Civil Society and the National Health Insurance in SA.

FES & Section 27 NHI Programme

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Political Context: Social Democratic Values

- Social policy and the access to basic public goods are the cornerstones of this political system
- Strengthening African democracies is not sustainable without addressing the high levels of socio-economic inequality
- Citizens have unequal access to water, food, health and decent employment.
- Social inequality limits participation in the political realm.
- "*You can't participate in the economy or in politics if you are concerned with survival*" **(Dinokeng Scenarios Report 2009)**

Building a Social Democratic Political Economy

- Development must be measured beyond GDP
- Human development must be prioritized, especially health indicators
- Constitutional right to quality healthcare: Section 27
- Freedom Charter (1955): "*Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children*"
- COSATU Resolutions and Growth Path (2010)
- ANC Conference and Policy Resolutions (2012)
- ANC Election Manifesto (2014)

Solidarity Economy and Universal Health Care (UHC)

- Studies point out that there is a correlation between rise in life expectancy & economic development
- Impossible to build a dynamic economy without healthy people
- UHC Protects working class from poverty trap caused by high health expenditure
- Enhances financial freedom, working class can use financial resources for other economic purposes
- Principle of cross-subsidization and working class solidarity
- Solidarity economy = basis for Social Democracy

Socio-economic Context

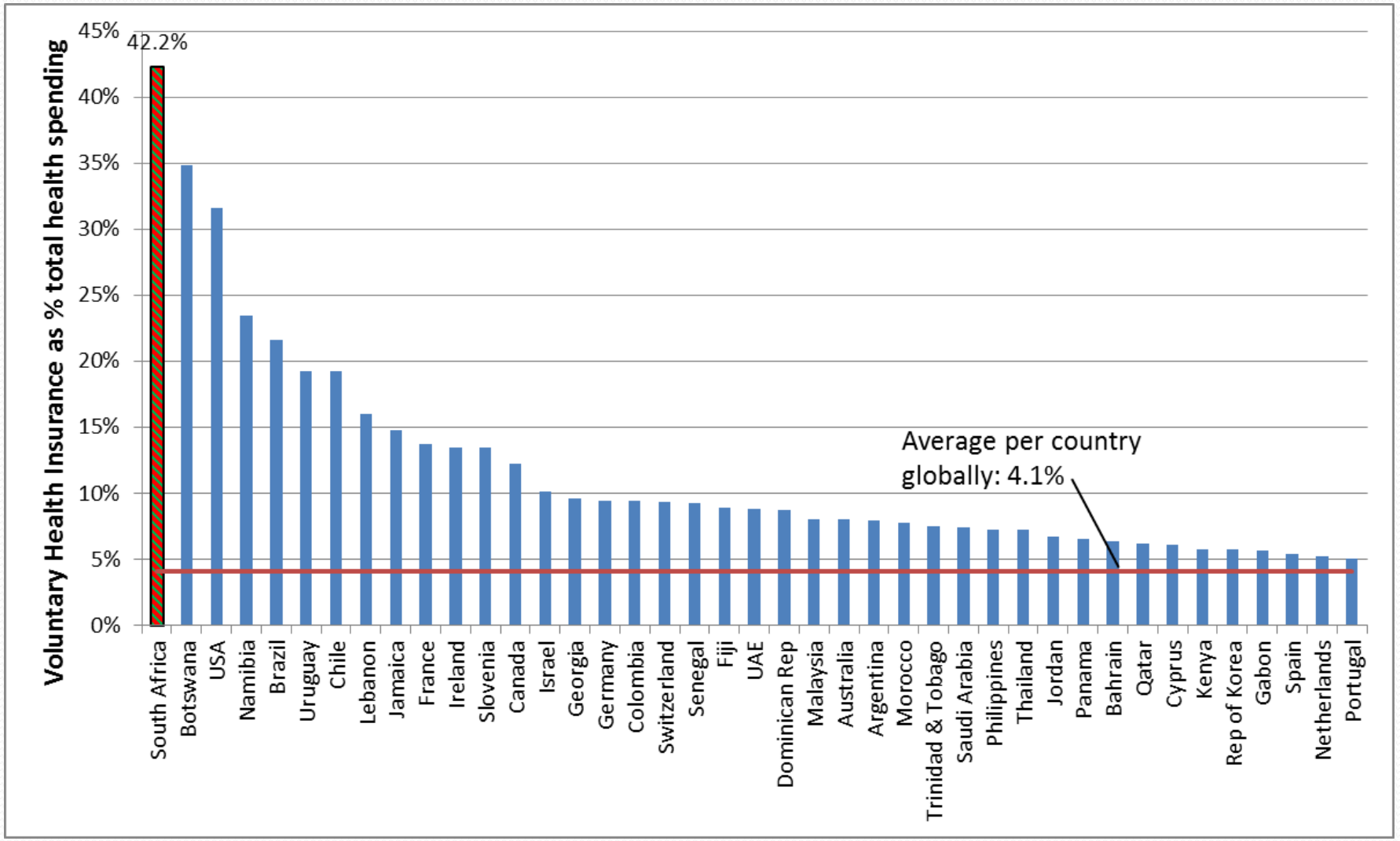
- SA is ranked number 118 out of 187 countries on Human Development Index (2013)
- World Health Organization Ranking (2000) : 175 out of 190
- 8.5 % of GDP is spent on health; 5 % services 16% of the population; 3.5% services 84% of the population (**Presidency 2014**)
- Health outcomes are very poor when compared to other middle-income countries **(see table below- Source : Minister of Health 2015. Presentation to COSATU Health Committee)**

