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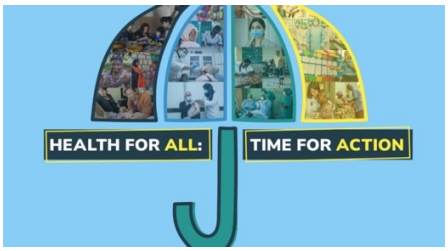

Universal Health Coverage Day Seminar Report

Theme: *"Health for All, Time for Action"*

Venue: Future Africa Institute
Hillcrest Campus, University of Pretoria

12 December 2023

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Acknowledgements

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Finally, the event would not have been a success without the various stakeholders, including guest speakers and panellists, taking their time to actively participate in the proceedings of the day.

List of Acronyms

CCMDD	Centralised Chronic Medicines Dispensing and Distribution
CMS	Council of Medical Schemes
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
MP	Member of Parliament
NCOP	National Council of Provinces
NHI	National Health Insurance
PHC	Primary Health Care
PMB	Prescribed Minimum Benefits
PPF	Progressive Professional Forum
RHAP	Rural Health Advocacy Project
SAMATU	South African Medical Association Trade Union
SANAC	South African National AIDS Council
SDGs	Sustainable Development Goals
SHSPH	School of Health Systems and Public Health
UHC	Universal Health Coverage
UN	United Nations
UP	University of Pretoria
WHO	World Health Organization

Introduction

Every year on December 12, the world commemorates Universal Health Coverage (UHC) Day. The day is dedicated to celebrating the advancements made towards achieving health for all and to increase public awareness of the necessity of resilient, equitable and robust health systems for the realisation of universal health coverage in all contexts.

The World Health Organisation (WHO) has themed the 2023 UHC Day ***"Health For All – Time for Action"***. The theme emphasises the need for immediate and tangible steps in creating the world we want and accelerating progress towards UHC. The world is at the midpoint of the 2030 United Nations (UN) Sustainable Development Goals (SDGS) and it calls for reflection on a decade of progress, challenges, and opportunities in advancing UHC. The focus is to urge leaders to enact policies that guarantee equitable access to essential health services without financial hardship and leverages on the momentum and outcome from the second United Nations High-Level Meeting (UNHLM) on UHC in September 2023: a renewed action-oriented political commitment that will refocus political attention and financial investments on accelerating progress.

Therefore, the National Department of Health, in collaboration with the WHO and other stakeholders, hosted a one-day workshop/seminar to reinvigorate pledges to accelerate UHC efforts in South Africa. The proceedings of the event were based on recognising the objectives for the day as outlined by the World Health Organisation (WHO), namely:

i. Recognise and celebrate UHC achievements
ii. Raise awareness to improve understanding on the importance of UHC for societal, developmental and economic wellbeing;
iii. Set the tone on how best to measure the actions we are taking towards achieving UHC; and
iv. Empower the public and civil societies to actively engage policy makers to deliver on their UHC commitments .

The UHC Day 2023 seminar took place at an opportune time for South Africa as the National Council of Provinces (NCOP) voted in favour of passing the National Health Insurance (NHI) Bill. This is indeed a monumental step that the country has taken towards the realisation of UHC. NHI represents comprehensive healthcare policy and legislative reforms aimed at addressing disparities in healthcare access and providing quality, affordable, and equitable healthcare services to all citizens irrespective of their socio-economic status. Through the creation of the NHI Fund as a strategic purchaser responsible for pooling resources, with the mandate to reduce financial barriers to healthcare, improve health outcomes, and create a more inclusive and sustainable healthcare system for the people of South Africa.

This report provides an overview of the proceedings and inputs that were provided by various speakers and stakeholders at the UHC Day celebrations on 12 December 2023 at The Future Africa Institute, Hillcrest Campus at the University of Pretoria.

Session 1: Setting the Scene

The key inputs for this session were provided by the following speakers.

i. Dr Mathume J. Phaahla, MP (Minister of Health, South Africa)
ii. Dr Sandile S Buthelezi (Director-General, National Department of Health)
iii. Professor Lekan Ayo Yusuf (Head, School of Public Health and Health Systems, University of Pretoria)
iv. Dr Owen Kaluwa (WHO Country Representative, South Africa)

Remarks by the Director-General: National Department of Health

In opening the UHC Day 2023 event and setting the scene, Dr Buthelezi acknowledged that the conference participants all had one faith: that health for all is desirable, achievable, and maintainable, that much is known and knowable and that through the application of what is known and through a staunch commitment of a people's government, health can become the possession of all. As human beings, our health, and the health of those we care about is a matter of daily concern. Regardless of our age, gender, socio-economic or ethnic background, we consider our health to be our most basic and essential asset. Ill-health, on the other hand, can keep us from necessary socio-economic conditions, from attending to our family responsibilities or from participating fully in the activities of our community. By the same token, we are willing to make many sacrifices if only that would guarantee us and our families a longer and healthier life.

