Discovery Health Medical Scheme

Discovery Health

Discovery Comments on the National Health Insurance Bill

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SECTION 1: THE PRINCIPLES OF A NATIONAL HEALTH INSURANCE SYSTEM

1. INTRODUCTION

These comments are jointly submitted by Discovery Health Medical Scheme and Discovery Health (Pty) Ltd, hereafter collectively referred to as "Discovery".

Discovery strongly supports the objectives of transforming the national health system in order to achieve the goal of universally accessible, high quality, affordable health care for all South Africans. We are supportive of the following key principles and objectives for universal health coverage (UHC) in South Africa as set out in the NHI policy framework:

- Universal access and moving toward greater equality in access to healthcare.
- Moving towards patient–centred care by addressing population needs and improving service delivery mechanisms.
- Striving for better efficiency and effectiveness of all components of the South African health system, including the public and private health sectors and the interface between them.
- Improved local governance and accountability.
- Establishment of regulatory bodies and other mechanisms to encourage and monitor quality of care.
- Reducing the reliance on fee-for-service, and utilising alternative reimbursement methods.
- Risk pooling on social solidarity principles.

The National Health Insurance Bill, 2018 ("NHI Bill") is largely focused on the establishment of the NHI Fund and how it will function, but provides limited detail on the service benefit package. There are many countries worldwide that are reforming their health systems towards achieving UHC. Experience shows that each UHC reform programme involves several components, that each component requires careful policy choices, and that the quality of implementation of the individual components matters significantly to the final outcome.[1]

This document considers various elements of the proposed NHI framework and makes suggestions and recommendations about strengthening the envisaged system. This document is accompanied by detailed commentary on the NHI Bill, which includes some recommendations.

[1] Cotlear D, Nagpal S, Smith O, Tandon A and Cortez R, Going Universal: How 24 developing countries are implementing universal health coverage reforms from the bottom up. World Bank Group Ref 99455.

It is noteworthy that this Bill was released prior to the completion of the assessment report on Phase 1 of the transition towards NHI, and prior to the release of the provisional Health Market Inquiry (HMI) report. In addition, the NHI Bill was released at the same time as the Medical Schemes Amendment Bill which is also heavily impacted by the provisional HMI report. The HMI has made a number of recommendations which will affect efficiencies in the delivery of healthcare and hence there is an opportunity to align the regulatory framework with these recommendations and also to ensure that medical schemes and the NHI Fund are coordinated in achieving UHC.

A commentary on the socio-economic impact assessment system (SEIAS) report also accompanies this document, as Annexure B.

Both the NHI Bill and the Medical Schemes Amendment Bill (MSAB) have been released without an accompanying Explanatory Memorandum, which makes it difficult to assess what the intentions were behind a number of clauses in the Bills.

2. THE SINGLE PAYER NHI MODEL

While the NHI Bill is based on the model of a single public purchaser it is not clear whether this is an update to the model set out in the White Paper of centralised purchasing through a single fund as the most suitable model for South Africa. The single fund model based on assumptions of economies of scale and monopsony buying power, however no adequate justification for selecting this model has ever been provided in the process leading up to the publication of the NHI Bill, neither in the Green and White Papers nor in the SEIAS. The single fund model does not take into account the numerous realities of South Africa's economy. Nor does it take into account the current health system structure - which includes an existing publicly funded and owned healthcare system modelled on the UK NHS, which already provides a basic form of UHC, and a parallel well-organized and well-functioning multi-payer medical scheme system. Given this existing system, it is almost certain that a multi-payer model, which incorporates the best elements of both current systems, would be less disruptive and more effective than an effort to develop an entirely new single-payer NHI model to replace the existing systems.

Not only does the single fund approach ignore the reality of our current healthcare system, but it is also has significant implementation risks which have not been addressed in the policy process leading up to publication of the NHI Bill. It is also critical to note that the most fundamental challenges to the current achievement of UHC in our country are due to the failure of our current publicly funded healthcare system to deliver adequate services to those who depend on it. There is no evidence to suggest that the imposition of an entirely new single payer financing mechanism will address the fundamental problems plaguing public sector healthcare delivery. While there is no doubt that both the public and private healthcare systems suffer from significant structural weaknesses, which must be addressed, and that access to healthcare in our country is grossly inequitable, it is far from clear that imposing a new, single-payer NHI model is the most effective way to address these issues.

One of the significant arguments put forward by proponents of the single payer approach is that this is the only method of achieving risk pooling for the whole population. Risk pooling is clearly an essential part of creating a robust health financing system, and it is critical in a society of with high levels of inequality. Health system efficiency and stability are dependent on pooled resources for health. In South Africa it is estimated (Lancet, April 2018) that about 40% of the gain in the UHC Index could come from pooled resources per capita, while the remaining gains would come from changing the context and efficiency of the system.

However, neither the White Paper nor the Bill have shown why risk pooling cannot be achieved on a virtual basis, with an NHI Fund and medical schemes all offering cover for the NHI benefits. Not only is this approach likely to be more effective, but it is also far less risky than a single fund approach.

In conclusion, there is no clear evidence that the single-payer NHI model will address the most pressing challenges to achieving UHC, and given the massive re-organisation of both public and private financing required, this approach is fraught with risks. Nor has the alternative approach, of using a multi-payer model with virtual risk pooling, been adequately canvassed and debated. In our view, a virtual risk pooling approach is fully compatible with the NHI White Paper, and the objectives of the NHI Bill, and will also pose far less systemic and political risk to the successful implementation of the NHI system.

