Submission by ASSA on the NHI White Paper

Executive Summary
ASSA is committed to the provision of the best possible surgical services to the country as a whole. Surgical specialists remain an extremely valuable and also vulnerable group of specialists. The funding of the yet to be defined healthcare services for universal coverage at all levels to all patients, including refugees and others who have constitutional entitlements to healthcare, requires substantial further detail. Surgery is an indivisible, indispensable component of health care.

ASSA has considerable expertise to contribute to all six of the proposed work streams for NHI. Due to their central and fundamental role, ASSA would like to suggest that a defined and separate work stream for Academic Medicine (academic complexes, training and research) and possibly Professional Matters (statutory bodies, scopes of practice, peer review and ethics) be considered.

ASSA recognizes and supports the need to provide an equitable level of care to all South Africans.

ASSA has unambiguously submitted our objections to the CON and motivated for it to be removed as legislation from the National Health Act.

ASSA welcomes the acknowledgement of HR management being one of the core four areas where public service healthcare capacity is lacking. It bears repeating that real or perceived cadre deployment and corruption need to be replaced with accountable and competent people and transparent processes.

There is no single model that is the solution to the healthcare needs of South Africans. There is a need to work collaboratively and proactively towards equitable healthcare rights. These rights may very well be realized through what the private sector clinicians and other capacity can offer society.

There is great uncertainty as to provider payment mechanisms, and that such payments should reward performance and compliance with accreditation criteria. It is not clear what these accreditation criteria would be and how performance will be rewarded.

There is a danger in bloating and duplication of structures and mandates as per the multiple new offices, departments and structures included in the White paper. The administrative costs and staffing requirements represent non–core health costs.

The Association of Surgeons of South Africa
The Association of Surgeons of South Africa (ASSA) is a duly constituted society under the South African Medical Association. ASSA was founded in 1943 and represents approximately 500 members.

As per our constitution the aims and objectives of the association are to:
1. Promote the science, practice, quality and image of surgery.
2. Represent and further the interests of surgeons in South Africa.
3. Sponsor and promote scientific publication in the field of surgery.
4. Encourage and support surgical research in South Africa.

ASSA is committed to the provision of the best possible surgical services to the country as a whole. Our members represent all sectors and levels of the profession, incorporating subspecialists, specialists, and medical officers, registrars in the public sector, private sectors and academia. ASSA organizes and hosts a biennial Congress with prominent and respected international and South African speakers and delegates. Financial support for registrars and members from the continent who would not otherwise be able to attend is provided in partnership with industry. There are local and international scholarships aimed at horizontal and vertical development of relevant surgical skills, primarily for younger surgeons.
Surgical specialists remain an extremely valuable and also vulnerable group of specialists. The training of surgeons takes a long time (13–15 years). South African surgeons are well respected internationally and competition for surgeons as a resource is global.

**The Federation of Surgeons of South Africa**

ASSA is a founder member of the Federation of Surgeons of South Africa (FoSAS), which has the role of representing the interests of the broader surgical community. Multiple surgical societies and other organisations exist in South Africa representing various interest groups and surgical specialties. These societies and organisations share many aims and goals and face similar challenges. The role of FoSAS is to act as a unified and broadly representative body for surgeons in matters of local and national government, surgical education, surgical congresses, professional affairs, patient advocacy, social responsiveness and private practice affairs. The membership of FoSAS includes the:

- Association of Surgeons of South Africa (ASSA)
- Vascular Surgery Society of Southern Africa (VASSA)
- South African Society of Endoscopic Surgeons (SASES)
- Hepatobiliary-Pancreatic Association of South Africa (HPBASA)
- Breast Interest Group of South Africa (BIGOSA)
- South African Colorectal Society (SACRS)
- College of Surgeons of the College of Medicine of South Africa (CS of CMSA)
- South African Burn Society (SABS)
- Society of Neurosurgeons of South Africa (SNSA)
- South African Urological Association (SAUA)
- South African Society of Surgeons in Training (SASSiT)
- South African Association of Paediatric Surgeons (SAAPS)
- Surgical Research Society of South Africa (SRSSA)
- Association of Plastic and Reconstructive Surgery of South Africa (APRSSA)
- South African Society of Anaesthesiologists (SASA)
- Society of Cardiothoracic Surgery of South Africa (SCTSSA)
- Surgicom