The DG articulated the importance of ***Health for All*** as he reminded the attendees that the right to health is a fundamental part of our human rights and of our understanding of a life in dignity. The right to the enjoyment of the highest attainable standard of physical and mental health, to give it its full name, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".* The preamble further states that *"the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."*

The 1948 Universal Declaration of Human Rights also mentioned health as part of the right to an adequate standard of living (article 25). The right to health was again recognised as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. Since then, other international human rights treaties have recognised or referred to the right to health or to elements of it, such as the right to medical care. The right to health is relevant

to all States: every State has ratified at least one international human rights treaty recognising the right to health. Moreover, states have committed themselves to protecting this right through international declarations, domestic legislation, and policies, and at international conferences.

In recent years, increasing attention has been paid to the right to the highest attainable standard of health, for instance by human rights treaty monitoring bodies, by the WHO and by the Commission on Human Rights (now replaced by the Human Rights Council), which in 2002 created the mandate of Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health. These initiatives have helped clarify the nature of the right to health and how it can be achieved.

In closing, he commended all health activists and the government of South Africa for their efforts in creating an enabling legislative environment for the implementation of universal health coverage (UHC) in our lifetime.

Remarks by Prof Lekan Ayo Yusuf

The Chairperson of the School of Health Systems and Public Health (SHSPH) in the Faculty of Health Sciences at the University of Pretoria (UP), Prof Lekan Ayo Yusuf, echoed the sentiments that people should have access to healthcare regardless of their socioeconomic status. He quoted President Nelson Mandela who said, “Health cannot be a question of income; it is a fundamental human right”. He highlighted that National Health Insurance (NHI) opens the door to access to preventative care and life saving intervention. He announced that UP is committed to NHI as SHSPH advances public health excellence in South Africa and Africa at large.

He made a call to professionals, educators, and policy makers to support the NHI. It is not enough to have buy in, but it is more important for people to believe in the NHI. The issue of public trust is important, and the public has raised concerns that money should be used for what it is intended for. He emphasised the importance of investing in training public health medicine specialists as they are individuals who can navigate the intricate landscape of the health system. Public health medicine specialists have a cultural competence, deep understanding of diverse needs of the population essential for responsiveness of the health system. He ended his remarks by saying that we must celebrate with a sense of accomplishment and renewed commitment. The NHI is guiding us to a place where health care is a right and not a privilege.

Remarks by Dr Owen Kaluwa - “A commitment to supporting Health for All”

The WHO Country Representative, Dr Owen Kaluwa, highlighted the importance of celebrating UHC day annually to raise awareness about the many people who are unable to access health care and falling into financial hardship. In 2019, One billion people faced

financial woes because of out-of-pocket spending. This year's theme for UHC Day: "Health for all, time for action", reminds us that time is not on our side. As WHO turns 75 years old in 2023, he recognised that a lot has been achieved and the key priority has been achieving health for all. The world has seen major improvements, with the biggest gains made in poorest countries, in the past 20 years indicators such as maternal mortality has fallen. However, it is still important to recognise that the challenges of today are different to those of past decades. The challenges include non-communicable diseases, tobacco still kills millions, antimicrobial resistance is on the rise and the existential threat of climate crisis to name a few of today's challenges. This highlights the importance of resilient health systems and the role of research to address these challenges.

WHO commends the National Department of Health for the recent Primary Health Care (PHC) conference held in East London. The conference reinvigorating primary health care as a strategic component in a unified health system dispensation. The conference reiterating the importance of achieving UHC and ultimately the attainment of health for all.

He concluded by reminding the attendees that the annual UHC Day is a rallying point for health for all. There was a unanimous commitment for health for all in September 2012 in the United National General Assembly, a declaration was made that placed UHC Day at the heart of health, highlighting that it is crucial for access of essential health for all and that governments must continue to invest in health for all. As this day is celebrated, we must work together to enact laws that enable all people to access essential health care services. Collaboration with civil society and private sector is key as South Africa progresses to UHC. The WHO will continue to support all efforts of government in realising UHC. Good health is not a privilege for a few but a right for all.

Keynote address by the Minister of Health – "Progress towards Universal Health Coverage in South Africa"

The keynote address for the meeting was delivered by Dr. Mathume J. Phaahla, MP the Honourable Minister of Health. In the address, the minister began by acknowledging that this year's event comes six days after the NHI Bill was passed by the National Council of Provinces, which is a significant milestone that marks the end of a five-year journey through Parliament. He acknowledged and congratulated the hundreds of people who were involved in steering this foundational reform legislation to this point and tens of thousands who participated in the process through public hearings and submissions. He further reassured the meeting that all comments were considered even though they may not have been incorporated in the Bill. He hopes that Parliament will now send the Bill to the President for his assent.

The Minister reminded the attendees that 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. He then reinforced the essential reforms of the NHI which include:

a) **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.
b) **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.
c) **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.
d) **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.
e) **Comprehensive health care services:** The NHI Fund will cover (pay for) a comprehensive set of health benefits that cover a continuum of care.
f) **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.
g) **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.

The Minister also addressed what can be anticipated after the Bill is assented and sections of the Act systematically proclaimed into law and is described below as:

i. 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. 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.
ii. 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 that has been done, the Minister may proceed with establishing the autonomous public entity.

iii. In the first three years, the new agency will 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.
iv. 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.
v. 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).

