KEYNOTE ADDRESS BY THE MINISTER OF HEALTH, DR MJ PHAAHLA,
AT THE POLICY DIALOGUE ON UNIVERSAL HEALTH COVERAGE IN SOUTH AFRICA
ON THE EVENT OF *UNIVERSAL HEALTH COVERAGE DAY*
12 DECEMBER 2023

Programme Director, Prof. Nicholas Crisp
Chair of the Portfolio Committee on Health, Dr Kenneth Jacobs, MP
Members of the Portfolio Committee present
MECs of Health present
Dr Owen Kaluwa, World Health Organisation Country Representative
Director-General, National Department of Health, Dr Sandile Buthelezi
Heads of Provincial Departments of Health
Senior members of the National and Provincial Departments of Health
Esteemed Speakers and panellists
Distinguished guests
Ladies and gentlemen

A very good morning to you all.

I am pleased to welcome you all to this year's Universal Health Coverage (UHC) Day event. Last year we were in the shadow of the COVID-19 pandemic and the health system was hard at work to catch up with lost ground in achieving key health targets and outcomes. In my address last year, we spoke about the progressive realisation of UHC through the phased implementation of National Health Insurance (NHI).

This year's event comes just six days after the NHI Bill was passed by the National Council of Provinces (NCOP), a milestone which marks the end of a five-year journey through Parliament. Hundreds of people have been involved in steering this foundational reform legislation to this point. Tens of thousands of South Africans have attended hearings, made submissions, and commented on the contents and intentions of the Bill. Congratulations and thank you to every person who participated in the process.

We are aware that not every person's comments were incorporated in the Bill that was eventually passed by the NCOP. However, I would like to categorically state that every comment was considered and has enriched the debate on how best we as a country can make meaningful progress towards achieving UHC. As would be expected, some stakeholders are not satisfied with the outcome and still oppose the provisions of the Bill. However, the majority

are in support, and we trust that Parliament will now send the Bill to the President for his assent. This will put us on a path to reform which is aimed at a true UHC.

Once the President has assented the Bill into law, the statutory mandate will be established for the Minister and National Department of Health to begin the process of creating the entity that will manage the Fund. Nothing changes until the relevant sections of the Act are proclaimed as law, and regulations, directives, and other operating procedures occur.

We will not go into the technical detail now except to say that the Board and other governance structures will be implemented first, and in the coming three years between 2024 and 2026 the administration and its associated governance structures will be established. Since this will be the first time that a Board is appointed, the entire process must be clearly regulated from the initiation. Regulations that describe all the processes will be published for at least three months inviting people to comment.

When these regulations are published, members of the public are encouraged to make inputs so that the provisions can be as comprehensive as possible and the governance of the NHI entity clear to everyone. When that has been done, the Minister may proceed with establishing the autonomous public entity.

Ladies and gentlemen, approximately half the world's population lacks access to essential health services. This is despite the world having made significant progress in the innovativeness with which such services can be provided and accessed. We have recently reported on the progress that our country is making significant and sustained progress towards improving the overall health status of the population.

For instance, according to the 2022 Mid-year population estimates, South Africa's total life expectancy at birth showed improvement, rising from 61.7 years in 2021 to 62.8 years in 2022. However, pre-COVID-19 figures indicated a higher total life expectancy of 65.4 years, surpassing the 2018 baseline of 64.6 years and the Medium-Term Strategic Framework 2024 target of 66 years.

Despite a slight decrease in the infant mortality rate from 25 deaths per 1,000 live births in 2020 to 24.3 deaths per 1,000 live births in 2022, the baseline of 27.2 deaths per 100 live births in 2018 remains higher than the Medium-Term Strategic Framework 2024 target of less than 20 infant deaths per 1,000 live births. Notably, the under-five mortality rate saw significant improvement, declining from 35.2 child deaths per 1,000 live births in 2020 to 30.7 in 2022,

compared to a baseline of 37 deaths per 1,000 live births in 2018. However, the under-five years severe acute malnutrition case fatality rate increased from a baseline of 7.1% in 2018 to 8.2% by end August 2023. The Rapid Mortality Surveillance Report for 2019 and 2020 indicated progress in achieving the Medium-Term Strategic Framework target for Maternal Mortality Ratio (MMR), with a decrease from 164 deaths per 100,000 live births in 2015 to 109 deaths per 100,000 live births in 2020. Nevertheless, the impact of COVID-19 is expected to affect Maternal Mortality Ratio reporting, as adult mortality and institutional Maternal Mortality Ratio figures increased during the pandemic period, reflecting potential challenges in maternal health.

However, there is much to do to reduce the inequitable access to resources and services. Last year, we noted that the health sector has numerous stakeholders with various interests. We implored all role-players to find a way to work more closely to find practical solutions to pressing issues such as effective health workforce management and use as well as developing partnerships in moving towards UHC. This year we repeat the call. We have a framework for reform, and we again invite every interested party to work with the department as we steer our way into the future.

