressive levels of appeals in terms of alternative dispute resolution structures. Relief should be at no cost or delay to the consumer of healthcare. The staged progressive complaints system that is contained in the Medical Schemes Act should be used as a basis for protecting members' rights. However, the time to resolve complains should be improved by streamlining the processes, capacitating the complaints unit and shortening the timelines. The following progressive dispute channels should be considered:

- Dispute committee
- Complaint to the regulator
- Appeal to the appeal council
- Appeal to the appeal board.

Exceptions should be allowed to fast track complaints where the patient's life is threatened or if the patient doesn't receive immediate or urgent care which will seriously affect the patient's lifestyle or health.



SECTION 3

Barriers to leveraging universal health care

The introduction of National Health Insurance (NHI) and increased insurance coverage for the population does not necessarily lead to Universal Health Coverage (UHC). The political willingness to provide universal health coverage is a step in the right direction but the benefit of it will depend on the quality of healthcare services provided.

For NHI to achieve UHC, it would need to deliver on key elements. The World Health Organisation (WHO) identifies three critical elements that indicate whether universal healthcare coverage has been attained. The three elements are:

1. **Equity** in access to health services - those who need the services should get them, not only those who can pay for them;
2. **Quality** of health services must be good enough to improve the health of those receiving services; and
3. **Financial-risk protection** - ensuring that the cost of using care does not put people at risk of financial hardship.

South Africa's two-tier healthcare system demonstrates attainment of some of the elements but none of the two satisfy the criteria in full. South Africa has a public sector that is over-burdened, disempowered, resource constrained and demotivated. Despite pockets of excellence, overall, the quality of care in the public sector is poor, and this is confirmed by the annual reports of the NDoH, the HMI, the NDP and other commentators. The private sector provides better quality (albeit with questionable value for money as stated by the HMI) but is only accessible to 16% of the population. Both systems are designed such that users are protected from financial ruin, if they access services within their designated system.

WHO criteria for UHC	Public sector	Private sector
Equity and access based on need and NOT ability to pay	Yes	No
Quality good enough to improve health outcomes	No	Yes
Financial-risk protection	Yes	Yes

In discussing how NHI or a transformed healthcare system should address each of these elements in order to provide UHC, the FIA makes reference to the China experience. A study undertaken in China offers valuable lessons to countries that have selected NHI as a route to achieving UHC. Following the 2005 WHO call on member states to provide UHC aimed at achieving affordable and accessible medical care for all citizens, China launched a series of health reforms which accelerated NHI coverage for its 1.3 billion citizens. Through strong governmental interventions and subsidies, a very high population coverage (96%) has been achieved. However, the benefits and structure were such that it did not provide the desired healthcare equity, financial-risk protection and there was ineffective supervision and administration of funds. The lesson that can be learned from China is that the way in which NHI or a transformed healthcare system is implemented is of higher importance than the fact that it is implemented. Implementation of a transformed healthcare system does not automatically result in real access to quality care and improved health outcomes[2].

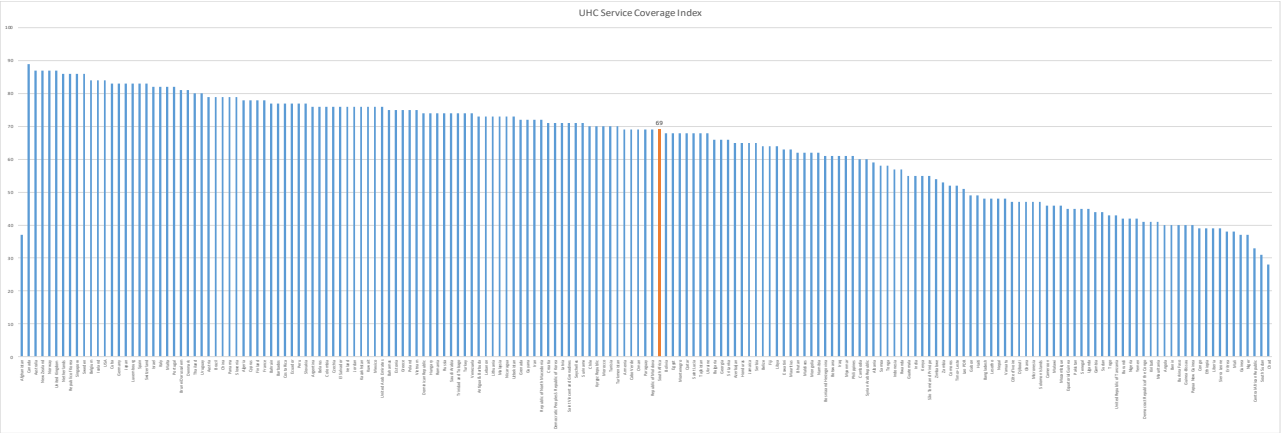
[2] Measuring Global Health, Wendy Walker, Institute for Health Metrics and Evaluation, University of Washington

The study also mentions that insurance may stimulate healthcare consumption, bringing disproportional negative consequences to the disadvantaged populations, especially when a high percentage of out-of-pocket payment is required.

There is consensus that although NHI was successfully implemented, UHC was not achieved. Refer to Annexure B for details of the study.

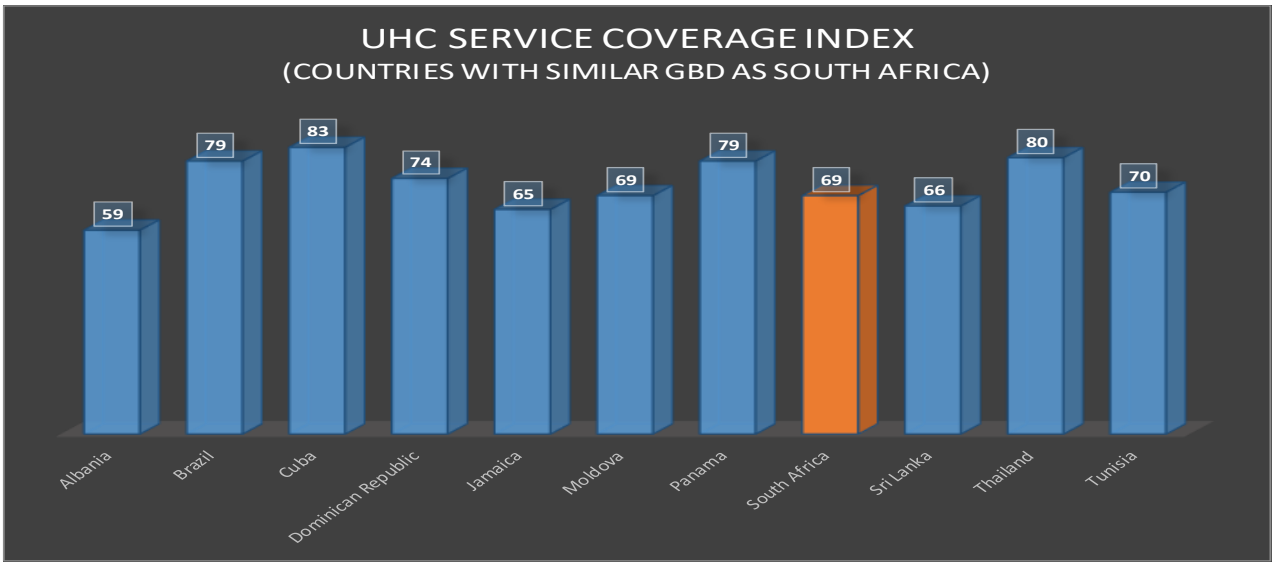
Equity and access based on need

South Africa has achieved a relatively high indexed score for Universal Healthcare. According to the 2019 Universal Health Coverage Report of the WHO, South Africa was ranked 86 out of 183 countries in terms of the Universal Health Coverage Index as depicted in the graph below.



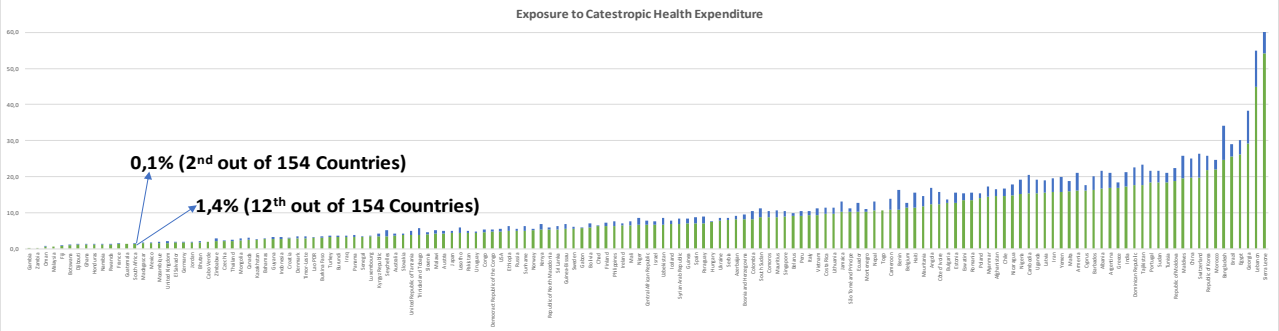
(Source: 2019 Universal Health Coverage Report, WHO)

If South Africa is compared to countries with a similar burden of disease, they in general spend less than South Africa on healthcare, and achieve a higher Universal Health Coverage indexed score as depicted in the diagram below.



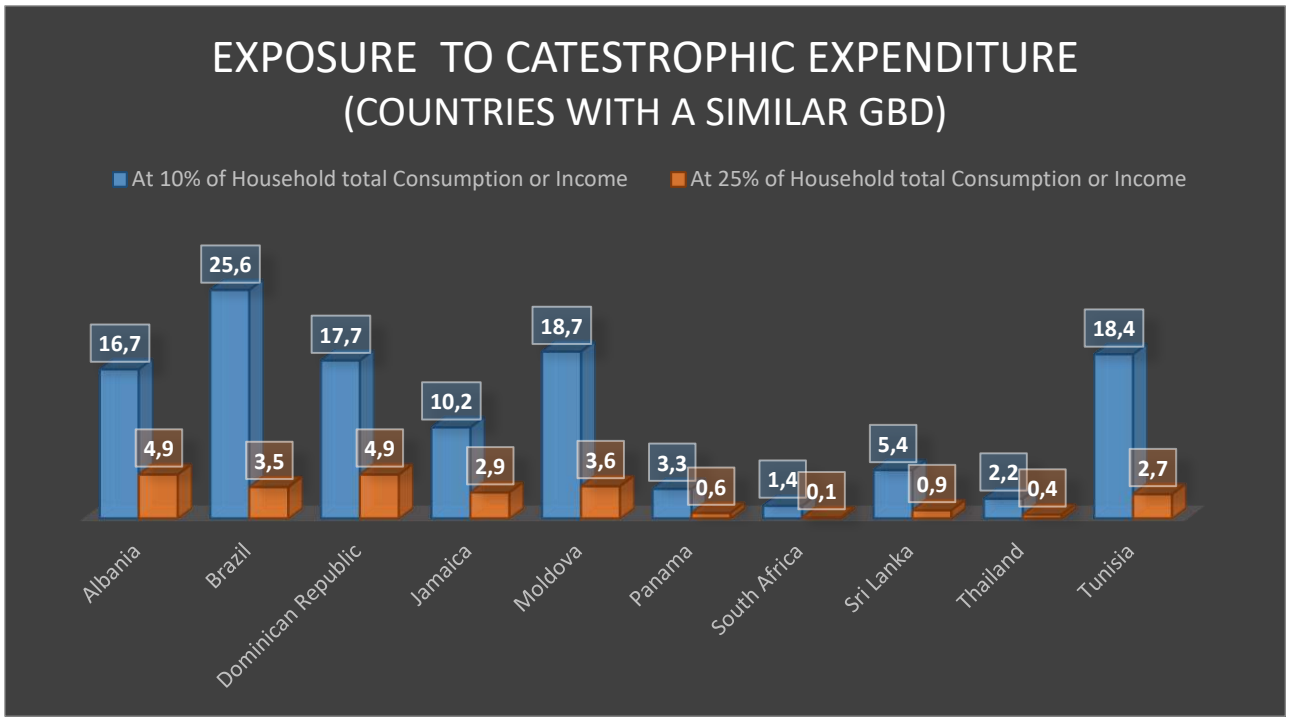
(Source: 2019 Universal Health Coverage Report, WHO)

Universal health coverage means that all people receive access to the health services they need without a requirement to pay at the point of service. Another measurement used to determine the level of universal access is to assess the proportion of households exposed to large expenditures on health as a share of total household expenditure or income. The WHO uses a 10% and a 25% threshold. The two diagrams below depict South Africa as performing well compared to 154 countries and to countries with a similar burden of disease.