The Minister concluded by reminding the participants that the status quo in our health system cannot remain. The task is to get everyone to rally around the reforms that are coming as the Parliamentary process is now concluded. Inequity must be addressed; and social solidarity is not a luxury but a necessity. He invited everyone to be a part of the journey towards realising the unitary health system that we can all cherish.

Session 2: Stakeholder Inputs

The stakeholder inputs for this session were provided by the following speakers, in order of appearance:

i. Mr Russel Rensburg (Health activist)
ii. Mr Godfrey Selematsela (Civil society)
iii. Dr Nkateko Mnisi (Organised Labour)
iv. Dr Honours Mukhari (Health Professional Organisations)
v. Dr Magome Masike (HPCSA)
vi. Dr Sipho Kabane (CMS)

Remarks by Mr. Russel Rensburg – Health Activist

Mr Russel Rensburg reminded the attendees that, according to the Bill of Rights, the government must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of our right to health. He reminded us that although there are many challenges that we face, we are not starting from zero, but we have many successes in terms of improved health outcomes. There has been progress in population health outcomes, human immunodeficiency virus (HIV) and related diseases,

success of the roll out of antiretrovirals, maternal mortality decline, improvement of under-five mortality and improvement in social determinants of health such as running water in more households. But we need to unify the health system to ensure that everyone can enjoy these health outcomes.

There are challenges in the public health care system depending on the geographical area. There is limitation of uniform implementation of national policy in provinces. The implementation of the NHI will mean that everyone will be able to access the same PHC package regardless of province they reside in. This presents an opportunity to develop a package for the district health services and specialised services. The NHI presents an opportunity to sync national health. We need to start where we are currently. We need to dig down into the districts and understand the significant disparities within districts. Rural areas require decentralised care. Health management information systems must be improved, communities need to be engaged and proactive in matters of health. Managers must set priorities that speak to the current needs. The immediate challenge is governance which is more than corruption but about making the right decision when it comes to health.

Political accountability is needed. There is a need for a stronger department of health that will address centuries old challenges. Civil society must make sure that it is part of the solutions needed for access to health care.

Remarks Mr Godfrey Selematsela – Civil Society Representative

Mr Godfrey Selematsela commented that the role of Civil Society is to ensure that communities access health services without any hindrance or financial hardship and that the NHI is there to address the health challenges that people face. He further commented on other programmes being run by the Department of Health in the provinces, such as the Central Chronic Medicines Dispensing and Distribution (CCMDD) programme which allows people to access chronic treatment with ease. Although there are challenges with the CCMDD programme, especially in the delivery of medications in rural areas, it has made it easier for people to collect their chronic medications, including those with HIV/AIDS.

The CCMDD programme was compared to the NHI in that there may be challenges with the implementation of the NHI, but as it is phased in, people will access health care with ease.

Mr Selematsela stated that lack of human resource will become a hindrance to access health services. An appeal was made to the Department to increase human resource so as to increase access to care. He mentioned that those hesitant towards NHI need to be patient and understand that it has to start somewhere for the country to realise its goal of UHC.

Civil Society supports the introduction of the NHI as it will assist majority of people, especially those in rural areas. He stated that Civil Society understands that there may be technical issues and challenges in the implementation of the NHI; but the NHI – being the “new kid on

the block'', needs support and the country needs one health system for all. Civil Society has seen the good things being done in facilities in the rural areas. The belief is that more can be done with the implementation of the NHI. The public and private sectors need to work together to increase access. He emphasised that health is a right and that together, we can work towards enhancing the realisation of the NHI by working towards ensuring that *"Health is not a privilege for few, but a right for all!"*

Remarks by Dr Nkateko Mnisi – Organised Labour, South African Medical Association Trade Union Representative

Dr Nkateko Mnisi reminded the audience of the Alma Ata Declaration made in 1978 to reengineer PHC and to improve health services for all – one of the momentous and important occasions in the 20th century. The NHI, as part of PHC reengineering, has come at an important time in our lives to improve PHC and fulfil the theme of the day being "health for all". It is not just a declaration but a time where we move paper into action. Dr Mnisi affirmed South African Medical Association Trade Union's (SAMATU) support for the NHI to see UHC realised for all.

She further mentioned that currently, there is a lot of injustice, inequalities and challenges at the workplaces of health care professionals. An example was made of a grandmother who waits for more than a year to get a gynaecological intervention for cancer. In addition, there is lack of resources (human and equipment), unemployment amongst nurses and doctors, casualisation of healthcare workers where permanent contracts are transformed to short-term or casual basis and theatre cases being cancelled due to water and linen shortages and lack of specialists. She was passionate about the fact that these and many other health service inequalities and challenges should not continue in our lifetime.

She highlighted that health is the most important commodity we have in our lifetime. Health is the ultimate source of wealth and it should not be something that is used in order to make our pockets deeper. It is a commodity that must be used to ensure that every single person has access to quality health. Health is a commodity that can improve the life expectancy in the country. South Africa aims to be the economic powerhouse in Africa, this cannot be achieved if people don't have access to health care. We need to ensure that everyone has access to quality health care.

Many things need to happen in the implementation of the NHI in order to ensure that UHC is successful. SAMATU, as stated by Dr Mnisi, will observe the implementation of the NHI to ensure that there is:

a) Good governance and ethics throughout the process
b) Multi-sectoral and multi-organisational approach
c) Good quality health institutions/infrastructure;
d) Accessibility to facilities;

e) Accessibility to transport;
f) Collaboration between all sectors including the public and private sectors.