Distinguished guests, we need a resilient health system that delivers UHC and leaves nobody behind. The WHO UHC index, which is reported on a scale of 0 to 100, is computed from 14 tracer indicators of health service coverage and financial risk protection. The long-term objective for this indicator is for a country to record a value of 100. It is encouraging that South Africa's UHC Index has almost doubled in the past 20 years, from a score of 36 in 2000 to a score of 67 in 2019. We have a long way to go to achieve the free health care that is provided for in the systems of France, Italy, Singapore, Japan and Spain.

Adam Wagstaff at the World Bank published an assessment of 111 countries on UHC Day in 2019. In that report he noted three main trends:

> **Firstly**, achievement on one dimension varies across countries with a similar level of achievement on the other. Countries with a similar level of service coverage often have different levels of catastrophic expenditures. He noted specifically that South Africa has fairly good coverage score but extremely poor score for catastrophic health expenditure.
>
> **Secondly**, countries vary in their mix of service coverage and financial protection for a given level of UHC. For example, Brazil and Serbia, both upper-middle-income

countries, have the same UHC index value (75). However, Brazil's service coverage score far exceeds Serbia's (61%), but this is counterbalanced in the UHC index by Brazil's substantially higher incidence of catastrophic expenditure (26% vs 8%).

Thirdly, unsurprisingly, a country's UHC index score tends to be higher the higher the country's income group. However, there are variations within income groups. Some high-income countries are faring less well than others.

The point he makes is that countries must score on all dimensions of UHC in building solutions to improve a sustainable and resilient health system. South Africa needs to work on all three dimensions, but it is our failure to protect people from catastrophic health expenditure that defines our greatest need.

South Africa remains the most unequal country in the world, where 10% of the population owns more than 80% of the wealth. The legacy origins of this disparity remain. Further, just over 1% of the population spend over 10% of their household budget on healthcare, whilst 0.1% spend over 25% of their household budget. Our two-tiered healthcare system has regressed with the public state-funded sector serving an increased majority of the population (estimated at around 86%), and a private sector serving around 14% of the population on a regular basis. It is the funding structures of our system that perpetuate this inequity, and which must be radically reformed.

I want to repeat what I said last year so that we can reinforce the information on the key elements of the reforms that we will now embark on. The essential elements of our NHI reforms include:

- **Strategic purchaser:** As a strategic purchaser, the NHI will proactively identify population needs and efficiently and effectively purchase health goods and services from providers in BOTH public and private sectors. The advantages of strategic purchasing are enhancement of equity in the distribution of resources, increase efficiency, managed expenditure growth and promotion of quality in health service delivery. NHI will also serve to enhance transparency and accountability of providers and purchasers to the population.

- **Single-payer:** The NHI Fund will be the entity that pays for all personal health care costs on behalf of the whole population. The term "single-payer" describes the funding mechanism and not the type of provider.

- **Single fund:** All sources of funding will be integrated into the NHI Fund. The multiple public sector funding streams, namely equitable share allocations and conditional grants will be pooled into the Fund. The pooled funds will be utilised by the NHI Fund to purchase personal health care services for all.

- **Universal access:** All who live in South Africa will have access to quality health care when and where they need it without suffering financial catastrophe.

- **Comprehensive health care services:** The NHI Fund will cover (pay for) a comprehensive set of health benefits that cover a continuum of care.

- **Financial risk protection:** South Africans will not suffer financial hardship in accessing health care services. The NHI seeks to eliminate user fees, co-payments and direct out of pocket payments. The aim is that every person receives health care free at the point of service.

- **Mandatory prepayment:** The NHI will be financed through mandatory prepayment as opposed to current voluntary prepayment and out of pocket payments. That means that the funds will be collected through taxes INSTEAD of collection through medical schemes.

As we reform our system, we will follow the UHC 2030 campaign which states and I quote:

> *"The essence of UHC is universal access to a strong and resilient people-centred health system with primary care as its foundation. Community-based services, health promotion and disease prevention are key components as well as immunization, which constitutes a strong platform for primary care upon which UHC needs to be built."*

Detractors of this reform focus on only one clause and that is **Clause 33** which deals with the future role of medical schemes within the broader NHI environment. They will have the public believe that vast sums of money will need to be raised from scratch to pay for this financial security. Therefore, I would like to take this opportunity to outline some of the core elements of the funding for NHI.

According to National Treasury we the inhabitants of our beautiful country spent R542 billion on health care in 2022. We did this through R265 billion existing taxes that Parliament allocated to the National Department of Health, nine provincial governments for their

respective departments of health, the South African National Defence Force, Department of Correctional Services, etc. About 85% of the remaining R277 billion went to meeting the health needs of the more affluent public, entrusted to medical schemes to purchase some of our health care needs, and the final 15% of this amount we paid out of pocket.

