FISH HOEK VALLEY RATEPAYERS & RESIDENTS ASSOCIATION

(Incorporating Fish Hoek, Clovelly and Sun Valley)

P.O. Box 22125, Fish Hoek 7974 – Tel: 021 782 1950
E-mail: bdyoungblood@gmail.com

TO: ANBAN PILLAY Anban.Pillay@health.gov.za

SUBJECT: NATIONAL HEALTH INSURANCE BILL 2018 (GAZETTE 41725_21_6) AND DRAFT MEDICAL SCHEMES AMENDMENT BILL (GAZETTE 41726_21_6)

DUE: 20 SEPTEMBER 2018

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1. **DISCUSSION**

Although both bills contain many good sections or revisions, there are glaring gaps, such as no details on how National Health Insurance (NHI) will be funded or the benefits it will provide. We agree that medical aid schemes must pass back savings to members and not over exploit to make a profit.

Abolishment of prescribed minimum benefits for comprehensive service benefits could be good as items that are not on the list, are often paid from the member's savings. Even when items are on the list, it is typically a delayed two-step process of getting paid at the scheme rate and then claiming the excess from one's own medical savings account held by the medical schemes.

NATIONAL HEALTH INSURANCE BILL 2018 (NHI) [1]

We have some concerns with Section 3.(3) "The [National Health Insurer] Fund is the single public purchaser and financier of health services in the Republic". Although bulk buying power usually translates into discounted products, the State's control of purchased items so far, lacks the necessary discipline to prevent stock losses (pilferages), spoilage, proper rotation of stock to prevent expiry dates lapsing and proper distribution to local clinics. With the recent estimates of ten years before recovering from the last state capture (Section 6.(1) l. prevent corruption or fraud), we need proper controls in place to ensure this does not happen again. We have lost faith in the government's capacity to deliver services. Public health care leadership in particular is questionable in light of the Life Esidimeni scandal.

We are encouraged that in Section 5.(1) "The fund must (d) enter into contracts with … private services providers on the health care needs of users" and Section 6.(1) (o) may conclude an agreement with any person for…the rendering of health care services" when the State does not have the capacity or cannot do the task for less money. However, this will be dependent upon (e) … "the regular, appropriate and timely payment of health care providers" for no private going concern can function forever under the abuses dished out by most public enterprises to their suppliers. You'll need to think carefully about (i) "the continuity and portability of health care services" as many HIV / Aids patients will try to hide their status and visit several different City of Cape Town and Western Cape Provincial clinics.

Leave investing to the gurus. Section 6. (1) The Fund – (b) [need to purchase] "shares, debentures, stock, securities" is not required.

How is the NHI going to Section 6. (2) (b) "guarantee that there will be no interruption to supply" when hospital staff go on strike?

We have witnessed excellent professional medical care at Groote Schuur Hospital in terms of Section 9 (g) "professional standard of care", but the waiting list for surgeries is too long vs Section 9…"a user is entitled- (f) to access health service benefits within a reasonable time

[1] http://www.gpwonline.co.za/Gazettes/Pages/Published-Separate-Gazettes.aspx

period;. Just queuing to get records takes too long. Also, Groote Schuur Hospital has examples of shoddy services from auxiliary health care providers. If it weren't for medical school training centres, how do you propose to attract specialists when there is already a shortage, such as oncologists?

We hope that in Section 14. (8) "The Minister may remove a Board member" should mean immediately without further pay or compensation as opposed to the typical suspension for two years with pay.

It is our opinion that in this bill, the Minister appoints too many directly: Benefits Advisory Committee, Health Benefits Pricing Committee chair and deputy chair, Stakeholder Advisory Committee, Appeal Tribunal, Chief Executive Officer and recommends the Board. This is prime example in the lack of Human Resources support vetting curriculum vitae with proper background checks that candidates actually graduated as stated, interviewing and making suitable proposals of candidates to a board.