With this, UHC can be successful and a reality that all want to see. Dr Mnisi reiterated SAMATU's support for UHC. SAMATU will ensure that NHI is a successful and well implemented Bill and future Act.

Remarks Dr Honours Mukhari – Health Professional Organisation

Dr Honours Mukhari represented the Progressive Professional Forum (PPF) in his capacity as the PPF's NHI National Task Team Convenor. The Progressive Professional Forum is an organisation of academics, businesspeople, doctors, specialists, other healthcare workers and other professionals. He was accompanied by other members of the PPF NHI National Task Team; namely:

i. Dr Nhlanhla Khumalo
ii. Dr Nomfundo Nhlapo
iii. Mr Benjamin Magoye

WHO has themed the 2023 UHC Day: ***"Health for all: Time for Action."*** Dr Mukhari commended this theme, stating that enough has been said about the NHI, now is the time for action, now is the time for the NHI to be implemented. He further stated that UHC Day is dedicated to celebrating the progress made by different countries towards achieving free quality healthcare for all, and to increasing public awareness of the necessity for equal, equitable, efficient, and effective health systems dedicated to the progressive realisation of UHC for all population across the world.
The world is at the midpoint of the 2030 United Nations (UN) Sustainable Developmental Goals (SDGs), and the UHC Day event was a good point to reflect on the decade of progress, challenges and opportunities that the country has made in advancing towards UHC.

According to Dr Mukhari, It is important for South Africans to understand the strategic objectives and goals of the UHC in order to understand what the NHI seeks to achieve in moving the country towards UHC. The WHO defines UHC as the measure of ensuring that all people can use the health services they need, when they need them, and that this services must be of sufficient quality to be effective, while also ensuring that the use of this services does not expose the user to financial hardships. This, as stated by him, is exactly what the NHI seeks to achieve for the people of South Africa.

One of the arguments by those against the implementation of the NHI is about the quality of healthcare to be rendered. This criticism, as Dr Mukhari points out, ignores many clauses in the NHI Bill about the provision of quality health services, and the requirement of licensing, certification and accreditation of healthcare service providers to comply with quality norms and standards. By requiring contracted service providers and health establishments in both

private and public sectors to meet minimum certification and accreditation standards, the NHI aims to ensure that service providers deliver high quality care. Health outcomes based remuneration of service providers and services monitoring is essential for ensuring that contracted service providers deliver high quality of service.

He further noted that the NHI alone cannot achieve UHC. NHI is just one of the building blocks in the formation of the complete health system. A number of other interventions is needed to support progress towards UHC, such as:

a) Strengthening of the health information systems
b) Service delivery
c) Health workforce and training of human resources
d) Medical products, Vaccines and technologies
e) Improving governance and management capacity
f) Infrastructure and Equipment
g) Accountability
h) Ensuring quality norms and standards
i) Monitoring and evaluation of service providers

The Progressive Professional Forum as an organisation, is confident that South Africa is making progress and advancing well towards achieving UHC. After almost 15 years of public consultative processes, public hearings, written and oral submissions and parliamentary procedures, the NHI Bill was passed by the National Assembly on the 12th of June 2023, and the Bill was adopted without any amendments by the National Council of Provinces (NCOP) on the 6th of December 2023. Some opposing the NHI Bill are of the opinion that it was rushed in Parliament and rubber stamped by the NCOP; however, this opinion does not take into consideration the above very wide public consultative processes. The Progressive Professional Forum believe that such criticism is not informed by the interest of healthcare for the people of South Africa, but rather by people's own vested business interests.
Those who are opposed to the NHI Bill argue that NHI is not implementable and that it will collapse the heath system. However, PPF is very confident that the NHI can be progressively implemented in phases and that its implementation will result in a unified strengthened health system, with improved access to healthcare services in both private and public service providers. PPF's confidence in the implementation of the NHI Bill is also informed by section 57 of the Bill on Transitional arrangements in the implementation of NHI in two phases, and the Bill states:

a) **Phase 1 for 3 years:**
    - "Continue with the implementation of health system strengthening initiatives, including alignment of human resources with that which may be required by users of the Fund."

- "To include the purchasing of personal health care services for vulnerable groups, such as children, women, people with disabilities and the elderly."

b) Phase 2 for 3 years:

- "The continuation of health system strengthening initiatives on an on-going basis."
- "The mobilisation of additional resources where necessary."

Dr Mukhari concluded that PPF believes that the NHI Bill complies with the South African Constitutional mandate, especially section 27 of the Constitution, as well as the SDGs 2030, and the UN Convention on Human Rights. The NHI Bill is also in line with the goals of the National Development Plan 2030 of ensuring a revitalised and an integrated healthcare system, as well as improving the life expectancy of South Africans to 70 years of age. There are many deliberate distortions and negative propaganda by those who are opposed to the NHI Bill for their own business interests; however, as he mentioned, PPF believes that no amount of disinformation campaign can stop the right to free quality healthcare for all the people and for South Africa to advance towards UHC for all.