**ASSA Supports Universal Coverage**

All of ASSA’s members are aware of the challenges that face both the public and the private sector and support the move towards a system of universal coverage of all persons in South Africa. There has been some no cost coverage for individuals of certain categories of persons listed in the National Health Act (NHA) (section 4), and for the possible expansion of free services to more categories.

Currently public sector care is funded through general taxation, allocated by provinces and supplemented by grants made by the National Department of Health. The national grants are made to secure provincial budgetary allocations to stipulated projects (such as HIV and Tertiary Services). The provincial allocations to all levels of healthcare are made from general tax allocations to that province. The health sector therefore competes with education and other budgetary line items in a province. General provincial allocations are made on the recommendation of the Financial and Fiscal Commission, and are not health-specific.

The funding of the yet to be defined healthcare services for universal coverage at all levels to all patients, including refugees and others who have constitutional entitlements to healthcare, should be explored further.
A funding paper by the National Treasury and the National Department of Health is eagerly awaited. Legislative changes are required to not only the National Health Act (NHA), but also various pieces of financial legislation.

ASSA Requests a Formalised Participatory Process

The NHI processes are guided by a number of Work Streams:
Work Stream 1: Prepare for establishing the NHI Fund
Work Stream 2: Design and Implementation of NHI Health Care Service Benefits
Work Stream 3: Prepare for the purchaser-provider split and accreditation of Providers
Work Stream 4: The role of medical schemes in an NHI environment
Work Stream 5: Finalisation of NHI policy paper
Work Stream 6: Strengthening of District Health System

ASSA has considerable expertise to contribute to all work streams, including the areas below.

Design and Implementation of NHI Health Care Service Benefits
The scope and practice of surgery is fundamental to Universal Health Coverage. Notable examples include maternal and child care and access to caesarian section, male circumcision as part of a strategy to address HIV transmission, the epidemic of trauma and the increasing rate of non-communicable diseases. The role of surgery as a fundamental and vital component of any healthcare system has recently been highlighted in April 2015 by the publication of the Lancet Commission on Global Surgery. In May 2015 the World Health Assembly passed the resolution on essential surgery (WHA 68.15). The World Bank published the 3rd version of the Disease Control Priorities (DCP 3) with a whole volume dedicated to surgery. These align with the United Nations Sustainable Development Goals, which replaced the Millennium Development Goals in 2015.

Common to all of these activities is a recognition that, in the words of Jim Yong Kim President of the World Bank, “Surgery is an indivisible, indispensable component of health care.” Surgery has an essential role to play in preventing death and disability and improving the health of communities.

The Academic Complexes, Research and Training
Due to their central and fundamental role, ASSA would like to suggest that a defined and separate work stream for Academic Medicine (academic complexes, training and research) and possibly Professional Matters (statutory bodies, scopes of practice, peer review and ethics) be considered. This is particularly pertinent regarding discussions on the law of tort and the present malpractice costs and their impact on health budgets and insurance / indemnity cover.

Implemented Aspects of NHI
NHI depends on the successful implementation, expansion and development of programmes and projects already in existence. ASSA believes that clinicians and their representatives need to be at the coalface. The actual “how” of NHI requires the input of clinicians who have professional knowledge and experience of the process and workflow of clinical practice. ASSA is committed to the identification and allocation of such resources to the NHI process. ASSA welcomes any invitation from the National Department of Health to formalise participation in the work streams. We appreciate the invitations to the consultative meeting thus far, however we look forward to being formally engaged and recognised as active and critical participants in each work stream.