(Source: 2019 Universal Health Coverage Report, WHO)

Where South Africa performs very poorly against countries with a similar burden of disease in terms of the efficiency of our health system, we perform exceptionally well in terms of financial risk protection as depicted in the graph below.



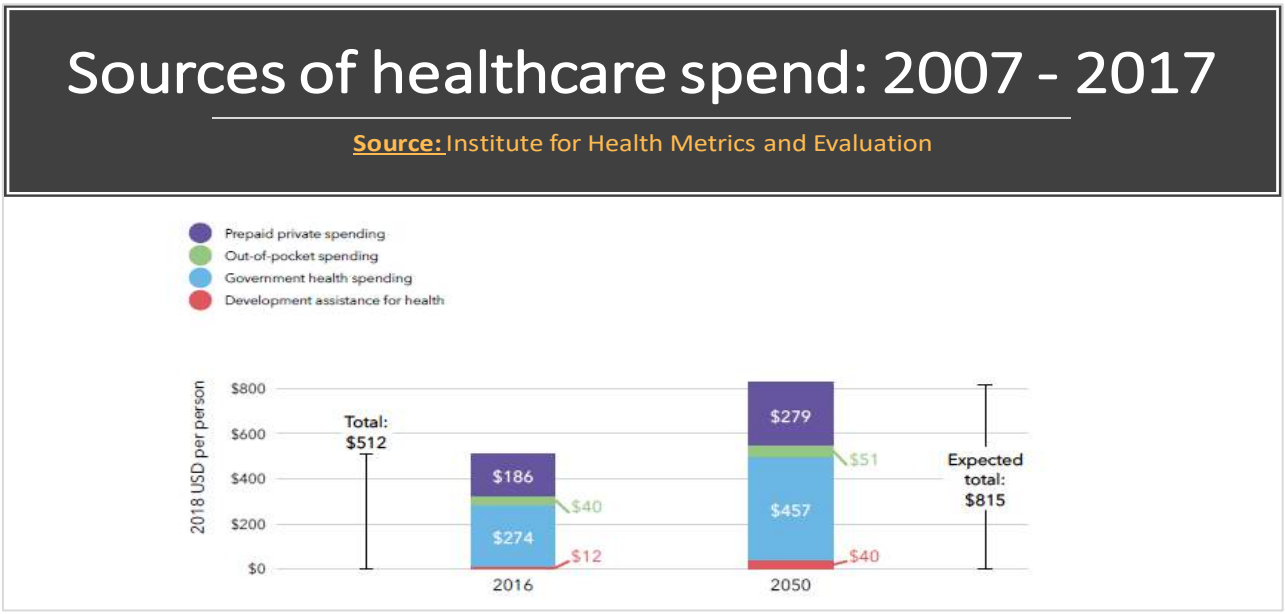
(Source: 2019 Universal Health Coverage Report, WHO)

The public sector in South Africa rates very high on equity, and grants nominal but not real access for users, regardless of ability to pay. There is a national Uniform Patient Fee Schedule that provides a guideline on how patients should be charged, but in application however, citizens are not denied care based on affordability. The private sector provides access to care to those who can afford to belong to private medical schemes. The

private sector also provides healthcare services to those who do not belong to a private medical scheme but who wish to make use of the private sector service. This two-tier or multi-payer healthcare system is often criticised for not being equitable.

Whilst equitable redistribution of resources is a key principle that informs most of our legislation, policy and the Constitution, the criticism seeks to argue that if more money is redistributed from the private sector to the public sector that healthcare delivery will improve. This argument regarding equity has flaws which we discuss below. An analysis of 10 peer countries shows, that there are 7 countries that contribute less towards public healthcare and in 100% of the cases the life expectancy at birth is better than that of South Africa. Also, when 10 causes for death and disability in these countries are evaluated, South Africa performs worse.

The diagrams below depict the healthcare spend in the public sector in South Africa[3]. Prepaid private spending consists of medical scheme contributions, Health Insurance and other healthcare products such as occupational health and primary care products. Members using medical schemes have the highest quantum of out-of-pocket expenses, but unemployed and uncovered people voluntarily using the private sector also contribute to out-of-pocket expenses. The public spending also includes the COIDA and RAF contributions.

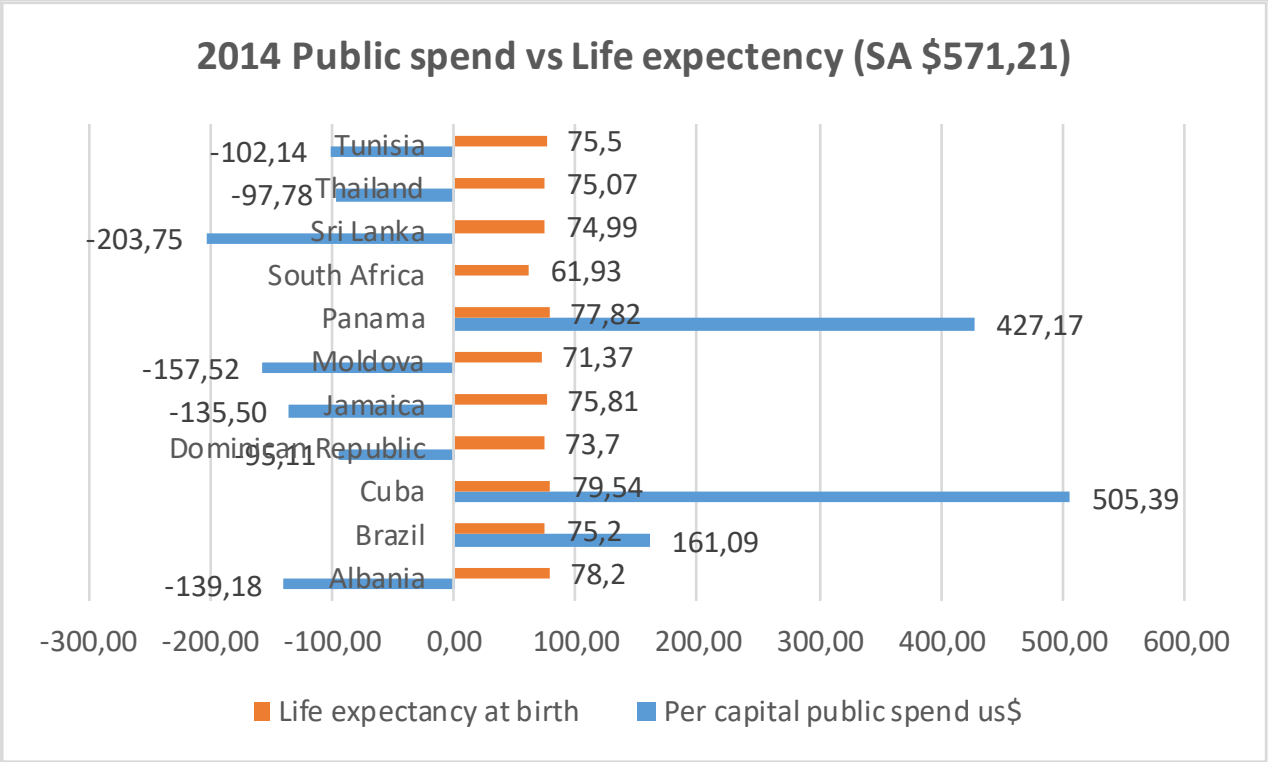


The diagram below depicts the deviation from public per capita healthcare spend in the public sector in South Africa compared to that of countries with the same GBD and their life expectancy[4]. Seventy percent of the countries spend less than South Africa but their life expectancy at birth is substantially higher than South Africa. Therefore, delivery of healthcare is the issue, and not the funding. It can be argued that the private sector contributes to equity because:

- The private sector is a major taxpayer (except VAT and levies);
- The private sector pays for medical scheme membership (approximately 9 000 000 people) from after tax money;
- The private sector reduces the demand burden on the public sector;
- The private sector can accommodate up to an additional 3 500 000 people if the LIMS proposals are adopted;

[3] Measuring Global Health, Wendy Walker, Institute for Health Metrics and Evaluation, University of Washington
[4] Indexmundi.com

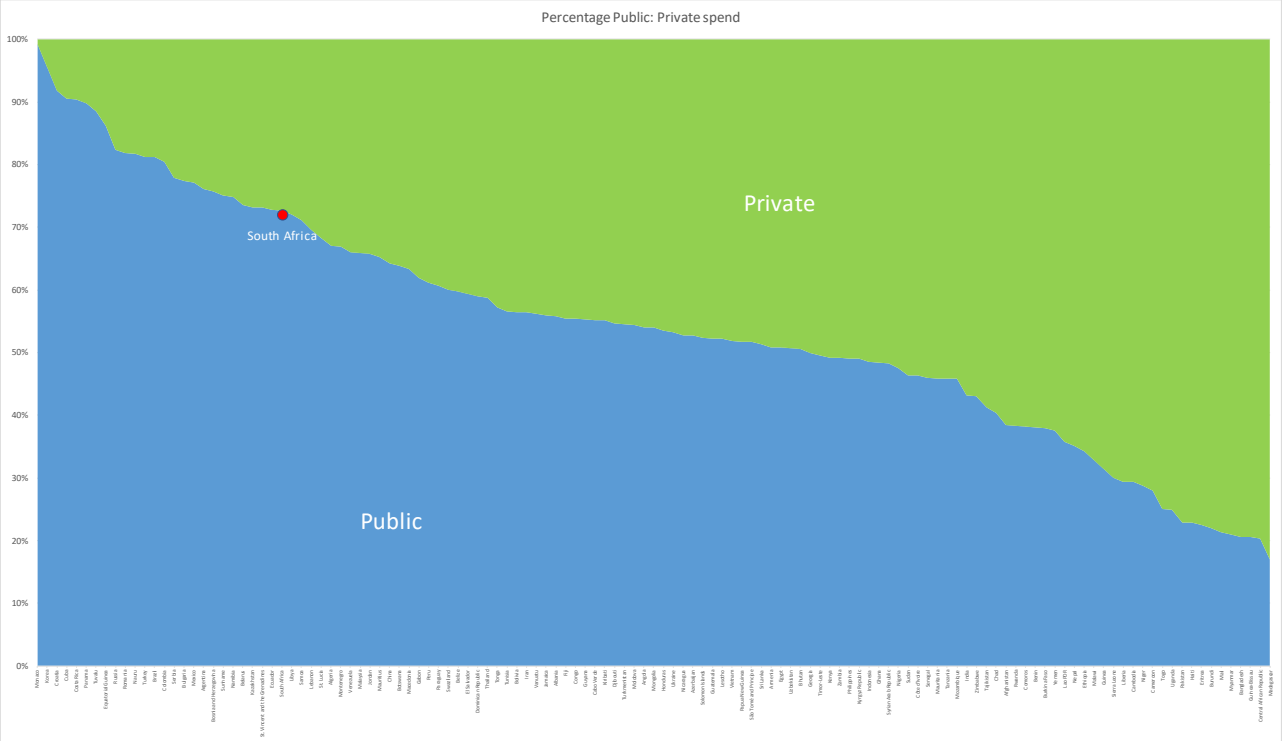
- Primary care products, occupational health products and health insurance products cover approximately 2 000 000 people all reducing the demand burden on the public sector;
- Large employer and mine hospitals and clinics reduce the burden on the public system;
- Members on private medical schemes, primary care products, occupational health products, health insurance products and employees making use of employer-based facilities account for approximately 25% of the population.



Medical products are not supply-constrained. Therefore, demand in the private sector will have no impact on the public sector provision. The private sector pays a premium for private care and as a result thereof demands higher volume of healthcare. Both systems contribute to the cost differential but that is not an equity issue. At best, as stated by the HMI, the private sector is most likely exploited. To resolve this issue of exploitation the correct response is not an equity redistribution but proper regulation as proposed by the HMI.