PPF further wants to make it clear that section 33 of the NHI Bill, which addresses the role of Medical Schemes, is sacrosanct and a cornerstone in the implementation of NHI towards UHC. This section ensures cross subsidisation of all segments of the population in order to achieve social solidarity and equitable access to quality health care for all. Finally, Dr Mukhari indicated that PPF believes that the Honourable President, President Cyril Matamela Ramaphosa, will sign the NHI Bill into law.
"*The people of South Africa have spoken Mr President. Forward with NHI, forward!"*

Remarks by Dr Magome Masike – Registrar of the Health Professions Council of South Africa

Dr Masike introduced the Health Professions Council of South Africa (HPCSA) as the regulatory body that guides and regulates health care professionals and protects the public from practitioners. The roles of the HPCSA are in licensing and accreditation, regulation of health care professionals, monitoring and enforcement, quality improvement, and consumer protection. Regulatory bodies like the HPCSA are of great importance in the pursuit of UHC.

Alignment was drawn between the sustainable development goal on health, UHC and the NHI. He noted that the goals of UHC may only be achieved if the health care system is accountable, affordable, accessible and reliable.

Some of the risks to the health care system that are seen by the HPCSA include health care providers involved in identity theft, claiming on behalf of deceased providers and claiming to operate in multiple locations at the same time. There has been an increase in 'bogus' providers, and in practitioners providing sub-quality health products. Dr Masike noted that

through collaboration, allowing processes to unfold, and displaying pockets of excellence that inspire hope, we can work together to implement NHI. As the NHI is being implemented, the integral role of the HPCSA will continue within the NHI framework

Remarks by Dr Sipho Kabane – Registrar & CE, Council for Medical Schemes

Dr Kabane began by describing the role of the Council for Medical Schemes (CMS) as the statutory regulator to safeguard medical scheme members and potential members (i.e.. everyone in the country) by ensuring that medical schemes abide by the legislation governing them. The CMS is currently involved with prescribed minimum benefits (PMBs), quality health care and outcomes, financial resources, solvency, legalities and governance of schemes. The mandate of the CMS aligns with the priorities of the Ministry of Health and as the health system landscape shifts, the regulatory roles of the CMS are expected to evolve.

He shared findings from their Industry Report which illustrated some of the problems with the current payment model for private health care services. These health care services are primarily paid for by medical schemes. There are currently 71 medical schemes which covers a total of 9 million beneficiaries. There were 29 medical schemes with less than 6 000 members each, and 10 schemes that were government-funded or linked. Contributions by members into all medical schemes added up to R232,5 billion in 2022. In addition to contributions, members of medical schemes also paid for health care services 'out-of-pocket.' These are instances when, for example, claims were rejected by medical schemes, or co-payments had to be made for medication at private pharmacies, and totalled R39,8 billion.

The funds from medical schemes are used primarily to reimburse health care establishments and providers for the health goods and services provided to their members. The bulk of this reimbursement is on hospitals (35%), specialists (27%) and medication (16%); with much smaller proportions of 8% and 5% going to allied health care workers and general practitioners (GPs) respectively. Over-and-above these payments, medical schemes have spent R18,9 billion on non-health care expenditure, of which R15,9 billion went towards administration of the schemes.

There are currently 23 medical scheme administrators, 2 185 broker organisations and 7 567 individual brokers. The bulk of the market share of medical scheme administrators is held by three major administrators: Medscheme Holdings (Pty) Ltd (31,7%), Discovery Health (Pty) Ltd (31,5%) and Metropolitan Health Corporate (Pty) Ltd (18,9%).

Dr Kabane stated that medical schemes cannot exist in their current form for perpetuity as there were many challenges identified. For example, medical scheme legislation mandates that payments for PMBs cannot be charged to a member's savings account. Despite this, around R80 million has been identified annually that is in direct transgression of this protective mechanism, with some medical schemes repeatedly transgressing this rule. The out-of-pocket payments by medical scheme members has been rising annually, and despite

the expectation of protection by medical schemes, there are still examples of catastrophic health expenditure.

During the transition period into full implementation of the NHI, certain risks were identified by the CMS that are likely to increase in frequency. These include litigation against the NHI reforms, fraud, wastage, transgressions of legislation and the increased availability of illegal health products. It is important to develop risk management plans to address these.

Dr Kabane urged medical scheme members to become active in the governance of their medical schemes to help ensure that the decisions made on behalf of members are to the benefit of members. He also urged the audience to think critically about who is opposed to the NHI, particularly on account of Section 33 of the NHI Bill which covers the role of medical schemes, and how the objective numbers suggest that these opponents may be driven more by self-interest than by concern for users of health care services.

Final Remarks from the Panel Discussions

The panellists echoed that during the transition to a fully functioning NHI, we must build the understanding on how to integrate public and private services. We have a baseline of health assets, but we need to think carefully about how we arrange them in a way that works for users. We need to put selfish interests aside as we aim to change the status quo towards access to health for all.

The public was urged not to be complacent in monitoring the work of the NHI, including the benefits package developed by the benefits advisory committee which must be comprehensive and address important health conditions with the available health technology. There was a call for improving communication around NHI, particularly with users at community-level; and there was concern expressed about the affordability of the NHI.

