

## **BHF 2010**

### **SPEECH FOR DR ANNA MOKGOKONG**

**TOPIC: If we're not at the table, we're on the menu**

Facilitator: Dr Humphrey Zokufa

***A round table discussion with Funders and Administrator organisations on:***

- ***The current benefit package – What do we take forward to the NHI benefit package***
- ***Retaining current skills and expertise within the NHI***

Good morning distinguished guests , ladies and gentlemen.

In a few minutes we will begin our panel discussion on the topic “*If we're not at the table, we're on the menu*” - an appropriate title which underlines the importance of consultation and collaboration between the public and private sectors to solve South Africa's healthcare challenges.

But before we begin the discussion, I would like to say a few words to set the scene for the debate.

I would like to begin by quoting a few statistics that highlight the magnitude of the challenges facing the South African healthcare industry. You may well be aware of them, but they bear repeating:

- According the latest Annual Report from the Council for Medical Schemes, only 7,8 million people (or 16 percent of the total population of 49 million) are covered by medical schemes. The rest are dependent on the state for their healthcare needs.
- Health expenditure on those 7,8 million is six times higher than the expenditure on the rest of the population.
- This imbalance is mirrored in the imbalance in human resources. There is one pharmacist for every 1 000 beneficiaries in the private sector, and 17 000 beneficiaries to one pharmacist in the public sector. Similarly, there is

one GP for every 540 beneficiaries in the private sector compared to 4 000 in the public sector.

This is reflected in our health outcomes:

- In South Africa, the average life expectancy is 52. This compares with Brazil's 68, Chile's 75 and Mexico's 72.
- Our infant mortality rate is 69 per 1 000 live births compared to 20 in Brazil, 9 in Chile and 35 in Mexico.
- With a prevalence of about 5,5 million, South Africa shoulders approximately one quarter of the burden of HIV infection in sub-Saharan Africa – 29% of our pregnant women are HIV positive.
- The prevalence of tuberculosis in South Africa is among the highest in the world and the rate of co-infection between HIV and tuberculosis is as high as 73%.
- On an expenditure versus healthcare outcomes basis, South Africa rates 175th out of 191 countries surveyed – not surprising given the statistics I have just quoted.

Against this background, the South African government is obliged, under the Constitution and the National Health Act, to make healthcare accessible to the entire population and the mechanism of choice is a National Health Insurance system.

Although we do not have clarity regarding the final form an NHI system will take, we do know that the NHI will offer a comprehensive package of services. The package will move away from the PMBs - which focus on specialist and hospital conditions - to one which has its focus on primary and preventative care.

Because the burden of disease in South Africa ranges from pre-transitional diseases relating to poverty to infectious and lifestyle diseases as well as trauma, under an NHI system a substantial share of the resources must go to primary and preventative care to avoid high-cost interventions. The services will be provided by a blend of public and private providers.

We also know that the quality of health services to be provided under the NHI is non-negotiable and accreditation of healthcare professionals and service providers as NHI providers is a key component of an NHI system.

The NHI system will be based on two principles:

1. **The right to health** - which will mean health services will be free at the point of use; and
2. **Social solidarity** - where the affluent will contribute a percentage of their income to fund health services for the poor. The size of the individual contribution considered within the ANC's working group is between 3% and 5% of personal income.

Indications are that NHI system envisioned for South Africa is one based on the single-purchaser model. There are three key elements of healthcare financing – revenue collection; risk pooling and provider payment. In a single purchaser model, a central body or agency plays a central role across all these elements. This is referred to as a single purchaser. The single purchaser is likely to be an NHI agency with revenue collected either directly or through SARS.

This does not, however, preclude multiple payers including medical schemes and administrators from playing a role. To the contrary, the French NHI system – rated number one in the world by the World Health Organisation - provides universal coverage to comprehensive services through a multi-payer system. Indeed, the French multi-payer system has been effective in controlling costs whilst at the same time providing improved levels of access to increasing levels of service.