Arguments for equity are usually against a two tier (Private and Public) health system whilst nearly every country has an element of private and public spend as depicted in the graph below of 127 countries[5]. Inequity only refers to the inability of a group to access healthcare with social protection (pre-payment and no co-payment at point of service). People below the means test enjoy 100% equity and social protection, whilst private sector users enjoy a lower level of equity due to the means test if they make use of the public sector or co-payments in the private sector where and when they apply.

[5] Indexmundi.com



Quality good enough to improve outcomes

The determination of quality must be preceded by clarity on the health services considered to be central to attainment of UHC. WHO defines this as including the full range of essential services including the capacity for promotions encouraging healthy lifestyles, prevention of disease, treatment of disease, rehabilitation following illness and palliative care when needed.

Quality health care can be defined in many ways but there is growing acknowledgment that quality health services should be:

- **Safe** – avoiding injuries to people for whom the care is intended;
- **Effective** – providing evidence-based healthcare services to those who need them;
- **People-centered** – providing care that responds to individual preferences, needs and values; and
- **Timely** – reducing waiting times and sometimes harmful delays.

To realise the benefits of quality health care, health services must be:

- **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;
- **Integrated** – providing care that makes available the full range of health services throughout the life course;
- **Efficient** – maximizing the benefit of available resources and avoiding waste.

The key areas identified relate to the development of a coherent strategy to improve quality, to boost public health as a measure to reduce disease burden, to adopt evidence-based priority setting methods that ensure efficient spending of financial resources, to introduce an independent way of inspecting and regulating providers, and to allow for task-shifting, specifically in regions where staff retention is low.

Financial-risk protection

Financial risk protection is a key component of universal health coverage (UHC), which is defined as access to all needed quality health services without financial hardship. But in a broader sense, financial hardship in UHC represents the impact of the health systems on the non-health aspects of people's lives. Households can be impoverished or be faced with catastrophic health expenditure from accessing needed health services. Fundamentally, the assurance that people will not suffer financial hardship in using services, an integral component of UHC, is a recognition that health systems should not only improve health, but this improvement should not be done in ways that are detrimental to non-health aspects of well-being.

Many ways of measuring financial risk protection directly reflect the trade-offs people must make between paying for the health services they need and paying for other necessities such as food and basic education.

Two commonly applied concepts capture the lack of financial risk protection. The first, catastrophic health expenditure, occurs when a household's out-of-pocket (OOP) payments are so high relative to its available resources that the household foregoes the consumption of other necessary goods and services. The second concept, impoverishment, occurs when OOP payments push households below or further below the poverty line, a threshold under which even the most basic standard of living is not ensured. In terms of available resources, catastrophic health expenditures have been defined as health expenditures exceeding a share of either total expenditure, non-food expenditure, or expenditure net of basic food needs. Similarly, the threshold at which health payments become catastrophic has ranged from 10% to 40% of total household expenditure.

The South African issue is therefore not just about equity and total spend, but that of quality of outcomes. The issue of equity is far broader than NHI and requires simultaneous progress in several inter-related areas. We would therefore require strong political leadership and long-term commitment to drive the following:

- Actions to address social determinants of health such as education, living conditions and household income which affect people's health and their access to services;
- Actions to change unhealthy behaviour to healthy behaviour.

For non-insured users, the public sector may have limited services and a choice to access the private sector may expose non-insured users to financial risk. The insured users of medical schemes have prescribed Minimum Benefits to protect them to a large extent from financial risk.

SECTION 4

Previously adopted policies towards achieving universal health care but not implemented

The following policies were previously adopted; however not implemented. These proposals could strengthen the public and/or private sector, could increase the quality of care to all citizens of South Africa, and should be reconsidered for adoption.

Health White Paper of 1997: In 1996 and again in 1997 the DHS was prioritized for urgent implementation. Functioning districts were meant to be in place from the *end of May 1996*. The DHS framework outlined on the Health White Paper of 1997 was not implemented. The failure of the NDoH to properly implement the proposed decentralised DHS resulted in the public health system failure.

Taylor commission proposals 2002: In 2002 the Taylor commission recommended the following:

- Decentralisation of the public sector.
- Introduction of proper governance structures.
- Structural improvement in the regulation of medical schemes (only a small number of recommendations were implemented).
- Institutional reform of the public health system
- The tax funded public system will be the dominant mechanism to provide access to healthcare. However, the suggestions recognised the value of the private sector as a contributor to the healthcare system. Furthermore, it recognised that private sector demand reduced the demand on the public sector.
- Separation of the purchaser and provider functions within the provinces.
- Compulsory membership for the employed population.

Medical scheme reforms 2008: In 2008 the draft amendment to the Medical Schemes Act recommended the following:

- **Introduction of the Risk Equalisation Fund.** South Africa is the only country that has implemented open enrolment and community rating (Health Equity and social solidarity provisions) without implementing a REF. The implementation of a REF serves to protect funders against the unintended consequences of community rating and open enrolment attracting a disproportionate risk pool.
- **Minimum Benefit Package.** This minimum benefit package would have aligned or equalized the benefits between the private and the public sector.

National Development Plan: The NDP recommended the following:

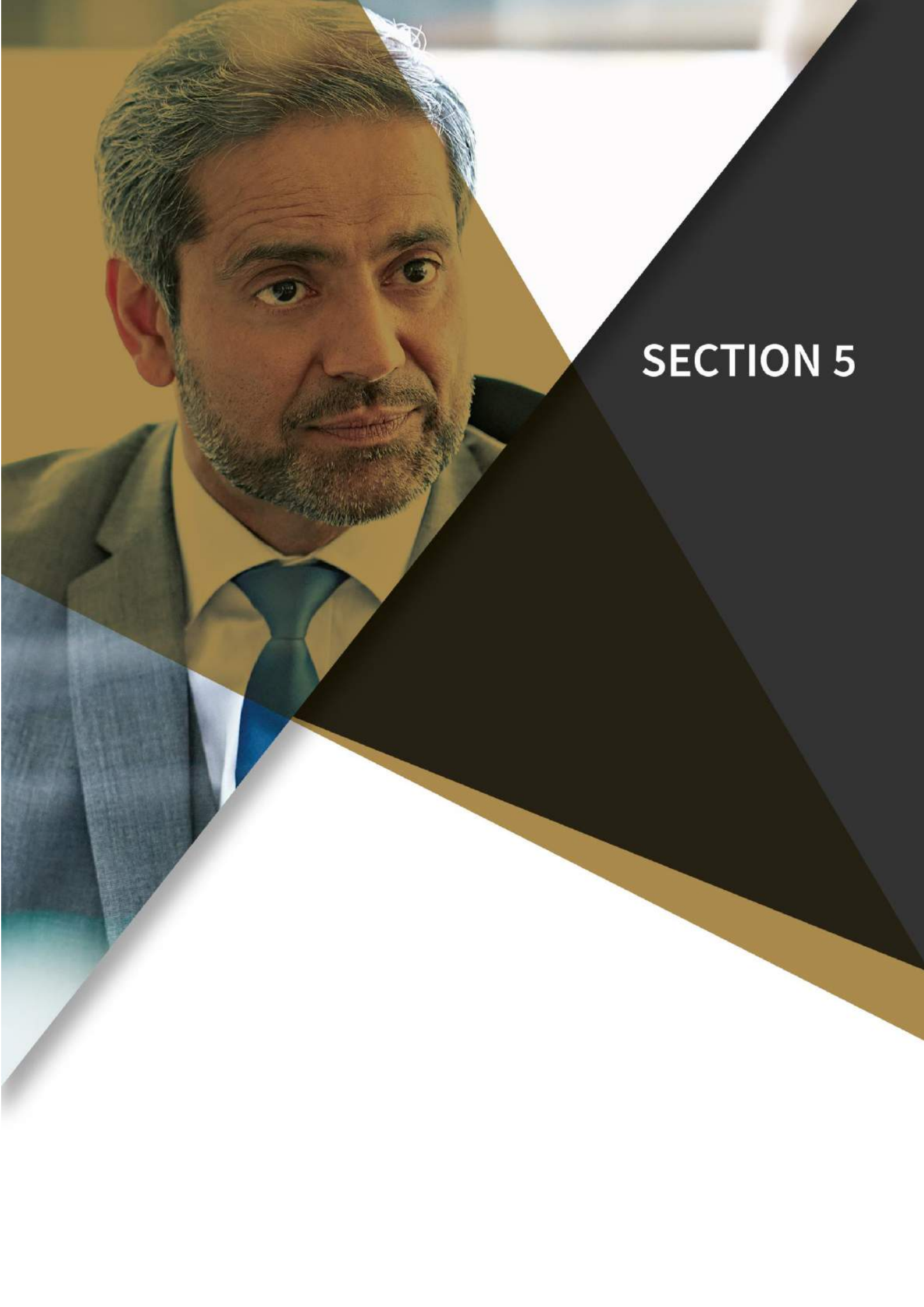
- Strengthen the health sector at district level. The NDP stated that the inability to get primary health care and the district health system to function effectively has contributed significantly to the failure of the health system. Furthermore, the NDP stated that the management of the health system is centralised and top-down. Poor authority, feeble accountability, the marginalisation of clinicians, and low staff morale are characteristics of the health system. Centralised control has not worked. According to the NDP the centralisation of hospital budgets and key functions such as supply chain management at provincial level has been detrimental to the public health sector.
- Prevent and reduce the disease burden.
- Recruit, train and deploy 700 000 community health workers.
- The NDP recommended that there should be incentives for employers to provide opportunities for employees to exercise and have access to information about healthy eating.

Low Income Medical Scheme Project: The LIMS project recommended the following:

- Establish a new class of medical scheme for low-income earners. However, this will require consideration to be given to:
  - Administration of the income threshold and protection against buy downs
  - Revised PMB regime and exemptions
- Allow the LIMS category of medical schemes to benefit from the REF
- Reducing the cost of goods and services

Health Market Inquiry: The HMI recommended the following:

- Introduction of previous proposals to establish a REF and mandatory membership.
- Proper regulation of the private sector by the NDoH and various regulatory bodies.
- The HMI made various supply side and demand side recommendations that need to be implemented.



SECTION 5

Reasons why the current NHI Bill may be harmful to South Africa

Rational policy design suggests that any proposed policy reform will attempt to serve rather than to harm public interest. This approach to policy design imposes an obligation on the legislator to base proposed legislation on thorough and accurate contextual information, a systematic evaluation, situation analysis, economic impact modelling and research. This research-based approach to policy design was unfortunately not commissioned. The only research that was commissioned was an evaluation of the success of the pilot projects. The pilot projects, to a large extent, did not provide a platform from where rational policy decisions can be leveraged. An exception was that the ward based PHC teams and the school-based teams yielded positive results.

The proposed NHI would require that the nearly 9 million members of private medical schemes will voluntarily transfer their complete coverage to the public system. The original green paper on NHI implicitly acknowledged that this consolidation will not happen if the public health system is viewed by medical scheme members as dysfunctional.

The need to decentralise health delivery

The current NHI Bill places undue powers in the hands of the Minister in terms of appointment of committees and personnel. Furthermore, healthcare delivery is centralised, disempowering districts and provinces. The NHI pilot projects already identified this as a problem and this may also become a focus for constitutional challenges to some of the proposals relating to the powers of provinces.

Whilst the renewed political will to transform the healthcare system exists there needs to be a separation between stewardship of the healthcare system and operationalization of the healthcare system. Decisions about the need for and quality of care need to be made at the point of health delivery. Furthermore, with the scarcity of health personnel, the management and operational running of the health system should be left to professional managers and supply chain professionals. Healthcare providers should be freed to focus on their skill in delivering healthcare services. Only with this decentralised approach will government be able to successfully implement a project of this magnitude and ensure that the correct checks and balances are in place to hold all stakeholders accountable for the quality and price of healthcare delivery.

Improve the delivery of Health Care. This is not dependent on receiving more money but on focusing on improving the efficiency within the current system

It seems that there is a belief that with more money obtained through the implementation of a National Health Insurance Fund, funded via the fiscus, with dedicated taxes being allocated to Healthcare delivery, we will be able to improve the service delivery of the Public Sector in South Africa. But, until we have addressed the inherent flaws in the current system, there is every probability that service delivery of Healthcare will not be improved. The current system is inefficient, and this is demonstrated in four ways:

Office of Health Standards Compliance: The battle for quality

The Office of Health Standards Compliance ('OHSC') was established to advise the Minister of Health on standards and norms which would be prescribed for the delivery of National Health. To this end, the office would certify health establishments ('HE's) as compliant and able to deliver services according to the norms determined through the same office. Furthermore, the OHSC would investigate complaints relating to breaches of the norms and standards.