In closing the panel discussion; there was assurance from the Prof Nicholas Crisp, the DDG for NHI in the NDOH, that the implementation of NHI is affordable. Through the NHI, by using what we have more wisely, through eradicating corruption, using finances more efficiently and with better accountability, lowering the price of medicines and health technologies, using all cadres of health care workers within their scopes of practice, restructuring systems and hierarchies, and ensuring that users receive the health care services that they need, the 8,5% of GDP that is currently spent on health care is enough. The NHI team is aware of the massive challenges in society, and the problems in the health care system as it exists today. The NHI has the mechanisms to address these challenges within the health system while being cognisant of other challenges faced by users. If we work together, rather than trying to profit off peoples' ill-health, we can run decent health services.

Closing remarks and vote of thanks by Mr Ramphelane Morewane

Mr Ramphelane Morewane closed the meeting by thanking all the speakers, attendees and organisers who contributed to the success of the event. He reflected on the insightful and rich panel discussions of the day.

He noted that the commemoration of UHC Day this year takes place as South Africa celebrates a significant milestone in the legislative process of establishing the NHI. The adoption of the NHI Bill by the NCOP is indeed a proud moment for South Africa as we endeavour to move towards UHC. This year's theme being "Health for All, Time for Action". This theme has been echoed by the speakers as they kept reminding us that access to good health is a right and not supposed to be a privilege for a few. He also agreed with many who said that we have had many meetings and talks about UHC and NHI, and so the theme today is very relevant because now is the time for action, no more talks! The people of South Africa need to see the progressive implementation of NHI.

Mr Morewane emphasised that the UHC Day seminar was being closed with a sense of commitment but also recognising that it is time for action. Indeed, there is no short cut as the Minister said we need to ensure the system is prepared for the implementation of the NHI and this will include education and training of health care professionals, improving infrastructure in public facilities and all the building blocks essential for a resilient health system. He made a call to action on every sector and the whole of society to be active participants to achieving universal health coverage in our lifetime.

Annexure A: Program and Speaker Bios

PROGRAMME:
Universal Health Coverage Day 2023
"Health for All, Time for Action"

Programme Director: Prof. N Crisp

Time	Item	Presenter
08:30-09:00	Registration	
09:00-09:15	Welcome and introductions	Dr SSS Buthelezi, Director-General: NDOH
09:15-09:35	"A commitment to supporting Health for All"	Dr Owen Kaluwa, WHO Country Representative
09:35-10:15	Keynote address on Progress towards Universal Health Coverage	Dr JM Phaahla, MP Minister of Health South Africa
10:15-10:45	Tea break	
	Stakeholder inputs	
10:45-11:00	Health activist	Russel Rensburg
11:00-11:15	Civil Society	Steve Letsike
11:15-11:30	Organised Labour	NEHAWU/SAMUTA Representative
11:30-11:45	Health Professional Organisations	Dr Honours Mukhari
11:45-12:00	Health Professions Council of South Africa (HPCSA)	Dr Magome Masike
12:00-12:15	Council for Medical Schemes (CMS)	Dr Sipho Kabane
12:15-12:45	Panel discussion (includes all stakeholder input speakers and Prof. Nicolas Crisp)	Ramphelane Morewane, Panel Facilitator
13:00-14:00	Lunch	
14:00-14:30	Closure/Vote of thanks	Dr S Dhlomo, MP Deputy Minister of Health, South Africa

DR JOE PHAAHLA, MP
Minister of Health

Dr Phaahla was appointed as Minister of Health from 05 August 2021.

Academic Qualifications
Dr Joe Phaahla holds a Bachelor of Medicine and Bachelor of Surgery from the University of Natal, a Diploma in Health Service Management from the University of Haifa, Institute of Science, Israel in 1992, and a Certificate of General Management, Marketing and Finance.

Career/Positions/Memberships/Other Activities
Head of the ANC Presidency responsible for coordinating the office of the President, Deputy President and National Chairperson during election campaign from November 2008 to 30 April 2009. Elected to the National Executive Committee of the ANC in December 2007, Former Director-General 2010 FIFA World Cup Government Coordinating Unit 2005-2008 CEO of the S.A. Sports Commission which was the overall coordination and regulator of all Sports Federations from 2000-2005.
The Sports Commission paved the way for the current S.A. Sports Confederation and Olympic Committee - SASCOC. Member of Provincial Executive Committee of ANC in Limpopo Province 1991-2001, Before unbanning of ANC in 1990 served in leadership positions in various mass democratic movement structures including in the NEC of the United Democratic Front MEC Education, Sports and Culture in Limpopo Province 1997-2000. First MEC for Health and Social Development in Limpopo Province from 1994-1997, Qualified as a Medical Practitioner MBCHB 1983 University of Natal and practised in various hospitals in KZN, Gauteng, Mpumalanga and Limpopo till April 1994.