What did we get for this? The various government departments provided care to an estimated 52,8 million people and the private schemes purchased care from private providers for the remaining 9,2 million people. If that sounds strange it is because these numbers add up to around R5,000 per person spent in the public sector and almost R30,000 per person spent in the private sector. However, we know that members of the public usually dependent on public services do purchase some services through out-of-pocket payments, so the figures are less rounded off but are still around R5,200 per person public spend as opposed to R27,000 per person private spend.

The difference in this spending is complex but we know that the complexity of the 72 private funding streams, further fragmented into more than 300 ‘benefit options’, costs about 15% to administer. This includes the cost of staffing and governing the 72 schemes and the in-house and outsourced administration of who may benefit from each of the complex options when they claim. Health services providers and establishments such as doctors, dentists, nurses and hospitals incur further costs to manage their practices and facilities, and still be able to claim from all or some of these schemes when patients come to them for care.

Furthermore, prices that used to be controlled in this private space are no longer controlled owing to a court ruling several years ago, so medical schemes do not cover all costs claimed for care. Those costs must be ‘insured’ separately through some form of top-up insurance or gap cover, with further administrative costs.

The public sector is not without its complexity either. Parliament does not allocate a ‘health budget’. Public budgets are allocated to national departments and provincial legislatures based on their functions. Since health functions are allocated to both national and provincial health departments in the National Health Act of 2003 funds are allocated to each of the ten health departments (plus other government departments) to deliver their mandates. The ‘health budget’ (R265 billion in 2022) is a loose term for the sum of these several department budgets.

Administering this complexity is duplicative and expensive. It also opens huge perverse incentives that result in corruption, fraud, and theft. Public corruption is widely published but the R30 billion annual fraud in the private sector is less often spoken about.

The NHI Fund will be established as a Schedule 3A entity outside of the public service but still a government (public) agency per the provisions of the Public Finance Management Act. This agency will be responsible for determining the benefits that can be afforded with the funding available each year and paying both public and private providers for providing us with health care. It will administer progressively large sums of money until more than R400 billion (in 2023 Rand terms) is under administration by this agency. This is more than the R263 billion that SASSA administers in 2023 but far less than R2,599 trillion that the state-owned Public Investment Corporation (PIC) administers.

The NHI Bill, once assented and the sections of the Act systematically proclaimed into law, will provide for the governance and related administration structures to be established. As I have alluded to earlier, we anticipate that these processes will take three years and for the new agency to receive and pay out the first tranche of payments to initial early adopter health care providers. The funding for this will come from redirecting some conditional grants that the National Department of Health presently transfers to provinces. Later, likely after the first three years, the Provincial Equitable Share (PES) portion that is presently spent on personal health care services will systematically be re-allocated through the national budget vote to the agency and no longer to provincial legislatures.

During this initial five-year period, the agency will begin to pay providers to care for individuals who are presently private patients but who choose to terminate their medical schemes for better cover from the NHI. This is likely to be the 25% of the 9,2 million people who have medical aids that are only hospital plans. That healthcare must be paid for in addition to current budget allocations. There are several sources for this funding. The most obvious is the ‘tax credits’.

A Medical Scheme Fees Tax Credit (also known as an “MTC”) is a rebate which is non-refundable, but which is used to reduce the normal tax a person pays. In 2023, the monthly rebates for medical scheme contributions are as follows: Taxpayer: R364; first dependant: R364; and every subsequent dependant: R246. Basically, the government subsidises medical scheme beneficiaries to the tune of around R37 billion annually to belong to medical schemes. For those who already battle to make scheme payments and who purchase minimal cover through ‘hospital plans’ this is a significant rebate. But for many R364 a month is a meal out

or half a round of golf. The aim will be to systematically terminate this MTC for higher income bracket beneficiaries, and then for all once the agency is purchasing a comprehensive set of benefits.

Finally, there will be a need in the future, once the NHI Fund is paying for comprehensive benefits for everyone, and nobody has a need for any medical scheme or 'gap cover' to pay for their health care, to raise the remaining funds required through taxes. The Bill anticipates this future and provides options other than current taxes to raise the difference. This includes the options of a payroll tax and a surcharge on personal income tax. Any such, changes will happen at the appropriate time through a money Bill introduced by the Minister of Finance and earmarked for use by the Fund (agency).

Ladies and Gentlemen, as I conclude, we have long agreed that the status quo in our health system cannot remain. We have concluded the Parliamentary process and now the task is to get everyone to rally around the reforms that are coming. We can and must redress inequity. Social solidarity is not a luxury but a necessity. We invite everyone to be a part of the journey towards realising the unitary health system that we can all cherish.

I thank you.