It is currently evident that the Public Health care sector is not well managed or run and is challenged with the following non-finance related inadequacies:

- Lack of leadership and management
- Poor governance and oversight of resources
- Lack of accountability
- A demotivated workforce and overworked health care professionals
- Lack of information and necessary technologies to enable the efficient delivery of care
- Wasteful expenditure

Public sector facilities will be a key component of a transformed healthcare system. These inadequacies are not addressed in the proposed NHI Bill.

The work of the OHSC is to promulgate the norms and standards; and review or inspect HEs to ensure they are meeting the necessary norms and standards to protect and promote the health and safety of all patients using both Public and Private institutions.

Based on the Annual Report of the OHSC for the 2017/18 financial year, a total of 923 HEs were inspected, representing 24.18% of SA's 3 186 public HEs. The report on these inspections is outstanding and still to be published. But based on the previous report from 2014/15 – 67% of Public Health facilities inspected were non-compliant. i.e. they would not be able to render services under NHI. None of the approximately 30 000 private facilities have been inspected. Adequate inspection rate and adequate compliance to the standards is required before NHI can be implemented.

The promulgation of norms and standards was delayed and only promulgated in February 2018, to come into effect in 2019. So up until this point it has been impossible for the OHSC to enforce compliance.

Even given the delay of the promulgation of the norms and standards, the OHSC is woefully behind schedule in terms of inspecting and reviewing the necessary HEs so that they can be accredited for participating in the delivery of Health Care under the National Health roll out. The necessary electronic tools are still in the developmental phase, and this is causing further delay. But the question remains as to how this office will be able to fulfil its mandate in terms of the accreditation of facilities by the proposed date of 2022/2026.

There is, therefore, a huge shortfall in terms of the number of accredited institutions which will be able to service the population – given the ambitious timeline for the roll out of NHI.

The Life-Esidimeni tragedy should serve as a horrible reminder of the consequences of policy implementation without inspecting HE's to ensure compliance with adequate and safe health standards. Never, in our lifetime, must we allow this harm to our citizens again.

The other issue is the number of complaints received by the OHSC. This has escalated from 73 in the 2015/16 reporting timeframe to 1 122 in 2017/18. This massive increase (1 537%) in complaints relate to patients' rights and patient safety, clinical governance and patient care. These are key determinants for a successfully transformed quality healthcare system.

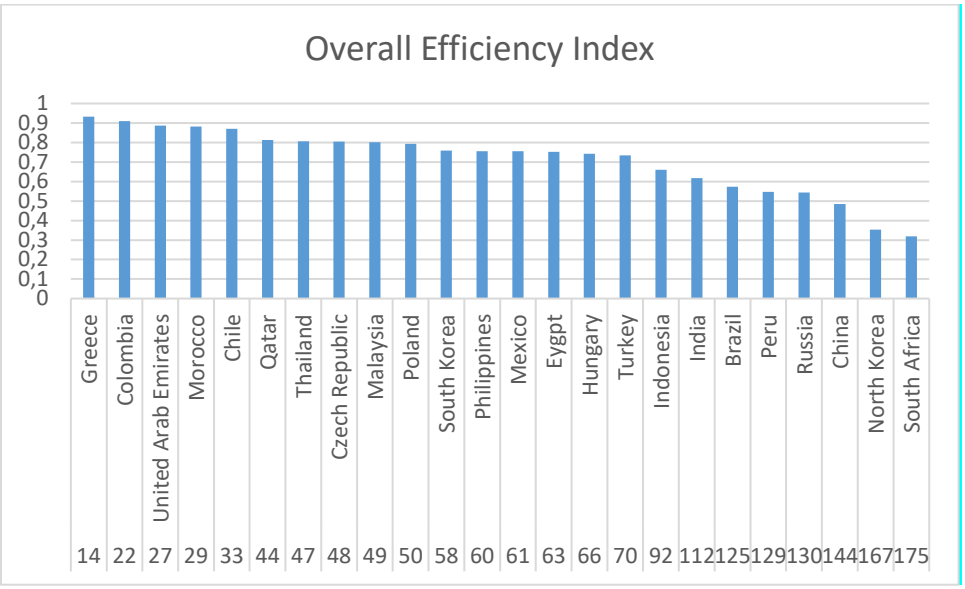
Health Outcomes in South Africa

In an overall efficiency rating done on all 191 WHO member countries, South Africa was rated 175 out of 191 countries[6]. The rating was based on:

- improvement in the health of the population;
- responsiveness of the health system;
- fairness in financing and financial risk protection.

Given the above outcome, and other publicized papers where South Africa has found to be wanting in terms of health delivery when measured against the current spend on Healthcare in relation to other emerging economies, it is clear that we have a sum of money which is being spent on Healthcare, but inefficiently, and therefore the money is not utilised effectively in ensuring the continuing improvement of health for the population.

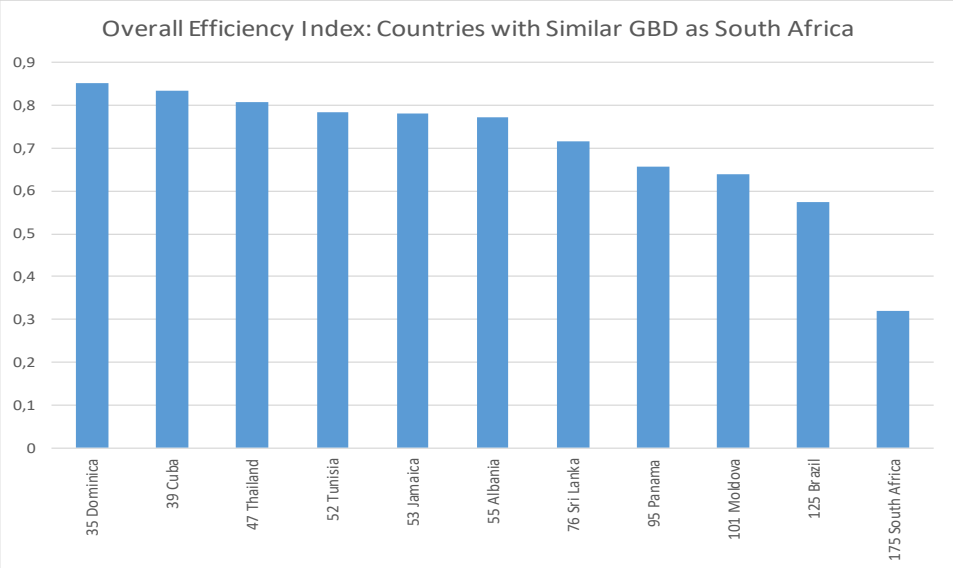
The graph below depicts South Africa's health system efficiency against emerging market economies.



The table below depicts the comparison where countries chosen were based on the GBD regional classifications, known trade partnerships and socio-demographic indicators[7].

[6] Measuring Overall Health System Performance for 191 Countries GPE Discussion Paper Series # 30 EIP/GPE/EQC World Health Organisation

[7] Measuring Overall Health System Performance for 191 Countries GPE Discussion Paper Series # 30 EIP/GPE/EQC World Health Organisation



The South African Health System performs better than most countries when it comes to preparedness to respond to a deliberate or accidental threat with the potential to wipe out humanity[8]. According to the Global Health Security Index (GHSI) South Africa scored 34th out of 195 assessed countries. Compared with countries with a similar GBD as South Africa we performed well. The table below depicts South Africa's performance compared with countries with a similar GBOD.

Country	Score out of 100	Rank out of 195
Dominica	24	172
Cuba	35,2	110
Thailand	73,2	6
Tunisia	33,7	122
Jamaica	29	147
Albania	52,9	39
Sri Lanka	33,9	120
Panama	43,7	68
Moldovia	42,9	78
Brazil	59,7	22
South Africa	54,8	34

[8] Global Health Security Index

One of the international panel of experts who worked on the new Global Health Security Index was former DA MP Wilmot James, now visiting professor in political science and paediatrics at Columbia University in New York. James is a former Dean of Humanities at the University of Cape Town.

The index assesses factors critical to dealing with threats, such as robust health systems, adherence to global norms, and political and security risks, including public confidence in government.

To improve Health Outcomes, you need to: -

- Manage resources and finances better;
- Leverage technology to optimise reach and efficiencies;
- Address human behaviours;
- Ensure that the Health care systems and processes are fair and effective in providing affordable interventions;
- Procurement is done astutely to ensure that the population is serviced according to its needs;
- Financing is sustainable;
- All HEs both private and public are regarded as a national asset and instrument of service delivery.

All the above needs to be demonstratively visible to the public to secure the trust in a fair and sustainable system.

Cost of litigation within the Department of Health: Symptomatic of poor health delivery

The cost of litigation within the Department of Health is a huge concern and symptomatic of poor health delivery. Money spent on litigation, erodes the amount of money available for Health Care delivery. Whilst this refers to the direct spend or loss of money, the indirect cost associated with the litigation due to preparation of evidence and expert witness testimony and loss of production should also be considered. At the Medical Malpractice Workshop of March 2017 – the contingent liabilities for medical malpractice across all the provinces amounted to over R40 billion.[9]

Dr Aaron Motsoaledi, the previous Minister of Health described the increasing number of medical mal-practice litigation claims against the Department of Health as an “explosion”. Last year Gauteng’s Health Department paid out over R1 billion in lawsuits, and the Eastern Cape is facing a bill of over R6 billion. Eastern Cape MEC Somyo has himself admitted that “This makes it difficult to deliver quality healthcare services to the people.” The answer in reducing the financial implications of these rising claims is to reduce sub-standard care, and to this end, transparency is critical in redressing the events and adjusting requisite protocols to ensure that patient care improves.

Pilot projects: Poor track record for rational policy implementation

It was envisaged in the white paper on NHI that NHI will be implemented in 3 phases. Phase 1 commenced in 2012 and ended in 2017. The NDoH commissioned an independent evaluation of Phase 1. Phase 1 consisted of the following 11 districts; OR Tambo (Eastern Cape), Thabo Mofutsanyana (Free State), Tshwane (Gauteng), uMgungundlovu and uMzinyathi (KZN), Vhembe (Limpopo), Gert Sibande (Mpumalanga), Pixley ka Seme (Northern Cape), Dr Kenneth Kaunda (North West), Eden (Western Cape). Amajuba district was the additional district included by KZN[10]. The projects covered 2 953 813 households in 2011 and 3 441 865 in 2016. Despite NHI being a national priority, only 76% of the allocated budget was spent on the NHI Pilot

[9] South African Law Reform Commission – Project 141: Medico-Legal Claims - 20 May 2017
[10] Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa - NDOH10/2017-2018 Final Evaluation Report – published July 2019

projects (R380 593 000 of the R 502 914 000 budgeted amount). It is unclear from the NHI Pilot projects which portion of the NHI proposals were piloted, what worked and what did not work and which policy or purchasing agreements should be amended following the pilot projects. The evaluation of the pilot project raises serious concerns about the readiness of the public health system and the NDoH to proceed with NHI. The following concerns are briefly summarised below:

- **WPHCOT's:** A total of 3 323 WPHCOT's (5,6% less than 2016/17) were deployed providing basic health services to children and adults at the end of 2017/18. The independent evaluation claims that 12 816 152 households were covered. At a full staff complement the WPHCOT's had to see approximately 3 households per working day. This seems unproductive or inefficient. These districts had 2 953 813 households in 2011 and 3 441 865 in 2016 therefore, the figure is either overstated, inaccurate or duplicated data. The latter may be more likely. Whilst the impact on health improvement was perceived as good by consumers of this service, data collection was insufficient to adequately monitor the effectiveness of the referral and follow up processes. This shortcoming is key to assess the effectiveness of this policy intervention. Aspects such as insufficient funds for transport and equipment seriously undermines the structural and operational readiness of the NDoH to implement and manage NHI. If it can't do so with a small portion of NHI in only 11 districts, confidence to do so on a larger scale should be lacking.
- **ISHP's:** A total of 4 339 875 learners were screened between 2012 and the end of 2017/18 (it is unclear if these are unique screenings or whether there were some form of duplication). 505 803 learners were referred for treatment. Aspects such as insufficient funds for transport and equipment were also evident in the ISHP's.
- **GP Contracting:** A total of only 330 GP's were contracted between 2012 and the end of 2017/18 (most of these doctors were Doctors within the public health service). The inability to contract with GP's will seriously hamper the successful implementation of NHI. Furthermore, due to poor control, opportunistic behaviour resulted in an overpayment of overtime. If overtime of 330 doctors can't be properly managed the ability of the NDoH to properly manage the full spectrum of contracting and human resource management of NHI should be questioned.
- **ICRM:** A total of only 3 434 facilities were assessed of which only 1 507 or 43.9% attained ideal clinic status by the end of 2017/18.
- **DCST:** 45 of the 52 districts had functional DSCT's with at least three members per team. Often the teams lacked critical specialists such as gynecologists and pediatricians. Specialists were also found not to be good mentors.
- **CCMDD:** A total of only 2 182 422 patients had enrolled on the CCMD programme by the end of 2017/18.
- **HPRS:** A total of 2 968 PHC facilities were using HPRS with 20 700 149 people registered on the system by the end of 2017/18. Poor connectivity at some facilities and challenges with hardware have contributed to the challenges experienced during NHI Phase 1 implementation.