DR. SIBONGISENI DLOMO, MP
Deputy Minister of Health

Career/Positions/Memberships/Other Activities
Former Chairperson of the Portfolio Committee on Health, 2020-2021Former MEC for Health in KwaZulu-Natal from 2009 – 2019. Former Public Health lecturer at the University of KwaZulu-Natal

Academic Qualifications
Dr Sibongiseni Maxwell Dhlomo holds a Bachelor of Medicine and Bachelor of Surgery from the Dr MBCHB from the University of Natal Master's in Public Health (MPH) from Medunsa; a Diploma in Tropical Medicine and Hygiene from Wits University; a Diploma in HIV Management from College of Medicines SA; Diploma in Palliative Care from UCT; Diploma in Forensic Pathology from College of Medicine of South Africa; BA Degree from University of South Africa; Post Graduate Diploma in Business Management from the University of KwaZulu Natal; Diploma in Project Management from Damelin College.

DR SSS BUTHELEZI
DIRECTOR-GENERAL: HEALTH

Dr Buthelezi is a seasoned public health medical practitioner with more than 15 years experience in health governance, policy, and programme management. After serving as a clinician and later Medical Superintendent in various hospitals in KwaZulu-Natal and the Free State province, he served for 10 years as KwaZulu-Natal's provincial head of Strategic Health Programmes which encompassed HIV, TB, maternal child, and women's health, nutrition, and communicable diseases programmes. Before joining SANAC, Dr Buthelezi had been South Africa's Country Director for ICAP at Columbia University, which is a division of the New York-based Mailman School of Public Health since 2014. Before this, Dr Buthelezi worked as the Senior Technical Lead for the DFID-funded SARRAH programme which was implemented by Mott-McDonald supporting the health reforms in South Africa.

Amongst others, Dr Buthelezi has served in the following portfolios:

- Clinician – hospitals in KwaZulu-Natal and the Free State province
- Director – Programs for multi-country AIDS programme – ICAP at Columbia University
- Senior Technical Lead – DFID funded SARRAH programme which supported SA's health reforms
- Health Systems Management and Governance Specialist – Institute for Youth Development South Africa (IYDSA) and the
- Foundation for Professional Development (FPD)
- During his tenure as SANAC CEO, Dr Buthelezi served as the Chairperson of the Global Fund (CCM) Country Coordination Mechanism.

DR OWEN KALUWA
WHO REPRESENTATIVE, SOUTH Africa

Dr Owen Laws Kaluwa specialized in Epidemiology and Preventive Medicine from the Free University of Berlin in Germany. Before he was appointed as WHO Representative for South Africa, he was the WHO Representative for Ghana, WHO Representative for Swaziland, and Regional Adviser for HIV/AIDS for the Africa Region. Before joining WHO, Dr Kaluwa worked in his home country of Malawi as the Head of Research, Monitoring, and Evaluation of HIV/AIDS Programmes at the Ministry of Health, National Coordinator of HIV/AIDS Strategic Planning, and as Programme Director of the National AIDS Commission.

 **PROF. NICOLAS CRISP** **Deputy-Director-General: NHI**	Prof. Crisp, the Deputy Director General of National Health Insurance (NHI) in the National Department of Health has served as a Coordinator of the National Covid-19 Vaccination Programme and helped to establish the South African Health Products Regulatory Authority (SAHPRA), Acting CEO of National Health Laboratory Service (NHLS) in 2006/7 and Chair of the Board of the South African Institute for Medical Research (SAIMR), to manage the merger of all government health laboratories into a single National Health Laboratory Service as a parastatal entity in 2000. Head of the Limpopo Department of Health and Welfare in 1995/9. As a medical specialist, he is experienced in Health Systems and Management with a demonstrated history of working in the public health arena in several African countries, and skilled in Health Sector Reform, Human Resources for Health, Epidemiology, and Healthcare Information Technology (HIT), He holds a MBChB Medicine from University of Cape Town, MMed(CH) Public Health and Diploma in Occupational Health Occupational Health from the University of Witwatersrand.
 **MR RUSSELL RENSBURG** **Program Manager: Health Systems and Policy – RHAP**	Mr Russell Rensburg advocates for equitable access to healthcare for rural communities. His work includes managing RHAP's rural proofing programme which advocates for the equitable allocation of resources for rural health care delivery. Before joining RHAP, he worked with the UNAIDS-supported Technical Support Facility, managing technical assistance to 19 focus countries across Eastern and Southern Africa.

Mmapaseka "Steve" Letsike
SANAC Board Member

Steve is a human rights advocate. Steve is a prominent leader, with high-level international policy and human rights experience for over 15 years.

Currently, she serves as the South African National AIDS Council (SANAC) Co-Chairperson, a portfolio currently co-chairing with the Deputy President of the Republic of South Africa, mandated in her capacity as the chairperson of SANAC National Civil Society Forum. Furthermore, she is the Co-Chair of the National Task Team established by the Department of Justice to address Hate Crimes and GBV. She also Co-Chairs the Commonwealth Equality Network with over 53 Commonwealth country members. Furthermore, she serves as a member of the Global UN Women LGBTI reference group, the Southern Africa UN Women Civil Society Advisory Group, the Women4 Global Fund Network, as well as the Queerwell board, appointed by the Minister of Health on the Ministerial Advisory Committee on Social and Behavior aspects of COVID-19 response in South Africa including serving as a Councilor on the South African Pharmacy Council.