Our hope is that all committees described and that Section 35 (3) …"transfer funds" to "Diagnostic Related Groups as determined by the Minister in consultation with the National Health Council and the Board from time to time as required" is carefully considered, especially in light of: "One of the greatest problems in medicine today is that academic medicine has been sold to the highest bidder. Under the guise of 'Evidence Based Medicine' the public has been sold fraudulent goods, and the result is that people suffer from unnecessary but lucrative procedures and take unnecessary but lucrative medications." [2] The real problem is that providers over service and increase their tariffs which they know schemes are obliged to pay in terms of prescribed minimum benefits. If the prescribed minimum benefits are to include primary and preventative healthcare, this will increase the costs borne by schemes, which is passed on to members. The Council for Medical Schemes review of the prescribed minimum benefits needs to be released, but that could be two years away

Section 46 (1) just says that "The Minister must, in consultation with the Minister of Finance, determine the budget and allocation of revenue to the Fund on an annual basis." SA's public finances are weak and SA is now committed to paying for free higher education, SA is in a low-growth trajectory. The National Budget would have to be reprioritised for NHI to happen and that could come at the cost of most other social benefits. SA citizens are already taxed too much in comparison with our peers and more so than many developed countries.

When the two bills were introduced, Dr Aaron Motsoaledi stated that currently the government feels it is partly subsidising contributions to schemes through tax rebates. However, these tax credits have played a vital role in ensuring medical scheme cover remains affordable, especially for lower-paid workers including unionised civil servants.

MEDICAL SCHEMES AMENDMENT BILL 2018 (Medical Schemes Act #131 of 1998 (MSA)) [3]

Although the abolishment of brokers could have been good as few add value and they do add hidden costs, brokers were not banned, but defined and their fee structure made transparent. This was a missed opportunity, although medical schemes would probably just bring the services in-house and hide the costs. While on medical costs, these are rising faster than inflation due to people living longer, medical technology is more expensive and the rise in lifestyle diseases, ex. diabetes. We need to be educated to live more healthily.

What purpose is served by repealing Section 14 where the annual report and financial statements of the Council are required and published? Isn't this just good governance?

We applaud the repeal of Section 29A regarding waiting periods as medical scheme membership should mean payment for benefits from the start, be transferrable and not subject to cancellation fees. However, we do not understand the need to add "in respect of a further condition the primary cause of which is a condition referred to" a previous medical condition in adding to the definition of condition-specific waiting period. Also, the insertion of Section 32B Waiting periods should be removed as it undermines the repeal of Section 29A.

We think the medical schemes will challenge the addition of Section 31 (5) and Section 44 (11) and that the courts will uphold the objections.

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[2] https://www.dietdoctor.com/vested-interests-and-evidence-based-medicine

[3] https://www.medicalschemes.com/files/Acts%20and%20Regulations/MSACT19July2004.pdf

We feel that the insertion of Section 32A Open enrolment will also be challenged by medical schemes. Each medical scheme will look at its total risk profile and set tariffs accordingly. Forcing a medical scheme to accept additional dependants or pre-existing conditions will just increase the tariffs for existing members. We think these should be covered by the NHI.

We object strongly to the insertion of Section 32F (1) (a) as the "contributions for mandatory benefits based on income" is a wealth tax. Medical schemes should be about the welfare of health and costed according to its risk profile for incurring health related expenses.

We feel that Section 32l. (2) …" a medical scheme must pay in full, without co-payment or the use of deductibles" will result in medical aid schemes increasing the premiums making it unaffordable for the retired and some will have to forfeit their membership becoming even more of a burden on the state. We further think that co-payments will be required in areas which the NHI does not cover (new disease), where the referral system has been jumped due to incapacities in the system or upon patients' discretionary decisions.

We hope that Section 34 (3) where the registrar "with the Minister, restrict the extent of benefits offered by medical schemes" will act to serve as a watchdog against vested interest "Evidence Based Medicine" and epidemiologic studies mentioned above, such as HRT. [4]

