2021 – Likely another year of promises lacking delivery – Dr Johann Serfontein

2020 turned into one of the largest challenges ever for the South African healthcare profession and almost every other individual living in the country. Very few people would have thought that the presence of a pandemic would have such a large impact on the ability to render normal healthcare services, or to run a financially sustainable private practice. At an industry level, the large shortcomings of government policy on a number of aspects affecting healthcare were also highlighted, and the way government responded to the pandemic raised serious concerns with future policy plans such as NHI.

Vaccines

While 2020 was the year of COVID-19, 2021 was supposed to be the year of the vaccine. In the South African environment, this looks unlikely. Government has promised that healthcare professionals would be vaccinated by February, but already the regulatory timelines involved in registering the drug makes that timeframe impossible. The fact that government indicated that they have been in talks with AstraZeneca for 6 months about providing vaccines, when AstraZeneca themselves indicated they do not have distribution rights for their own drug in SA, is a clear indication of the less-than-truthful approach taken towards providing transparent information on providing vaccines to the South African populace. These distribution rights lie with the Serum Institute of India (SII), who will be supplying the 1.5 million vaccine doses for South African healthcare professionals. With all current vaccines being two dose regimens, the 1.5 million vaccines will only vaccinate 750 000 healthcare professionals, or alternatively an additional 1.5 million doses would need to be acquired to cover this population. Practically, healthcare professionals should not bargain on a vaccine before June.

Corruption

The second issue highlighted by the COVID pandemic, was the rampant corruption present in government supply chain structures. The Special Investigation Unit (SIU) review of billions of rands in PPE tenders has shown that the supply chain practices are rotten to the core and one has to wonder how much money has been lost to corruption in the normal day-to-day procurement of supplies for the various provincial Departments of Health. It also raises the question about where exactly the NHI fund is going to find government officials with supply chain experience, and without an existing patronage network, to be employed in the supply chain of the NHI, who will be involved in purchasing all healthcare services and consumables, medicines and products for the entire country. Indicating that the NHI fund will have measures in place to prevent corruption, simply does not instil confidence, as presumably all government departments already have measures in place to prevent corruption. Surely, a good start to instilling such confidence would be to apply such existing measures in the current system to put an end to corruption. It seems our approach is to throw our hands in the air, scrap the current system and start afresh, hoping that the self-same individuals involved in the service chain would magically cease being corrupt.

NHI

The COVID pandemic has also shown the horrid state of provincial healthcare at a facility level. This will simply not be fixed by the introduction of NHI, as facilities in such a torrid state would not qualify to contract with NHI. Hospitals need to be fixed before NHI is implemented, not assuming that NHI itself will fix them. That is not how NHI ostensibly functions. NHI does not run hospitals, it simply contracts with them. The hospital needs to qualify to contract with NHI by being of sufficient quality before this contracting process can happen. It is also important to note that one does not need to implement NHI for that either. Poor facility quality can be addressed through the use of qualified and competent management. However, that would require labour union buy-in to get rid of incompetent managers, who happen to be paying members of such unions. An unlikely scenario.

The government is also still side-stepping pronouncements on the cost of NHI. In a scenario where South Africa has a budget deficit of R700 billion for the year, finding money for a tax funded NHI is going to prove impossible. One cannot continue with the rhetoric of saying “we cannot afford not to implement NHI” whenever asked of the costs.

The simplest calculation to do is to expand current public sector services to the entire population and finding out what that would cost. The NHI cannot render less services than are currently available in the state, as that would not be progressive realisation of access to healthcare, and therefore unconstitutional. Much like the Irish attempt to implement NHI, our government is well aware that NHI is unaffordable. But unlike Ireland, our government has not scrapped it to start looking at alternative ways to achieve Universal Health Coverage (UHC). Such a step is simply too ideologically unpalatable to those in power. It seems they would rather continue on a trajectory of promises without delivery and accountability.

Section 59 investigation

The regulatory year has already started with a court case, with GEMS and the BHF challenging the publication of the Section 59 investigation interim report into forensic clawbacks. The report apparently has some scathing findings regarding racial profiling in the medical scheme forensic processes in a number of schemes. Looking at the demographics of those appearing in HPCSA judgements for the last couple of years, which are published on the HPCSA website annually, it also appears that the problem is not isolated to medical schemes but may extend elsewhere. Time will tell how the industry will respond to this challenge and how it will ultimately be resolved into a fair and transparent process. Senior CMS management posts remain unfilled since April 2020, adding to the challenge of an effective medical scheme regulatory environment.

While one has hoped that the South Africa healthcare industry would reach a point of policy certainty, which is something healthcare professionals crave, it does not appear that 2021 will be the year for that to happen. Meanwhile, there are increasing numbers of healthcare professionals emigrating to countries that have such policy certainty, alongside positive socio-economic environments. One has to hope there are enough professionals left to render services in a UHC environment, once a practically implementable, non-tax funded, multi-payer model is finally conceded to by government. I wish everyone the best of luck for 2021, we will certainly need it.

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