Selected Health Statistics, BRICS Countries: Source

Indicator	Brazil	Russian Federation	India	China	South Africa
Total population (millions)	193.7	140.8	1198 0	1353 3	50.1
Total expenditure per capita (PPP int $)	943	1,038	132	309	862
Total expenditure on health as % of GDP	9.0	5.4	4.2	4.6	8.5
General government expenditure on health as % of total government expenditure	6.1	8.5	4.1	10.3	9.3
Life expectancy at Birth					
Males	70	62	63	72	54
Females	77	74	66	76	55
Both	73	68	65	74	54

Indicator	Brazil	Russian Federation	India	China	South Africa
Infant mortality rate (per 1,000 live births)	17	11	50	17	43
Under 5 mortality	21	12	66	19	62
Adult mortality rates, 15-59 years (per 1,00 population)					
Male	205	391	250	142	521
Female	102	144	169	87	479
Both	154	269	212	116	496
Maternal Mortality Ration (per 100,00 live births)	58	39	230	38	410
Distribution of years of life lost by causes (%)					
Communicable	20	11	52	15	79
Non Communicable	56	64	35	65	15
Injuries	24	25	13	19	6
Prevalence of HIV among adults aged 15-49 (%)	0.6	1.0	0.3	0.1	17.8
Prevalence of TB (per 100,000 population)	50	132	249	138	808
Tobacco smoking 15+ (%)					
Males	19.4	70.1	33.2	59.5	29.5
Females	12.0	27.7	3.8	3.7	9.4

South Africa skewed health financing system



Source: WHO estimates for 2012, countries with population > 600,000

Reasons for Poor Health Outcomes 1

- Public / Private divide:
  - Private health accounts for 50% of the total expenditure (**CMS 2014).**Only supports 16 % of the population
  - Public sector accounts for 47% of the nation's health expenditure. Supports 84 % of the population(**DOH 2014; Presidency Twenty Year Review 2014).**
  - 63.4 % percent of Africans used public health services; while 84 % white citizens used private facilities
  - Only 8% of Africans had medical cover in 2003;while 65 % of their white counterparts had access to medical aid (**General Household Survey 2003)**
  - Only 10.4 % of the African population had medical insurance in 2012 and 75 % of the white population had access to medical aid (**General Household Survey 2012**)

Reasons for Poor Health Outcomes 2

- Hospicentric health system
  - System is over-reliant on hospitals which are curative health centres
  - Patients only deal with diseases& injuries at an advanced stage
  - Inefficient primary health care
- Fragmentation : institutional and financial
  - Various institutions providing health services
  - Different budget lines
  - Insufficient fiscal and institutional coordination
  - Skewed patient and health institution ratio

Reasons for Poor Health Outcomes 3

- Commercialisation
  - Council of Medical Schemes paid 25.5 million to private specialists in 2013; 14% increase from 2012 (**CMA Report 2013**)
  - Admin fees accounted for 90 % of Discovery Health's operating profits between 2010 and 2011 (**SAMJ 2013**)
  - expenditure on private hospitals was way above inflation between 2000 and 2010. In this period the consumer price index (CPI) was 6%; hospital inflation was 8.5%; but private hospital expenditure exceeded 12.2 (**Econex 2013**)
  - Oversupply and induced demand: private sector had a bed over-supply of 10 000 by 2008 (**DBSA 2008**)