Multi-payer systems harness competition to:

- control costs
- improve quality and consumer rights through incentives
- provide expertise to collect data
- conduct health technology assessment
- monitor fraud and abuse
- act as an intermediary between the government and the member resulting in improved accountability and overall governance.

In his keynote speech, the Deputy Minister of Health, the late Dr Molefi Sefulare, mentioned that the government had consulted broadly on matters of health and the

result of these consultations is that government “has identified the critical challenges of the public and private health sector. Solutions to these challenges are expressed in the Health Road map, the Ten Point Plan and the 2009 Health Program of Action.”

They are:

- Provision of strategic leadership and creation of a social compact for better health
- Implementation of the National Health Insurance (NHI)
- Improving the quality of health services
- Overhauling the health system and improve its management
- Improved human resources planning, development and management
- Revitalisation of infrastructure
- Accelerate implementation of the HIV and AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increase focus on TB and other communicable diseases
- Mass mobilisation for better health for the population
- Review of drug policy
- Strengthen research and development

Dr Sefulare also reminded the conference that government’s invitation stands to “study this POA and identify areas where you will be best placed to contribute positively, particularly in the areas of leadership and social compact, the NHI and the overhauling of the healthcare system.”

The first Budget Speech under the Zuma presidency also provided indicators regarding the implementation of an NHI system. Budget allocations were not announced, the commentary notes provided in the Budget review and supporting documents underline government’s resolve to implement the ten point plan from 2009 to 2014 and the wide range of NHI proposals being explored.

What is clear is the establishment of an NHI system in South Africa requires several parallel reform processes that build on existing resources and capacity in both the public and private sectors. Research is now focused on identifying measures that might enable a feasible transition to an NHI model over the next five years.

In September last year, the Honourable Minister of Health, Dr Aaron Mosoaledi, appointed a 27 member NHI Ministerial Advisory Committee and a first draft of the NHI white paper was submitted to the Cabinet. The Cabinet required further work to be done by the committee regarding costing scenarios, the economic benefits of an NHI, how migration from the present system to the new one would occur, a communications strategy and the relationship between primary care and an NHI.

In March this year Health Minister Dr Aaron Motsoaledi reported that inputs from the committee had been incorporated and that Cabinet had selected an inter-ministerial committee to interrogate the document before it returns to Cabinet.

Clearly the Minister is proposing significant changes to the focus of a national health system, ie moving away from an unsustainable and unaffordable curative-based health system to one which has prevention as key focus. The Minister has also conceded that the NHI would be unaffordable if based on the current curative public healthcare system aggravated by costly private treatment. He is reportedly set on overhauling the whole system and redirecting its centre of attention to the provision of primary care.

There is also the issue of processes and systems to consider.

National health systems across the world invest continually and massively in IT software, systems and solutions to keep pace with demands. Given that all South Africans will potentially be able to make use of state facilities, the ability to gather

healthcare data on a hospital-by-hospital, province-by-province basis will be needed to facilitate healthcare budgeting, spending and planning. A state-run operation would also need to have the capacity to track a broad spectrum of health risks and their prevalence across society.

An integrated information platform that has the ability to constantly gather information on healthcare issues such as tuberculosis and the spread of HIV/Aids would be invaluable in planning the effective distribution of resources which is the backbone of an effective health service.

Upgrading the public healthcare system in isolation is not an option. On the other hand, NHI costing models have reflected some daunting figures - the Econex report commissioned by HASA in March 2010 for example found that additional tax revenue of R244 billion would be required – roughly four times the current spend. South Africa does not have the resources or the tax base to achieve this and the government cannot, nor does it intend to, “go it alone”.

At last year’s BHF Conference the Deputy Minister of Health, the late Dr Molefi Sefularo, said that “it would therefore be helpful for the private sector to come up with helpful proposals on how to make the NHI work in South Africa, how we can make it affordable, and how we can preserve what is good in the current system and discard what is bad.”

From the same platform, BHF Chairman Dr Clarence Mini proposed a BHF model that promotes the participation of medical schemes within the NHI environment in a mutually beneficial, constructive manner. The model proposed that medical schemes and administrators work actively towards the success of NHI to the benefit of their members and their businesses respectively. In turn, the NHI system would benefit in terms of information management, health service quality monitoring and control, contract management, managed care initiatives, public-private partnerships and consumer advocacy by schemes on behalf of their members.