Dr Honours Mukhari

Dr Honours Mukhari is a medical doctor who qualified in MBCHB degree at the Medical University of Southern Africa (MEDUNSA)-now known as Sefako Makgatho Health Sciences University.
Dr Mukhari is currently registered for a Post Graduate Diploma in Health Economics student at the University of Cape Town.
He is serving as a director in different companies and currently serves as a council member of the Council for Medical Schemes (CMS).
Dr Mukhari is a community health activist with a special passion and commitment to the implementation of the National Health Insurance (NHI). He is a National Executive Committee (NEC) member of the Progressive Professionals Forum (PPF), where he is the National Convener for NHI. He is also a Chairperson of the Gauteng Provincial Health and Wellness Task Team, part of the PEC subcommittee of the ANC in Gauteng Province.
Dr Mukhari is of Christian faith and a member of the Evangelical Presbyterian Church in South Africa (EPCSA).

 **Dr Magome Masike** **Registrar, HPCSA**	Dr Magome Masike is a South African politician and businessman who served as the North West's Member of the Executive Council (MEC) for Health from November 2010 to December 2018, becoming the province's longest-serving Health MEC. Minister Joe Paahla appointed the former Northwest MEC Dr Masike as the CEO of the Health Professions Council of South Africa (HPCSA) in May 2023. His achievements as a leader in the healthcare industry include his leading role in the amalgamation of the Tshepong and Klerksdorp Public Hospitals. He holds an MBChB and a master's in Business Administration (MBA). He is also a candidate for a Doctor of Philosophy in Public Health.
 **Dr Sipho Kabane,** **Registrar & CE, Council of Medical Schemes**	Dr Sipho Kabane is the **Chief Executive Officer and Registrar** of the Council for Medical Schemes (CMS), which is a regulatory body for medical schemes in South Africa. He has been in this position since 2019, after acting in the position for a year. Dr Kabane has extensive experience as a senior health manager with an outstanding record in managing province-wide health service provision with a focus on quality, reform, and continuous improvement, including the management of diverse and multi-disciplinary teams; as well as the financial and operational aspects of health departments. He holds a Bachelor of Science degree majoring in Chemistry & Mathematics, minor in Biochemistry & Physics, obtained from the University of Fort Hare. He also obtained his MBChB from the then Medical University of South Africa (Medunsa); an MBA from Heriot - Watt University (Edinburg Business School) in the United Kingdom; a master's degree in Economic Policy from the University of Stellenbosch; and a PhD in Health Systems from the University of Pretoria.

Ramphelane Morewane
Acting Deputy Director-General: HIV/AIDS, TB and MCWH

Ramphelane Morewane holds the following Masters Degree in Development and Policy and Practice. He also holds the following other qualifications Post Graduate Diploma in Health Management, B Tech Business Management, and several post-graduate diplomas.

Ramphelane leads the national efforts towards the attainment of the UN Targets of 95-95-95 in HIV and AIDS. He has led the conceptualisation and implementation of the 100-health facilities project; He is also the leader in the implementation of the TB Recovery plan to trace and link the patients back to care. The leader in the implementation of the Maternal Clinical Guidance, Neonatal Health Guidelines, New guidelines for HIV Testing and Screening, etc. He has presided over several national and regional forums such as Incident Management Team for the COVID-19 pandemic; the SADC Malaria E8 Technical Committee, and the departmental lead in the United Nations Convention on Climate Change.

He was the co-author of several policies and strategic documents: Ideal Clinic Realisation and Maintenance Programme; The Role of Traditional Leadership in the Implementation of Health Programmes; District Health Services Policy Framework and Strategy; Ward Based PHC Outreach Teams Policy Framework and Strategy, Reengineering of Primary Health Care programme; National Health Adaptation Plan for Climate Change; National Strategic Plan for Non-Communicable Diseases; the Tobacco Products Amendment Bill; the Draft Framework for Social Determinants of Health among others. He was the leader of the workstream that wrote the section on the health system strengthening in the development of the National Health Insurance Bill. He has led the nationalisation of the Port Health Services, from the provinces.

Mr Morewane has been the champion of the District Health System for the past 15 years and has developed national district health planning tools.

Annexure B: Keynote Address by the Minister of Health, Dr JM Phaahla, MP

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
The Deputy Minister of Health, Dr Sibongiseni M Dhlomo, 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
Dr Magome Masike, the Registrar of the HPCSA
Dr Sipho Kabane, Registrar and CE of the CMS
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), which milestone 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 commentated on the contents and intentions of the Bill. Congratulations and thank you to every person who has participate 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 part to reform which is aimed at true UHC.

Once the President has assented to the 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 2023 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 MTSF 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 MTSF 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 MTSF 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 MMR reporting, as adult mortality

and institutional MMR 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.
>
> **Second**, 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%).
>
> **Third**, 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 rather 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 R542bn on health care in 2022. We did this through R265bn 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 R277bn 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 52,8m people and the private schemes purchased care from private providers for the remaining 9,2m 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 R5200 per person public spend as opposed to R27000 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' (R265bn 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 R30bn 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 R400bn (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 to 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 anticpate 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 reallocated 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 9,2m 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 R37bn 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 time 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.

DR JM PHAALHA, MP
MINISTER OF HEALTH
SOUTH AFRICA.