Pilot projects in health policy development should enable the government to:

- **Determine the readiness for full-scale implementation.** The pilot projects provided no confidence that the NDoH are ready for a full-scale implementation of NHI.
- **Gauge the readiness the target populations reaction to the proposed policy.** The pilot projects provided some degree of acceptance.
- **Assist government to better allocate time and resources**. The pilot projects did not meet this objective.
- **Ensure that the government is well prepared to measure the success of the proposed policy.** The pilot projects provided a poor scientific base. Evaluation criteria and benchmarks were not determined at the onset of the project. The lack of base data was criticised in the pilot project evaluation report.

Given the poor health standards of healthcare facilities, the poor health outcomes and the poor results from the pilot projects as explained above, it is abundantly clear that the existing budget for Health Care needs to be spent more wisely and we cannot afford the current levels of wasteful expenditure.

Funding of NHI

The State President, Mr. Ramaphosa, recently addressed the nation on government spending and informed the nation that government don't have any surplus funds. Therefore, a logical deduction from the State President's plea for frugality of public funds is that wasteful expenditure should be avoided.

The well documented evidence of state capture and general lack of governance and responsiveness to the public that is served, in SOE's such as Denel, Eskom, Frere Dairy Project, PRASA, SAA and SABC should be avoided when a project of this epic magnitude is considered and implemented. The pilot projects already identified serious governance concerns, which if not rectified, will lead to wasteful expenditure. Some similarities are highlighted below:

Estina Dairy Project: This project was sold to the community as a project that would benefit the community and small farmers. Whilst this was a plausible social interest project with adequate political will, concerns were raised in the beginning about the lack of skill within the department to manage the project, poor research and financial prudency. The result was twofold, namely that the intended beneficiaries did not benefit, and money was wasted. Money which the country doesn't have. The concerns raised with the NHI pilot projects should be addressed before a project of this magnitude is embarked on.

Eskom: The failures of Eskom provide relevant examples due to the scale of the projects, the impact of failures on society and the economy. Various proposals were made in the past regarding infrastructure maintenance and alternative energy. However, these proposals were never implemented. This inability to implement good suggestions comes at a huge cost to the taxpayer. The building of the Medupi and Kusile power stations were poorly managed, took far longer than envisaged and cost far more than initially budgeted for. Different to commercial concerns, the cost of these poor decisions does not affect shareholders but come at a huge additional tax burden on the taxpayers. The inability or unwillingness to provide clear benefits for the NHI package and costing before the project is embarked on should not be allowed as it will lead to similar outcomes as Medupi and Kusile.

Public Rail Agency of South Africa: PRASA embarked on buying locomotives at a huge cost. However, the issue is not that the budget was exceeded or that the right procurement policy was not followed but that the locomotives do not fit on our railway tracks. There is no doubt that the purchased locomotives are of good quality albeit a bit expensive. However, if they don't fit on the railway tracks, the community they intend to serve will not benefit from them.

Similarly, to the examples above, the WHO does not prescribe to member nations how universal healthcare should be implemented and which model should be used. Universal coverage is achieved with multiplayer, single payer, the Beveridge, the Bismarck, competing insurance funder and non-competing insurance funder systems. This is like the locomotives. There are many funding models for universal healthcare. South Africa must decide which system will work for us considering our unique GBD. At no stage was the nation taken into the confidence of the NDoH and provided with proper research regarding the proposed single payer NHI funding model. The right approach that should have been adopted was:

Step 1: Conduct a thorough situation analysis of the failures and successes of the public and private healthcare sector. This should include detractors from and contributing factors to the health of the population.

Step 2: Identify feasible options for health improvement in the short, medium and long term.

Step 3: Conduct a thorough evaluation of the feasible options in terms of the economic, financial and health impact.

Step 4: Assess the feasibility of the desired option in terms of the economic impact, value and cost, the financial impact and the risks and moral hazards that the option will be exposed to.

What can be learned from the failures of the SOE's and the pilot NHI projects is that the financial impact of NHI is more than just a budget. The following questions needs to be answered before the NHI project should commence:

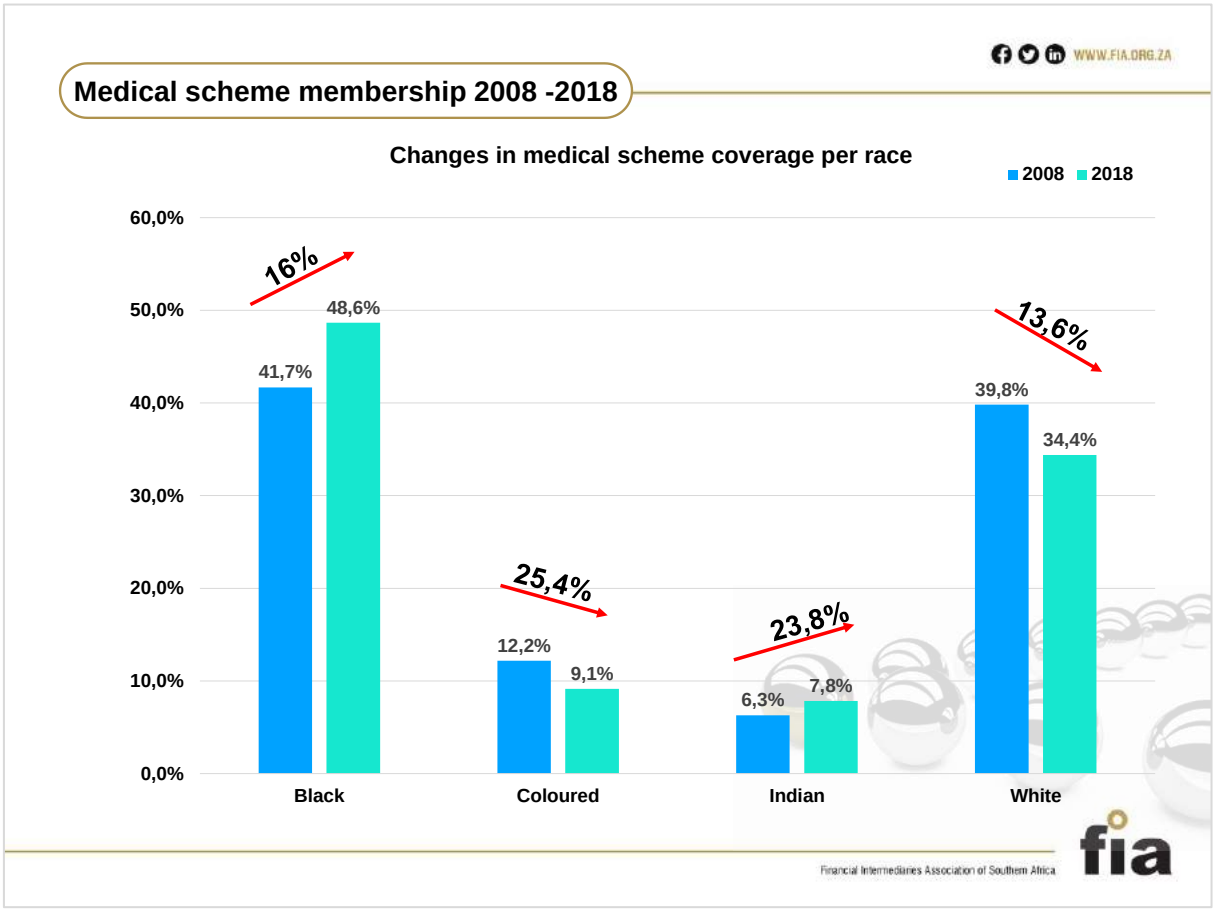
- How will the infinite demand for healthcare be balanced with the limited resources?
- What rationing mechanisms will be applied and how will consumers of healthcare be able to protect themselves against rationing of healthcare?
- What metrics will be applied to ensure that the share of household budget remains affordable?
- How will we ensure that healthcare expenditure keeps pace with GDP growth?
- How will we ensure health outcomes stimulate economic growth?
- Health services that are rendered by the State are exempt from VAT. The R46 billion that is rechanneled from the private sector to the state will result in VAT losses of nearly R7 billion. How will this VAT loss be dealt with?
- Will Civil servants that receive R 36 billion in subsidies willingly accept a reduction of their conditions of employment? If they are compensated for the reduction in conditions of employment, what will that amount be?
- Will civil servants that make use of the private sector be expected to transfer to the public sector if the same level of care is not available in the public sector?
- If the approximately 9 million users of private healthcare transfer to the public sector, what will the impact be on the supply and demand of healthcare?
- How will a payroll levy impact existing conditions of employment as it relates to subsidy and participation policies?
- How will a payroll levy impact post-retirement medical scheme contribution liability?

The Private Medical Schemes and Health Insurers – A National Asset

A key question which needs to be answered, is what role the private medical schemes and health insurers will play within a transformed healthcare system. The green paper and white paper on NHI limited the role of the private medical schemes to a mere top-up insurer of healthcare. Furthermore, health insurers were totally ignored in the two discussion papers. The proposed NHI bill currently before parliament seeks to continue with this view that medical schemes and health insurers must only fulfill a top-up role. The principles that frame the view of the legislator are twofold, namely that private medical schemes only benefit those that can afford membership and that private medical schemes support the unequal distribution of healthcare, and furthermore that the private medical scheme environment is unsustainable. The FIA disputes the accuracy of the premise of the legislators' views regarding the private medical scheme and health insurance market. However, what is of higher importance is the value or contribution the private medical scheme and health insurance market offers the healthcare system of South Africa. The private healthcare sector must be retained and co-exist with the public healthcare system to serve the universal healthcare needs of South Africa. The private healthcare system as a national asset must be leveraged to improve the health delivery within the public sector. The diagram below depicts the private medical scheme cover from 2008 to 2018 according to the General Household Survey. Nearly two-thirds of members on private medical schemes are non-white.

The following observations are made:

- 48,6% of members on private medical schemes are of Black descent. This membership has increased 16% since 2008. Whilst membership in this population group is expected to still grow, the black population make up nearly 50% of private medical scheme members.
- 9,1% of members on private medical schemes are of Coloured descent. This membership has decreased 25,4% since 2008.
- 7,8% of members on private medical schemes are of Indian descent. This membership has increased 23,8% since 2008.
- 34,4% of members on private medical schemes are of White descent. This membership has decreased 13,6% since 2008.



Source: Stats SA: General Household Survey2008.2018

Value of medical schemes and health insurers to the economy:

The value or contribution that medical schemes and health insurers make to the healthcare system in South Africa is substantial. The following points illustrate this:

- Approximately 9 million people are covered by medical schemes. This reduces the burden on the public system.
- Medical scheme members consist of employed and unemployed members. Some spouses and children are unemployed. Medical schemes also have several pensioners, no longer employed.
- Medical staff that attend to private medical scheme members (Nurses, GP's and Specialists) also provide services to non-medical scheme or private members. The Low-Income Medical Scheme Project estimated that the spend in 2005 was R 112 per GP visit and R 34 for medicines per visit.[11]
- Medical Schemes employ a huge number of staff in terms of administration, marketing, risk assessment management and underwriting and fraud detection to name a few areas of intellectual value they add to the healthcare system.
- Medical schemes are also strongly regulated with substantial regulatory intellectual property built up in the regulator.
- It is estimated that there are about 2 million people with health insurance products, primary care products and occupational health products. This excludes people who have access to large employer and mine health facilities.