The BHF believes that this scenario is the one most likely to ensure the success of NHI going forward because it marries the goals of government around NHI with the rights and interests of medical scheme members into a single system.

In broad outline the proposal is:

- Medical schemes and their administrators will collect contributions for NHI benefits from the NHI Agency as opposed to collecting directly from the members as currently pertains.
- Schemes will offer the benefits contained in the NHI package of benefits - possibly supplemented by optional additional benefits.
- For constitutional reasons the NHI benefit package of benefits will need to be comprehensive but it is likely that there will be some areas where top-up cover will be needed.
- The pricing of the NHI package of benefits will be negotiated centrally with providers by the NHI Agency as the single purchaser of healthcare. This will eliminate many of the problems which medical schemes currently experience concerning the various tariffs charged by healthcare providers and the significant cross-subsidisation of the Road Accident Fund and the COID Commissioner by medical schemes.
- Medical schemes will continue to collect contributions in respect of optional additional benefits from members.
- The proposed model promotes potential growth in membership of medical schemes without current concerns regarding the attendant erosion of reserves – the NHI Agency will be responsible for ‘reserves’ for the NHI system including those of medical schemes which function within the system as far as NHI benefits are concerned.
- Public and private providers will be contracted by the NHI Agency at uniform reimbursement levels to service NHI patients.
- Medical scheme members will be NHI patients.
- Medical schemes can cater for those that can afford it, as well as those who are only eligible for the NHI package of benefits. The model allows medical

schemes to provide top-up cover to members who want and can afford to purchase it.

The model creates for a seamless health financing experience for members of medical schemes as well as a smooth transition for them into the NHI system. People will not have to terminate their medical scheme membership and be forced into an unknown and at first unpredictable new health financing environment.

This will create a transitional mechanism for the NHI in the sense that medical schemes can continue to offer greater or lesser top-up cover as the NHI backbone grows. If the NHI experiences setbacks in terms of its implementation, medical schemes will still be there to shoulder some of the health funding burden.

In addition, the model ensures the workability of an NHI system in the South African environment without job losses within the private funding industry. It may even create jobs if administrators are subcontracted by the NHI Agency to administer certain NHI Fund beneficiaries. It recognises and protects the constitutional rights of medical scheme members to the quality, scope and levels of care they currently experience and precludes the reduction of access by the NHI in respect of current members of medical schemes.

Yet, as we have seen in the recent litigation and ruling regarding the National Health Reference Price List, the public and private sectors have yet to find a way to engage constructively to resolve the issues and collaborate to develop workable solutions.

The government is aware that the private healthcare sector has an enormous pool of expertise which can be applied to making an NHI system more effective. The private sector's challenge is to engage with government and develop innovative solutions to achieve the goal of wider access to healthcare.

At the close of the BHF Conference last year, Dr Sefularo said that he had been asked by many stakeholders in the private sector regarding what role they will play in the whole process of the envisaged health reforms and within the NHI when it is implemented.

His response was:

“It (has been) clear from the onset, that the implementation of an NHI system is a complex and demanding exercise, and that it represents a watershed moment for the future of our national health system. The roles and responsibilities of various entities, private and public including the national, provincial and local spheres of government will have to change with regards to how health policy is appropriately formulated, funded and implemented.”

The private sector has the essential role of sharing its experiences with government on their achievements and challenges in the management and administration of private health insurance schemes. This is necessary to ensure that the publicly administered and managed NHI Fund is appropriately poised to gain from the experiences of the past and to learn how to best address the challenges that it may encounter..

It will take time and the will of all parties to make a new healthcare system work in South Africa. Notwithstanding the recent litigation regarding the NHRPL, the gap between the vision of government and the private sector has never been as narrow or more “bridgeable” than it is now.

As underlined by the theme of this discussion, if we are not at the table, we are on the menu.

To borrow from the recent World Cup,

Ke Nako – Now is the time. .

Thank you.