The implementation of the following aspects of the NHI represent the building blocks of NHI. If they are not competent, transparent and functional, neither will the NHI be. These represent an opportunity for critical and honest appraisal.
The Office of Health Standards Compliance (OHSC)

Although great strides have been made with the OHSC, including the recent appointment of the Health Ombud, quality standards for the private sector have been in draft format since February 2015. The White Paper envisages that all facilities will have to be accredited prior to being able to render services into the NHI. This requires the completion of the standards, and the inspection of some 40 000 health establishments over a defined period. The matter of fines that could be issued by the OHSC, and the costs of compliance (e.g. where a compliance order is issued), also raises budgetary concerns – to what extent should health facilities budget for fines and compliance costs, or would that be included in the Diagnostic Related Groups (DRG) system?

Certificate of Need.

The OHSC is linked in the NHI to the Certificate of Need (CON). After the 2014 ruling by the Constitutional Court on the ill-fated promulgation of the CON sections in the Act, the Director General of Health confirmed that the principle of the CON is not in question, but the criteria might require review. ASSA has unambiguously submitted our objections to the CON and motivated for it to be removed as legislation from the National Health Act. ASSA recognizes and supports the need to provide an equitable level of care to all South Africans. However the CON is not going to help achieve this, rather it represents a real threat to training and retention of all healthcare workers and surgeons in particular. ASSA has met with Dr Anban Pillay from the National Department of Health in 2014, and suggested that the legislation be scrapped. The CON is universally abhorred by our members and represents a potential constitutional infringement.

Human Resource Management

An update of the Human Resource for Health (HRH) Plan is required. The Plan comes to an end at the end of this fiscal year (March 2017), and the achievements or failures of human resource interventions should be carefully appraised. The present perception of corruption and cadre deployment within the health system human resources process needs to be addressed, in an open, honest and transparent manner. Presently, we as a country do not have the required numbers of surgeons. Moreover the constraints on training posts and academic centres further limits developing increased capacity.

The Modernisation of Tertiary Services Plan, should not only address service provision at a tertiary level and the increased staff requirements associated with training and service provision to a more complex clinical group but such provision but also ensuring adequate theatres, theatre time and access to technology and medicines. Supply chain management and infrastructure maintenance are an essential component.

There are valuable lessons to be learned from the District Clinical Specialists Teams (DCSTs) projects, which have been unable to attract clinicians to render the necessary support in the primary care and district health system. Learning why practitioners were not willing or able to participate in these teams and/or why no steps were taken to identify or approach professionals, could provide valuable insight into possible barriers to contracting specialists into the NHI in future. Societies such as ASSA can help to help identify, advertise and communicate with surgeons. We commit to assisting in this, as well as guiding as to what a reasonable offer should be. The role and skill set of surgeons is not well understood at provincial health department levels.

NHI Pilot Sites

Some achievements, such as procurement and distribution of medicines have been well documented at the Health Systems Trust’s 2016 Conference. However, other aspects, such as implementation of treatment protocols, health outcomes implementation of coding and referral systems and matters beyond the care standards set by the OHSC, have, to the best of our knowledge, not been formally evaluated yet. The proposed new governance structures in districts should also be piloted prior to being
finalised, which should include the training and empowerment of such persons. ASSA requests there be transparency on any progress made, and barriers experienced at the NHI pilot sites.