Medical schemes contribute to Social Solidarity

- The means test applied in public hospitals supports social solidarity in that the employed must pay for services in the public facilities. However, this undermines the principle of universal access and no payment at point of service. It can be argued that most medical scheme members earn more than R 8 333 per month in their household and as such must pay the full price of treatment in public hospitals according to the means test. However even households with an income of R 4 167 per month must contribute towards treatment in public facilities. Furthermore, more than two thirds of members not on a medical scheme indicated that they make use of private facilities because they perceive it as good quality. This is in stark contrast to only 1% of people that used public facilities that viewed public facilities as good quality. The primary reason people use public facilities (93%) relates to their inability to pay for healthcare services.
- Medical schemes must conform to social solidarity principles such as community rating and open enrolment. However, due to the stringent management of contribution increases the CMS have also ensured that contribution increases for lower income options, where applicable, are absorbed by members on more expensive options.
- According to the General Household Surveys the bulk of out-of-pocket expenses are for non-catastrophic medical expenses incurred by families in the top income decile.

[11] Consultative Investigation into Low Income Medical Schemes, Final report, 7 April 2006, Jonathan Broomberg

Medical schemes are sustainable:

- The number of medical scheme members increased year on year to approximately 9 million beneficiaries. The growth in medical scheme members is indicative of sustained value demonstrated by medical schemes.
- Medical scheme solvency is increasing. This is an indicator of financial stability. However, it can be argued that the solvency requirements for the larger medical schemes representing more than 75% of members can be relaxed if a risk based actuarial solvency approach is followed.
- Medical schemes are amalgamating. Whilst the number of medical schemes is decreasing, the average size of the risk pools are increasing. This adds to a sustainable environment.

SECTION 6

Proposed response to the health crisis in South Africa

The poor health of South Africans, their poor living conditions and access to clean water and sanitation, poor lifestyles and poor health outcomes creates a health crisis. Therefore, solutions to arrest this crisis and to transform the healthcare system are the responsibility of every South African. A transformed and alternative healthcare system must avoid the following 3 pitfalls in order to offer sustainable universal access to all citizens:

- **The health system must not disproportionally focus on a narrow offer of specialised curative care:** This pitfall should be avoided in and out of hospital. In avoiding this the healthcare system should focus on preventing rather than treating disease. Diseases such as HIV, Diabetes and Hypertension to name a few are cheaper to prevent than to treat. These diseases have a strong correlation to lifestyle choices citizens make. In fact, the World Economic Forum mentioned that 8 lifestyle behaviours lead to 15 diseases that account for 80% of the cost associated with chronic conditions.
- **The health system must avoid a command-and-control approach to disease control, focused on short term results and fragmenting service delivery:** The World Health Organisation ('WHO') warns against a "command and control" approach to disease control which leads to fragmentation. This refers to vertical programmes for specific diseases that operate in parallel to integrated delivery platforms. The way in which South Africa manages the treatment of HIV and AIDS and TB is a good example of how this pitfall has been avoided. The Taylor Commission proposed that our healthcare system must be depoliticized, that the healthcare system must be decentralised, and that the personnel rendering the healthcare services must be responsive and accountable to the community they serve.
- **The health system must not be categorised as a system where a hands-off or laissez-faire approach to governance is tolerated. Furthermore, the unregulated commercialisation of health should not be tolerated:** The WHO's warning that the failure to exercise proper stewardship over the private sector will lead to unregulated commercialisation of health, should guide policy decisions regarding the private healthcare sector. When regulated properly the private healthcare sector will be a contributor to the health of the nation. To a large extent this is true for the private healthcare sector in South Africa. Examples of this proper regulation are open enrolment, community rating and capping of broker commission. However, compulsory membership of the employed population (above a certain income level and risk equalisation) will further strengthen the value the private healthcare sector will have to South Africa. This way the private sector can co-exist with the public sector to serve the nation.

Alternative solutions need to consider the following realities regarding the healthcare system in South Africa:

- Health professionals, according to Econex, Discovery Health and Persal data, are predominantly employed in the public sector. In 2011 it was estimated that approximately 73% of health personnel are employed in the public sector and the remaining 27% in the private sector.
- According to the Health Systems Trust, 76% of Hospital beds are provided in the public hospitals with private hospitals accounting for only 24% of hospital beds.
- The private healthcare spend does not only consist of medical scheme expenditure. Entities such as the Compensation fund, the Road Accident Fund, Rand Mutual and Mine hospitals, to name a few also contribute to the private healthcare spend.
- Medical schemes do not only cover the employed population. Children and unemployed spouses also form part of private medical scheme cover.
- Unemployed citizens have access to universal access at no cost at point of service. However, due to the application of the means test the employed population only have pre-paid access to universal cover if they belong to a private medical scheme. If not, they will have to pay at point of service.

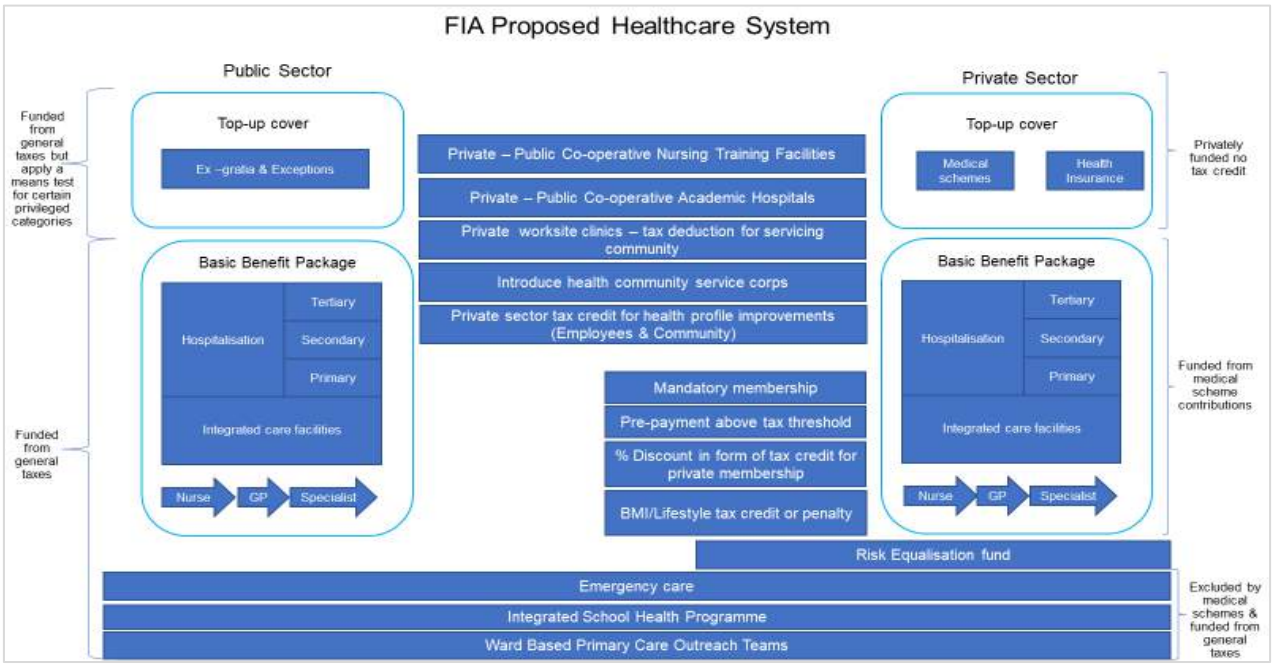
- Private medical schemes are structured to support social solidarity. This is achieved by prohibiting private medical schemes from refusing membership based on age or ill health. Contributions are also community rated and not based on the health risk of the individual.
- The private healthcare industry is a national asset which must be leveraged and strengthened to support universal healthcare.

An expected set of objectives would look asfollows:

- All residents must have access to a minimum level of health protection without facing an income barrier;
- All health services must be provided to a high standard of care;
- All health services must be provided efficiently and at reasonable cost;
- Access to all health services must be fair;
- The supply of health services must be responsive to the reasonable expectations of all citizens;
- The private and public healthcare system must co-exist to provide universal access in a cost efficient and sustainable manner. This co-existence should compete to provide care to the employed population. This competition should be on price and quality. Private medical schemes should be allowed and incentivised to purchase services from the public sector. Private medical schemes today spend less than 1% on public hospitals whilst more that 25% was spent on public hospitals 3 decades ago[12].

The diagram below depicts a proposed co-existence but transformed healthcare system that will provide all citizens universal access to healthcare. Furthermore, the proposed healthcare system seeks to create synergies and co-operation from the private sector. The proposal also contains suggestions on how lifestyle improvements can be incentivised and poor lifestyle penalised. Equity is achieved via the minimum benefit package, compulsory pre-payment, partial tax credit for private use and no tax incentive for top-up cover. This proposed healthcare system needs a thorough analysis in terms of its economic impact, cost and fiscal implications, risks and moral hazards. However, we believe that this proposal meets the socially desirable objectives of improved health, equity and universal access.

[12] CMS Annual reports



The proposed transformed health system is comprised of the following:

- **Focus on prevention a key focus:** All citizens should have access to the ward based primary care and the integrated school health programme and emergency care (whether rendered in the private or public sector). These services may not be provided by medical schemes and are funded from general taxes.
- **A set of minimum benefits must be developed for the public sector:** This will include referral pathways starting with nurses, then GP's and then specialists. The integrated clinic will provide specific primary care and diagnosis, care and treatment for chronic conditions. Hospital treatment will be included. These services will be funded from general taxes. In designing a set of minimum benefits, the NDoH will be challenged as all citizens currently have access to a set of unlimited not defined benefits. Whilst this set of minimum benefits will contain some version of what exists, attention will need to be given to protocols, formularies, rationing mechanisms and exclusions. A provision can also be made for exceptions and ex-gratia service provision. However, a means test can also be applied to fund these exceptions partially or in full. The minimum benefit package must at least contain the level of benefits as contained in Annexure A of this submission.
- **The same set of minimum benefits must be provided by private medical schemes:** The same set of benefits with the same protocols and formularies and referral pathways will have to be provided by all medical schemes. These benefits will form part of the private medical scheme contributions. These benefits must form part of a risk equalisation fund. Contributions must still be community rated and open enrolment must still be enforced.
- **Top-up and supplementary benefits can be provided by medical schemes and health insurers.** Additional benefits outside the minimum benefit package can be provided. However, medical schemes will still be obliged to apply open enrolment and community rating and health insurers can only underwrite as per the current demarcation rules.
- **Mandatory membership:** personal income taxpayers over the tax threshold will have to make a compulsory contribution to medical cover. However, these people can opt out of the public service cover. In this case they will have to provide proof of cover in the private sector. When taxpayers opt out of the public sector, they will be able to receive a tax rebate. However, a portion of the public contribution will not be rebated.