Retirement / Legacy

Dr Aaron Motsoaledi has had a good health track record introducing the sugar tax, largest HIV / Aids treatments globally, banning of alcohol and tobacco advertising, "Roll Back Malaria", but he is not the correct person to lead the NHI. Our concerns lie with the management of state facilities during his tenure includes the governance issues at each and every state hospital and clinic. Aged infrastructure and poor maintenance cannot attract talent. In fact, he appears to have a deep antipathy towards Human Resources Departments which has led to a lack of sufficient surgeons to perform surgeries and admin staff to pull the records. There is also a distinct lack for preventing of stock losses, spoilage, rotation of stock, monitoring of inventory levels to prevent stock-outs. There is a lack of leadership and oversight of staff, ex. Life Esidimeni scandal. Also reported is a gross mismanagement of funds, fraud, corruption, misconduct by hospital health care workers, lack of fund tracking and performance monitoring resulting in a massive backlog of unpaid service providers are just some of the charges. The auditor-general said there was a lack of policies and procedures to track the department's records and lack of accuracy. [5]

Health care should be considered essential services and, therefore, staff should not be allowed to strike. Government either needs a better relationship with the unions or needs to rewrite our labour legislation.

CONCLUSIONS

We cannot dispute the concept of universal health care, but……..

Capacity

The inefficient management and corruption at all the other SOE's is evidence that the State will not have the capacity to run the NHI Fund.

The deterioration of state hospitals and health services to their current abysmal state in many provinces is evidence that the State does not have the capacity to provide a national health service described in the Bills. The private health care sector may also be unwilling to provide the service at rates set by the State as such statements have already been made by private health care associations, and we may see a mass exodus of private health care practitioners.

The National Treasury does not have the funds necessary for the NHI Fund.

Rhetoric

The Minister of Health has stated that 50% of spending on health insurance in RSA goes to support the needs of 16% of the population. He believes that these funds should be used for

[4] https://www.dietdoctor.com/vested-interests-and-evidence-based-medicine
[5] http://www.corruptionwatch.org.za/misdeeds-plague-health-ministry/

the whole population. In effect, by revoking medical tax rebates and allocating medical aid payments to the NHI Fund, he would be imposing an additional tax on people in formal employment (the "rich" in his words).

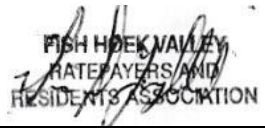
The Bill makes provision for procuring services not offered by NHI, but not for services as an alternative to NHI. So even if some people pay the NHI "tax", they may not be able to pay for private insurance or health care.

The Bills may have the unintended consequence that people who currently do not have comprehensive medical aid cover and effectively use their tax rebates and reduced fees to pay for private medical care may no longer be able to afford anything except inadequate state health care. This is the classic case of "the virtue of socialism being the equal sharing of deprivation".

2. **RECOMMENDATIONS**

Therefore, for the reasons set out in this report, our recommendations are to:

- Improve primary health care and the quality of public health care before implementing universal health care;
- Revamp dilapidated health care infrastructure;
- Improve public hospitals by getting rid of unqualified managers;
- Put in a proper human resources plan with sufficient resources to recommend committee and board members, adequately staff hospitals and clinics to reduce the patient care backlogs;
- Run an expanding pilot to prove that the Health Department can properly manage central tenders, prevent stock losses, spoilage, rotation of stock, prevention of stock-outs and distribution without fraud and corruption;
- Articulate the source of funds (Section 46(1)) for the NHI Fund (employers paying a payroll tax as personal income tax is already one of the highest in the world and which pensioners can ill afford);
- State the Rand amounts scales for the unified tariffs of those that can afford to pay the mandatory payments as economies of scale should mean that current scheme payers will actually pay less especially with the consequential reduction of standards of care and longer waiting periods;
- Remove MSA's Section 32F (1) (a) the "contributions for mandatory benefits based on income";
- Remove MSA's Section 32l (2) "without co-payment or the use of deductibles";
- Remove "shares, debentures, stock and securities" from NHI Section 6 (1) as the Health Department cannot even do fund tracking; and
- Wait for at least the preliminary public findings of the Competition Commission's Health Market Inquiry (HMI) that is probing barriers to competition and care in private health care.

NAME & SURNAME	*Brian Youngblood, Chair: Fish Hoek Valley Residents and Ratepayers Association (FHVRRA)*
CONTACT NUMBERS	*021 782 1950 / Cell: 084 3 99 99 33*
E-MAIL ADDRESS	*bdyoungblood@gmail.co.za*
SIGNATURE	
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Additional Source

Tamar Khan, *Lacking Vitals*, Financial Mail, 28 June to 4 July 2018 issue