**Specific concerns**

**Academic Complexes**

As alluded to above, the academic complexes are the foundation of future service delivery. South Africa has a quadruple burden of disease. The demand for healthcare this creates is disproportionate to our population size. The funding for academic complexes needs to allocate the necessary resources for training. Appropriate academic staff numbers, registrar post numbers, medical student numbers, non-specialist training and human resource management are present stumbling blocks to increasing capacity

ASSA suggests a separate and discrete workflow and a national academic skills strategy to be adopted. The White Paper is however silent on the exactly how the central hospitals as “national assets” will be transformed as is envisaged in paragraph 16 of the White Paper:

“...Their governance and funding model must promote good governance, academic excellence and support to lower levels of care. A transitional funding mechanism that promotes sustainable financing will be created to directly fund central hospitals”

ASSA recognizes that many provinces have not provided adequate leadership, funding or other support in order to make central facilities and academic facilities function. It is envisaged that central hospitals will be removed from provincial to national competence. This raises practical concerns as to who the employer would be, and where salaries would be budgeted and paid from. Outreach and support of lower levels of care would in turn mean some collaboration between provincial and national structures. This complicates the purchaser-provider split between provincial tertiary hospital, regional hospital, and central hospitals.

Regional hospitals could also be sites for training and research but little detail is provided about the roles undertaken at academic complexes and how they will be funded

**Human resources**

ASSA welcomes the acknowledgement of HR management being one of the core four areas where public service healthcare capacity is lacking. It bears repeating that real or perceived cadre deployment and corruption need to be replaced with accountable and competent people and transparent processes. Areas in which ASSA feels it has a role to play in improving matters include:

- Expand training platforms to the private sector
- Expand training platforms to regional hospitals.
- Ensuring and planning for sufficient infrastructure to take increased numbers of trainees
- Ensuring and planning for sufficient personnel to teach and supervise increased numbers of trainees.
- Retain and attract academic specialists by increasing their remuneration by 20% above the non-academic specialist in lieu off their increased academic workload.
- Ensuring that knowledge levels are not compromised in favour of output.

The surgical profession would like to work together with a Human Resource Development specialist to look at and devise a detailed plan for the provision of surgical services as a whole for the country. The Surgeons Practice Study in 2002 showed that surgeons are underpaid in both the private and public sector with respect to, their colleagues internationally and more importantly, to other professions with similar qualifications (Law, Commerce and Engineering). Moreover the costing study was one of the documents used to determine the Occupational Specific Dispensation (OSD). This would include
identifying the right workforce with the right qualifications, at all levels, so as to most effectively provide the right services at the right facilities. This goes beyond the expanded, and much needed, development of specialists, but looks also at skills such as those that may be provided by medical officers, clinical associates and nurses. As a society, not only is ASSA able to give realistic input into the required skills levels and tasks, but may also be able to assist in the training and development of the requisite skills.

**Patient Care**

The objective of the NHI is to provide patients with access to care they require, irrespective of whether they personally have the means to secure access to such care. It is unfortunate that the NHI White Paper does seem to imply that there is some level of malice in the private sector. (The public sector is described as being subject to “cost drivers” (3.1.1) whereas the private sector is described as the “costly private sector” (section 3.1.2)). This is despite significant evidence presented at the Health Market Inquiry that demographics and other factors, such as the failure to implement all the intended reforms in the medical schemes environment, probably much more than provider prices, are leading to premium increases in the private sector.

It is not necessary to replace the private sector. ASSA believes that Private Public Partnerships can, and do work. National Health Insurance should, as envisaged in principle, acknowledge and engage with the positive contribution that can be made by the private sector. In particular the areas mentioned by the Minister of Health, Dr Aaron Motsoaledi, at the NHI White paper consultative meeting in March 2016, as being significant obstacles to healthcare provision in the public service, namely:

a) Human Resource Management  
b) Financial Management  
c) Procurement and Supply Chain  
d) Infrastructure and Maintenance

The challenge lies in preserving this capacity while incorporating and involving the private sector into an NHI plan. The risk is that the capacity will be mismanaged and therefore destroyed.

There is no single model that is the solution to the healthcare needs of South Africans. There is a need to work collaboratively and proactively towards equitable healthcare rights. These rights may very well be realized through what the private sector clinicians and other capacity can offer society.

**New Structures**

The White Paper envisages the creation of structures under the NHI Fund, such as an NHI Commission, which appears to function similar to a Board, as an oversight body, accountable to Parliament. The relationship between these structures, and those already in existence in the NHA should be clarified.