- **Tax incentives:** Taxpayers should be incentivised for healthy lifestyles and penalised for poor lifestyles. The formula and criteria should be simple but should drive the correct behaviour. The same should be applied to companies where they should be allowed a tax deduction for improvement of the health of their employees and an additional tax rebate where their programmes also improve the health of the community they serve. However, the FIA is sensitive to the fact that proposing any tax incentives in the current economic climate would necessarily help our fiscal crisis. Therefore, tax penalties instead of tax incentives can be considered by National Treasury.
- **Community service:** School leavers over the age of 18 must be compelled to perform mandatory community service. Whilst medical doctors are compelled to serve the nation with compulsory national service, the FIA believes extending this principle to school leavers will serve the healthcare system well. This will assist school leavers to gain workplace experience whilst gaining an appreciation for healthy lifestyles. School leavers can be used in the ward based primary care teams, at clinics and at hospitals. Their services can range from cleaning, administration and health promotion to name a few. Exemptions will have to be created to ensure health personnel or other professions are not prejudiced. Furthermore, the way community service is introduced must meet the constitutional muster of freedom of trade, occupation and profession. Healthcare intermediaries serve existing members of medical schemes with education regarding healthy lifestyles and utilisation of benefits and the rights of the private healthcare consumer. The HMI acknowledged the market conduct value of healthcare intermediaries to guide, educate and protect members of private medical schemes. These intermediaries can, in order to retain their license, be required to perform a specific minimum community service in association with WBPHCOT's to educate community members on a pro-bono basis regarding healthy lifestyles and their rights in terms of the benefits offered in the public sector.
- **Worksite clinics:** Employer based clinics must be allowed to form part of the Health system where services can also be rendered to the community surrounding the employer. Employers rendering these services must be able to either claim for the services rendered to the community or receive a tax incentive for rendering these services or both.
- **Production of health personnel:** Public private partnerships must be established in terms of academic hospitals and nursing training facilities. Both spheres of the health system, public and private must be able to make use of these facilities in production of health personnel.
- **Delayed pre-payment:** Healthcare is not free. Someone must pay. Whilst, social solidarity will not require the unemployed to pay for healthcare services, an appreciation of the cost of healthcare needs to be instilled. Healthcare is not a free service. Therefore, when the unemployed are employed they need to repay a portion of the "free services" they received. This concept is modelled on the Fee-assist model of the Australian Education System. It is then proposed that when children or spouses not employed or unemployed people becomes taxpayers 10% of the tax subsidy is forfeited to offset the cumulative cost of healthcare for that person. This offsetting principle must only apply if the person does not make use of the public system. If an unemployed person becomes employed and make use of the public system, no offsetting is applied. Furthermore, the accumulated cost of healthcare must be capped at a certain amount and must never form part of the liabilities of the person and must not be a debt to the estate of the person. Due consideration must be given to ensure that the system is not administratively overburdened and that the value of the pre-payment of healthcare is not undermined. **We believe that this supports the ILO's observation that healthcare is not a "free" service and that when people understand the cost of healthcare that quality also improves.**

SECTION 7

Conclusion

The first section of the FIA's proposal started with a dream of a transformed healthcare system. A South Africa where every citizen has real access to quality care is possible. Madiba said it best when he pleaded that we arrest the HIV/AIDS pandemic namely: '***It's in our hands***". To a large extent we have done so. We did so by acknowledging that there is a problem, we accurately defined the problem, we changed our policies in consultation with civil society and business, and our success speaks for itself. The same can be done to create a transformed equitable healthcare system.

The FIA would like to acknowledge some of the successes of our public healthcare system. The first open heart transplant was done in a public hospital. The Nelson Mandela Children's hospital is a great example of the private and public sector collaborating. South Africa was one of the first countries to implement the GeneXpert TB diagnostic system. GeneXpert significantly reduced the turn-around times for diagnosing both drug-susceptible TB and rifampicin resistant TB. Furthermore, South Africa also spearheaded the use of bedaquiline as part of standard MDR TB treatment regimens in the country beyond the WHO basic recommendation. Bedaquiline has a higher success rate and replaces painful injectables. These successes in the public system are examples of excellence that can be built upon to transform the public healthcare system.

The following enablers will support all South Africans to jointly own and have access to a transformed equitable healthcare system that is focused on improving healthcare.

Enable from the top and the bottom

According to the WHO, a key enabler for transformed healthcare systems is the political will. There can be no doubt that the Government has the political will to transform the healthcare system. However, a project of this importance requires the full support of the President, the Minister of Health, Cabinet, Parliament, Business, Organised Labour and Civil Society.

Furthermore, the delivery of healthcare must be decentralised and districts and wards that deliver care must be empowered to make decisions regarding the healthcare of the community they serve. These entities should be accountable to the community they serve, and the community must be able to actively hold them accountable for poor health delivery.

Finally, citizens must understand the need for healthy lifestyles and must be empowered to make healthy choices.

Governance

Governance can be defined as the processes of governing – whether undertaken by the government of a state, by a market or by a network – over a social system (family, tribe, formal or informal organization, a territory or across territories). Governance includes aspects such as laws, norms, power or language of an organised society[13]. Furthermore, governance includes the process of interaction and decision-making among

[13] Bevir, Mark (2012). Governance: A very short introduction. Oxford, UK: Oxford University Press.

the actors involved in a collective problem whether it leads to the creation, reinforcement, or reproduction of social norms and institutions"[14].

Governance will require rational policy decision. Therefore, before major policy decisions are embarked on governance requires thorough understanding of the institutional failures and causes of failures in the private and public sector. To date the most thorough analysis was done on the private sector by the HMI. This will allow government to develop feasible options in the short – medium and long term. Every option then needs to be evaluated in terms of its economic and financial impact. Once a preferred option is then chosen an in depth economic, financial, risk and moral hazard assessment must be done. To date this has not been done and is required to meet the requirement of proper governance.

Governance also addresses institutional and structural reforms to strengthen the public healthcare system. This includes, but is not limited to, leadership, capacitating and resourcing of the healthcare system, performance management, mandates, data collection, infrastructure development and maintenance, stock control and prevention of stock-outs and consistent quality improvements.

Governance also requires more than research. It also deals with the structures, the ability to influence decisions and the power to deliver results. If the health of the country is in a crisis, delivery of better health outcomes becomes the focus area. Therefore, decision making power should be decentralised to the level where care is rendered, and communities must be empowered to appoint and fire the key stakeholders and to actively hold them accountable for healthcare delivery.

Implement before redesign

The Taylor Commission of Inquiry and the National Development Plan Commission, to name only two, made recommendations regarding the healthcare system. Both, these entities were funded from taxpayer's money, but the recommendations were not implemented. The following recommendations should be implemented without further delay before a new course of action is embarked on. These include but are not limited to:

- Basic Benefit Package;
- Risk Equalisation Fund;
- Mandatory private sector cover for the employed;
- Developing an enabling environment for low cost medical schemes;
- Decentralisation and depoliticization of appointments. Healthcare decisions, funding and management should be decentralised to district level and the community should hold the providers accountable for health outcomes and health quality. The depoliticizing of health facilities should also include the different regulators such as the CMS and OHSC to name only two.
- Establish ward-based healthcare teams and revitalize the school health programmes. These should have been staffed, capacitated and resourced already and should not have been part of the NHI pilot projects;
- Improve access to housing, water and sanitation;
- Offer tax incentives to employers improving the health of their employees.

[14] Hufty, Marc (2011). "Investigating Policy Processes: The Governance Analytical Framework (GAF)

CONCLUSION

Empower healthcare providers to care

Community health workers, nurses and GP's are responsible for healthcare delivery. However, they are often disempowered and demotivated. This should change. Medical staff should be empowered to take health related decisions. However, the existing fee-for-service system that perversely incentivises the practitioner to deliver more services and prohibit health promotion and health retention should be replaced with a system where the practitioner benefits from health improvement.

Develop a sustainable and equitable co-existing healthcare system

FIA propose, what we believe to be, a sustainable equitable healthcare system where the private sector and the public sector with the community, can take hands and improve the health of all the citizens of South Africa. We understand that this proposal did not undergo any economic and financial scrutiny. We would recommend that the proposed model of the FIA be considered for further assessment.

Public comment regarding NHI states that the economy cannot afford NHI. Furthermore, that the NHI proposals will not meet the constitutional muster. Alternatively, that the proposed NHI is not rational. These detracting positions, if successful will postpone the transformation of our healthcare system and prolong the suffering of those that make use of the public system and the exploitation of those in the private sector. This is a win-lose strategy with a high probability of postponing the transformation of the healthcare landscape. Therefore, the proposed solution of the FIA is to suggest a transformed solution with a high probability of acceptance and a lesser chance of delaying the process. The FIA members serve the needs of millions of people on private medical schemes, primary care products and health insurance products. Furthermore, we are actively involved in finding solutions for the employed but not covered population. We see the devastating impact that ill health has on the economy and the members we serve. As such it is "***In our hands***" to jointly-own the health crisis of South Africa and to constructively engage in finding sustainable solutions.

Annexure A: Proposed minimum benefit package

The FIA's proposed minimum benefit package, a derivative of the current prescribed minimum benefits, is detailed below. However, what is more important than the benefit list is what rationing mechanisms such as protocols, entry criteria and formularies will be applied. Furthermore, what is excluded should also be transparently provided.

Preventative care	Primary care	Hospitalisation
Nutrition	Basic radiology	Care, treatment & diagnosis
Lifestyle	Basic pathology	List to be defined. Can use DTP list of private medical schemes but amend to most critical according to our GBD
Education	Basic dentistry	Rehabilitation
Vaccination	Basic auxiliary and allied care	Palliative care
Immunisation	Reproductive, maternal new born, child and adolescent services	
Screening/ early detection tests	Immunisation	
	HIV/AIDS Care, treatment & diagnosis	
	TB/ MDR-TB Care, treatment & diagnosis	
	Malaria & IPTP Care, treatment & diagnosis	
	Chronic diseases Care, treatment & diagnosis Can use CDL list of private medical schemes but amend to most critical according to our GBD	
	Mental Health Care, treatment & diagnosis	
	Consultations (Nurse, GP, Specialist)	
	Pharmacy benefits according to a formulary	

Annexure B: A case study on China and Social Health Insurance

Extracts from an article published in the BMJ Journal regarding the challenges China face to achieve UHC[15]:

Introduction

In 2005, the World Health Assembly issued a call on member states for universal health coverage (UHC), with an aim to achieve affordable and accessible medical care for all citizens. The Chinese government followed suit quickly and launched a series of health reforms. The first step in China's reforms involved an expansion of social health insurance coverage. Three basic health insurance schemes, Basic Medical Insurance for Urban Employees (BMIUE), Basic Medical Insurance for Urban Residents (BMIUR) and the New Rural Cooperative Medical Scheme (NCMS), were established to provide healthcare-related financial protection to more than 1.3 billion people. The BMIUE covers urban employees (including retired and rural-to-urban migrant workers), with both employees and employers contributing to the insurance funds. The contribution of an employee goes to an individual medical saving account, which cannot be used by other members, whereas the contribution of employers goes to a social pooling account managed at the municipal level. A member can choose to use his/her individual medical saving account to pay for medical expenses that are not covered by the social pooling account.

The NCMS covers rural residents, with funding coming from government subsidies, collective assistance and individual contributions. The NCMS funds are pooled and managed at the county level. The BMIUR covers urban residents who are neither covered by the BMIUE nor the NCMS, such as the self-employed, the unemployed, the elderly, children and students. The BMIUR funds are pooled at the municipal level, with contributions from the individual members and government subsidies. While the BMIUE and BMIUR programmes are overseen by the Human Resources and Social Security authorities, the NCMS programme is largely left in the hands of the Health and Family Planning authorities.

Technically, these three basic health insurance schemes are not always mandatory. However, because of strong governmental interventions and subsidies, a very high population coverage has been achieved. Although in some programmes, individual contribution goes to an individual saving account, the contribution of governments and employers (if they exist) is put into a social pooling account with risk sharing functions. The membership eligibility, benefits and other aspects of those insurance programmes are also defined by the government. In China, they are labelled as social health insurance.

The rapid expansion of health insurance programmes in China has been extraordinary. Within a few years, about 96% of Chinese people were covered by health insurance programmes. However, it is widely accepted that the high coverage of health insurance does not necessarily provide a guarantee of UHC. According to the WHO, UHC should consider the population coverage, the range of services covered and the extent to which health service costs are covered.

Empirical evidence shows that people in China are still facing financial difficulties in managing illness. The funding level of health insurance has remained low despite a dramatic increase in governmental subsidies. The increase in medical expenditure exceeded the speed of wealth growth: from 2010 to 2013, the average annual growth of health expenditure reached 13.2%, 1.62 times higher than the growth of gross domestic product (GDP) in the same period. This resulted in limited benefits and serious inequity. Catastrophic health expenses continue to haunt some people, especially the poor and disadvantaged.

The international experience has demonstrated that a systematic approach is needed to achieve UHC. Action should be guided by a well-linked structure, processes and outcomes measures. There is consensus that the

[15] Shan, L., Wu, Q., Liu, C., Li, Y., Cui, Y., Liang, Z., … Han, L. (2017). Perceived challenges to achieving universal health coverage: a cross-sectional survey of social health insurance managers/administrators in China. *BMJ open*, *7*(5), e014425. doi:10.1136/bmjopen-2016-014425

Annexure B: A case study on China and Social Health Insurance

achievements of UHC depends on an efficient, equitable and sustainable healthcare system that can maximise health gains. The ability of health insurance programmes to contribute to such a system is determined by many factors, such as financial capacity (or bargaining power) of the funds, risk-sharing arrangements, provider payment mechanisms, management of consumer claims and cooperation across funds.