Reasons for Poor Health Outcomes 4

- Weak Human Resource Strategy
  - More than 60% of professional human resources in health are in the private sector (**COSATU 2008**)
  - High vacancy rate in public sector
  - Weak support for staff & work overload
  - Poor working conditions & labour relations governance
  - Insufficient infrastructure to support health professionals
  - Post-schooling sector is not supporting the public health system adequately

Solution= NHI & Primary Health Care

- Improved access to quality healthcare for all citizens
- Decrease financial risks associated with accessing healthcare by risk pooling
- Improve purchasing power by procuring health services on behalf of the public
- Strengthen public sector which is under-resourced & weak human capacity
- Reconfiguring the primary health care system

***Sources: Department of Health. National Health Insurance in South Africa Policy Papers: 2011 &2015**

New Health Paradigm: Primary Health Care

- Provided by both public and **private** health providers
- Dangers associated with using private providers: commercialization- ***Competition Commission Health Inquiry !!!!!!!***
- ***Principles of PHC: preventative health system, decentralization, accountability, responsiveness, local needs***
- Based on the following institutional arrangements:
  - District Health Teams
  - School Health Teams
  - Municipal Ward Teams
  - Restructuring the Hospital system

Institutions Supporting NHI

- National Health Fund(NHF) and Provincial Offices
  - Pool Funds, Purchasing Power and Contract Management
- Office of Health Standards and Compliance (OHSC)
  - Inspections, Setting Norms & Standards, Accreditation, Ombudsman
- District Health Authority supported by NHF office
  - Monitoring Contracts and Providers
- National Health Information System
- National Department of Health
  - Policy Guidance, Health Services, Human Resource Development Strategy , Infrastructure

The Class Struggle :Financing NHI

- Three Sources: individuals, fiscus and employers
- Cost estimation: 125 billion by 2012; 214 billion by 2020 and 225 billion by 2025 (**NHI Green Paper 2011**)
- Main expenditure target = 6.2% of GDP
- In 2010 over 227 billion was spent on health in SA.
- **Green Paper (2011)** includes: co-payments, investigation into multi-payer system, but silent on VAT. Opposes tax subsidies
- **White Paper (2015)** includes: increase in VAT& broader fiscal financial instruments.

* **More analysis of NHI White Policy Paper (2015) is required***

NHI Policy & Legislative Debates: 2015/2016

- Financing policy instruments
- Role of the private sector
- Developing a democratic and legitimate human resource strategy
- Coordination with process of developing a comprehensive social security system in SA
- Health literacy for all citizens
- Intragovernmental regulation & Coordination

Civil Society and the National Health Insurance

- Section 27 Policy Advocacy Intervention
  - Improve awareness and knowledge on health rights and NHI.
  - Mobilise communities to demand and access their rights
  - Advocate for improved services, a functional NHI, adequate medicine stocks, adequate human resources for the delivery of health care services.
  - Strengthen Health Crisis Action Coalition in provinces
  - Deepen public participation in the NHI policy process

* **Please full proposal in Kubo 2016**

Civil Society Advocacy Instruments

- Provision of Legal Services and Strategic Litigation
- Advocacy through Communications and Campaigns
- Civil Society Capacity Building
- Developing new human rights voices

Selected Pilot Districts and Respective Population Numbers

Province	District	Total Population based on STATSA 2010 Population Estimates
Eastern Cape	OR Tambo	**1,353,349**
Mpumalanga	Gert Sibande	**944,694**
Limpopo	Vhembe	**1,302,107**
Northern Cape	Pixley ka Seme	**192,157**
Kwa-Zulu Natal	uMzinyathi	**514,840**
Kwa-Zulu Natal	uMgungundlovu	**1,066,150**
Western Cape	Eden	**558,946**
North West	Dr K Kaunda	**807,752**
Free State	Thabo Mofutsanyane	**832,172**
Gauteng	Tshwane	**2,697,423**
TOTAL POPULATION		**10,269,590**

Notes: *KZN will pilot two (2) districts due to high population numbers and high disease burden