The NHI Fund structures include –

1) A Planning and Benefits Design Unit, which would have to interact with structures set up to determine the Essential Medicines List, Pharmaceutical and Therapeutics Committees, for example;
2) A Price Determination Unit, which it is assumed will be linked to the Council of Medical Schemes and the DoH’s 2010-proposed price negotiation structure;
3) An Accreditation Unit, assumed to link to the OHSC and the CON processes;
4) A Purchasing and Contracting Unit, which is assumed to be responsible for identifying possible contracting parties, inviting potential bidders and managing contracts awarded;
5) A Procurement Unit, which will link into another structure which would have to be set up to give effect to the NHI objectives, i.e. a Health Technology Assessment (HTA) body;
6) A Provider Payment Unit, which may then also be the Unit, so it is assumed, to be responsible for coding and the development and updating of the DRGs, and for setting (and recommending?) budgets for central and other hospitals;
7) A Performance Monitoring Unit, which would also need to link into the OHSC; and
8) A Risk and Fraud Prevention Unit, which it seems may be modeled on the units put in place by medical scheme administrators.

In addition, the new envisaged National Public Health Institute (NAPHISA), proposed in a Bill in March 2016, will also be important in the NHI as a mechanism to collect data critical for the implementation of and policy formulation in the NHI.

There is a danger in bloating and duplication of structures and mandates. The administrative costs and staffing requirements represent non-core health costs.

It is vitally important that the NHI learns and does not repeat the experiences in other social security systems currently affecting the health sector such as the Compensation Fund and the revamped Road Accident Fund. The Compensation Fund is centrally managed and controlled but also has provincial offices with some provincial powers, but no accountability, has been extremely problematic. Furthermore, a mechanism that is not supported by an efficient administrative system, which can effect payment to providers, is disastrous, and affects those who, are most vulnerable and are dependent on the system.

**Benefit package**

Emergency Medicine: While emergency medicine has, as do most clinical areas, a role in primary care, emergency medicine has a scope of practice well beyond that of only primary care. Without a functional step up facility, emergency care will not realize its value.

Other aspects relevant to the NHI Benefit package, relate to the fact that no regulations have been published to govern the determination of the Essential Medicines List (EML), the Essential Equipment List, as envisaged by section 90(1)(d). The social security principles of no double dipping, and no forum shopping, should apply.

**Provider Payment**

The NHI White Paper envisages "various" provider payment mechanisms, and that such payments should reward performance and compliance with accreditation criteria. It is not clear what these accreditation criteria would be and how performance will be rewarded.

In the present medical schemes environment uncertainty as to the acceptability of alternative reimbursement mechanisms conflict with the HPCSA and other professional councils’ rules. These legal impediments also hamper the formation of multi-disciplinary practices that could contract and be paid as a single unit by the NHI Fund.

Paragraph 353of the NHI White paper refers to capitated payments that will be paid “in an appropriate manner” and that there will be assistance in expenditure controls to providers. This is vague and open to ambiguity. This is a central issue for all practitioners. No success will be realized unless there is engagement and final agreement from healthcare workers in general and our members in particular.
Conclusion

In general, ASSA is concerned that the White Paper does not contain the specifics expected of a policy document, vagueness in relation to, for example provider payments, incentives and the setting of the benefit package introduces uncertainty and therefore suspicion and resistance. The impact of NHI on the health sector in its current form is unclear. We hope to foster a relationship of trust to deliver the most equitable healthcare possible to all South African.

The partial, or non-implementation of policy and legislative requirements, increases uncertainty and creates the risk of duplicate provisions, or incomplete reforms.

ASSA reiterates that the Work Streams must include clinicians at the coalface. ASSA proposes that, in addition, the issues relating to academic complexes and professional matters be included as a work stream within NHI. We commit to dedicating resources to these Work Streams so as to provide clinical and specialist insights into the next stage of NHI.

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