Despite extensive studies into the performance of social health insurance programmes in China, there is a paucity in the literature documenting how insurance managers/administrators perceive and act in response to the call for UHC. This study aimed to understand how insurance managers/administrators perceive the role of health insurance in facilitating UHC and to identify the challenges that may limit the full functioning of health insurance programmes. The study drew on the experiences of a wide range of health insurance managers/administrators, from those who develop policies to those who manage the daily transactions of funds. The findings of this study may provide evidence to support improvements to the healthcare system in China and offer lessons to those countries that are expanding their health insurance programmes.

Conclusion and policy recommendations

Health insurance managers in China are pessimistic about the achievements of the current health insurance system. They are concerned about the overall benefits that the insurance programmes can bring to members. Low levels of entitlements, large healthcare inequality, limited financial protection and poor portability are deemed as major challenges in the progress of UHC.

It is important to note that amendments to the structural design of the existing funds may not be enough to offer a satisfactory solution to these identified barriers. According to the perceptions of the health insurance managers, increasing funding capacity may be more important than singular adjustments of the share of premium contributions and the level of defined compensation. Increasing government investment in health is a necessary condition for improving finical protection. In the South African context, the real problem is not the quantum or distribution of funds but how the funds are utilised. The problem relates to policy, management and wastage.

The findings also indicate that unified and consistent policies are required to reduce healthcare inequalities within and across funds. Although it is too early to conclude that a national approach is needed, a higher level of fund pooling will bring benefits to improved portability, a better share of financial risks and more efficient operations management of funds. In recent years, there have been calls for the establishment of transitional funds at the provincial or national level, providing additional support to the poor and disadvantaged. The South African environment as proposed before by the Taylor commission and the NDP that healthcare policy should allow the decentralisation of health delivery. Pooling of funds will undermine the proposals for decentralisation in South Africa.

For those countries that are expanding their health insurance programmes, it is important to note that a high coverage of health insurance is not enough. Insurance may stimulate healthcare consumption, bringing disproportional negative consequences to the disadvantaged populations, especially when a high percentage of out-of-pocket payment is required. Equity needs to be considered in the design of insurance programmes. Effective and efficient management of fund is also important.

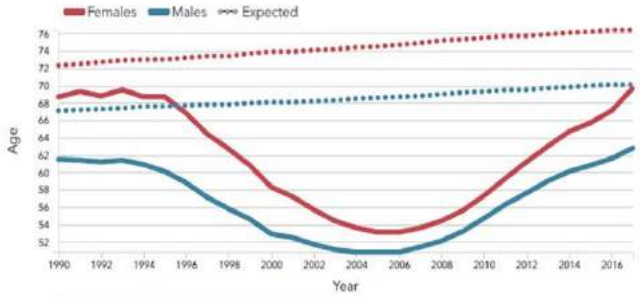
Annexure C: Measurement of South African Health Outcomes

This section summarises the South African health outcomes compared to the Global Burden of Disease, Injuries and Risk Factors Study (GBD)[16]. This study examined 249 causes of death, reviewed 315 diseases and injuries and 79 risk factors from 195 countries. The outcomes of this research are depicted below.

The diagram below depicts the life expectancy at birth from 1990 to 2017. The life expectancy lags what was expected by the IMHE.

Life Expectancy at Birth 1990 - 2017

Source: Institute for Health Metrics and Evaluation

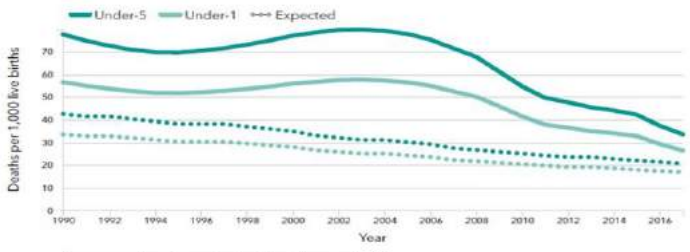


	Expected		Observed	
	1990	2017	1990	2017
Females	72.3	76.4	68.7	69.7
Males	67.1	70.1	61.5	62.8

The diagram below depicts the child mortality rates from 1990 to 2017. The child mortality rates lag what was expected by the IMHE.

Child Mortality : 1990 - 2017

Source: Institute for Health Metrics and Evaluation



	Expected		Observed	
	1990	2017	1990	2017
Under-5	42.6	20.7	77.6	33.6
Under-1	33.6	17.0	56.6	26.4

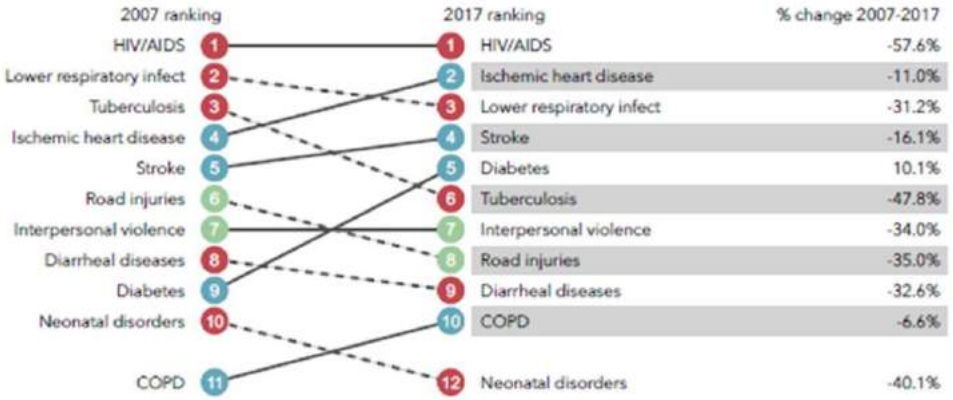
[16] Measuring Global Health, Wendy Walker, Institute for Health Metrics and Evaluation, University of Washington

Annexure C: Measurement of South African Health Outcomes

The diagram below depicts the causes of death. Lifestyle associated behaviour leads to an increase in Ischemic heart disease, stroke, Diabetes and COPD. Our healthcare system should address these burdens of disease.

Causes of death: 2007 - 2017

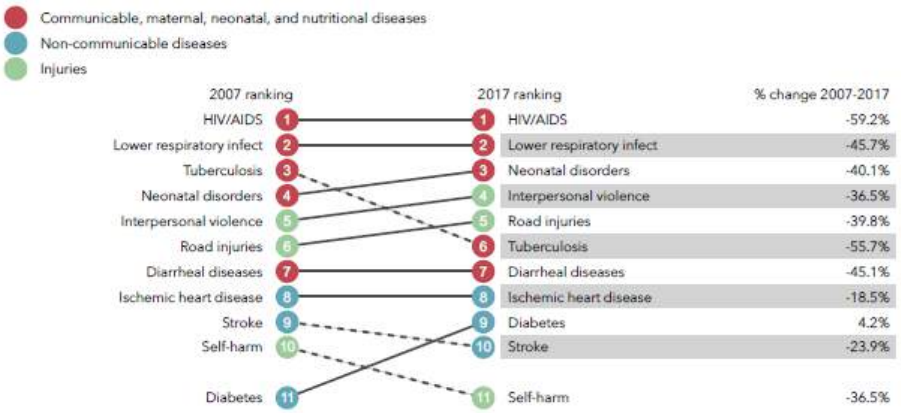
Source: Institute for Health Metrics and Evaluation



The diagram below depicts the causes of premature death.

Causes of premature death: 2007 - 2017

Source: Institute for Health Metrics and Evaluation

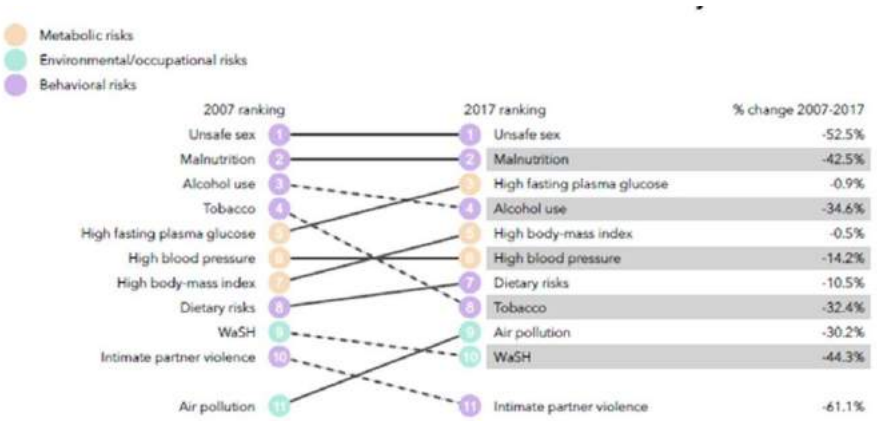


Annexure C: Measurement of South African Health Outcomes

The diagram below depicts the causes that drive death and disability. Lifestyle associated behaviour leads to an increase in elevated glucose levels, high BMI levels, poor diets and air pollution. Our healthcare system should address these specific causes that drive death and disability.

Risk factors that drive death & disability: 2007 - 2017

Source: Institute for Health Metrics and Evaluation



The diagram below depicts the top 10 causes of premature death compared to 10 peer countries with a similar BoD.

It is important to note that South Africa in 8 out of 10 causes scores significantly higher than the mean, with only 2 causes scoring significantly lower than the mean. Our peer countries score substantially better. Cuba scores the best, Siri Lanka 2nd best and Albania 3rd.

Causes of premature death compared to peer countries: 2007 - 2017

Source: Institute for Health Metrics and Evaluation

Annexure C: Measurement of South African Health Outcomes

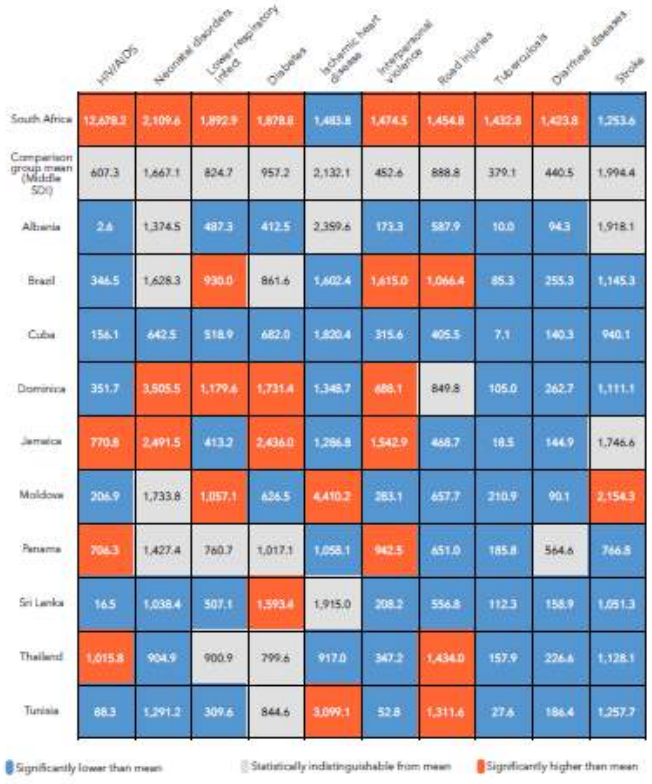
The diagram below depicts the top 10 causes of death and disability compared to 10 peer countries with a similar BoD.

It is important to note that South Africa in 8 out of 10 causes scores significantly higher than the mean, with only 2 causes scoring significantly lower than the mean. Our peer countries score substantially better. The same countries as in the case of the premature death comparison score the first 3 places.

This analysis of our health performance compares well with the health efficiency index as described in Section 5.

Causes of death & disability compared to peer countries: 2007 - 2017

Source: Institute for Health Metrics and Evaluation



Of the 10 countries in the diagrams above only Panama, Cuba and Brazil spend more than South Africa on their public health system. However, the health outcomes in all 10 countries are substantially better than that of South Africa. Therefore, the issue is not the amount of money that is spent but rather the way that the money is utilised.