These issues were fully canvassed in the High Level Panel on the Assessment of Key Legislation and the Acceleration of Fundamental Change, led by former President Motlanthe, whose final report included reference to an alternative approach to achieving NHI through a Hybrid Model. This Hybrid Model could address all the key constitutional imperatives of access to care, social solidarity and equity by leveraging existing health system assets though the implementation of a single mandatory package with national virtual pooling across a combination of three funding pools: a new NHI Fund for the unemployed and indigent, a consolidated public sector medical scheme, and accredited private sector medical schemes for the formally employed outside the civil service.
The relevant sections of the Report of the High Level Panel on the Assessment of Key Legislation are included as Annexure A.

3. THE ROLE OF MEDICAL SCHEMES IN SOUTH AFRICA'S UHC SYSTEM

Public and private coverage

It is important for discussions around the public and private healthcare sectors in South Africa to be in the context that there are significant overlaps in utilisation and it is not accurate to state that only medical scheme members are using private sector services.

The 2017 General Household Survey report published by Statistics South Africa reports that about seven in every ten households reported that they made use of public clinics, hospitals or other public institutions as their first point of access when household members fell ill or got injured. By comparison, a just over a quarter (27.4%) of households indicated that they would go to private

doctors, private clinics or hospitals. Nearly a quarter (23.3%) of South African households had at least one member who belonged to a medical aid scheme. However, only 16.9% of individuals in South Africa belonged to a medical aid scheme in 2017.

Another calculation is from the *National Income Dynamics Study*, conducted in 2014 by the Southern Africa Labour and Development Research Unit at the University of Cape Town. It surveyed a nationally representative sample of more than 28 000 individuals in 7 300 households. The study found that 41.5% of the respondents went to see someone in the private healthcare sector at their last visit.

The paper *Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge?* (by Di McIntyre and John Ataguba) prepared for the High Level Panel on the Assessment of key Legislation and the Acceleration of Fundamental Change highlights the high levels of inequality in healthcare access in South Africa but also notes that while 70% of utilisation by the highest quintile of the population occurs in the private sector, around 20% of utilisation in the lowest quintile also occurs in the private sector.

Thus, while it is true that the majority of South Africans do not benefit from private healthcare, it is misleading to equate medical scheme coverage – or the lack thereof – with the exclusive use of a particular healthcare sector. This is an important consideration in the reorganization of the public and private systems and in assessing the implications in terms of financial and human resources.

International experience

The vast majority of current UHC systems across both emerging and developed economies allow their citizens the option of purchasing both parallel and complementary private cover in addition to their participation in the country's UHC system[2]. This includes UHC systems structured as an NHI (defined as systems financed via explicit health insurance contributions) and those structured as a National Health System (NHS) (defined as systems financed by allocations from the fiscus).

The proposed amendments to Section 34 of the Medical Schemes Act allow the Registrar (in consultation with the Minister) to limit the benefits that medical schemes may offer with reference to the NHI Fund.

The implications of this provision are impossible to assess without much greater clarity on the details of the NHI benefit package, and without clear definitions of the terms "duplicative costs" for the "same benefits".

In addition, this provision is inconsistent with the draft NHI Bill (paragraph 10(2)(c) and paragraph 12(2)(b)), and with the definition of a beneficiary in the MSAB, both of which provide for medical scheme cover to co-exist with the NHI Fund. In particular, the NHI Bill makes it very clear that citizens

[2] Colombo F and Tapay N., Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems, OECD Health Working Papers, 2004

will only be able to claim benefits from the NHI if they adhere to the NHI's referral pathways, and that if they fail to comply with these referral pathways, they will not be funded by the NHI, but that they can cover these services through voluntary health insurance. If citizens can opt not to use the NHI's referral pathways, and hence cannot claim from the NHI, how can it be justifiable to restrict the ability of citizens to purchase cover for these services from a medical scheme, and to restrict the ability of schemes to cover these services? This provision also conflicts with the Minister of Health's public policy statements that medical schemes will continue to exist alongside the NHI, since medical schemes whose benefits may be reduced at the whim of the Registrar (albeit in consultation with the Minister) will be at risk of losing their relevance at any time.

This provision further conflicts with the freedom of citizens to purchase voluntary private medical scheme cover, once they have already contributed to the NHI fund. It is not clear what harm can arise from individuals purchasing medical scheme cover over and above their NHI contribution. In fact, such additional medical scheme cover will reduce the pressure on NHI services, since several million South Africans are likely to retain their medical scheme cover. This will therefore reduce the burden on the NHI Fund and will improve its capacity to serve the most vulnerable communities and patients who will depend on it.

There is also no precedent for countries that have prohibited the purchase of voluntary health insurance in the context of NHI or other systems of universal health coverage. The vast majority of current Universal Health Coverage ("UHC") systems allow citizens the option of purchasing both parallel and complementary private cover[3].

The UK for example, has a National Health System ("NHS"), and by definition all citizens contribute to the NHS through their tax payments. However, UK citizens are also allowed to purchase private medical insurance to cover services already provided by the NHS. 11% of the UK citizens choose to purchase such insurance. This approach protects the rights of citizens to exercise freedom of choice, while still obliging them to contribute to the NHS, to which they retain access at any time. This also relieves the NHS of some burden of care, since a meaningful proportion of the population self-funds its own care.

The co-existence of parallel and complementary private health insurance alongside publically funded NHI or NHS systems provides clear evidence that such approaches do not harm or undermine the publically funded systems. In fact, many governments encourage citizens to purchase private health insurance in order to relieve the burden on the publicly funded system.

[3] Colombo F and Tapay N., Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems, OECD Health Working Papers, 2004

In Australia, the government provides a rebate of up to 35.7%[4] on income tax, to encourage citizens to purchase private health insurance, and 56%[5] of Australian citizens take out such cover.

In Brazil, the national public health system, the Unified Health System ("SUS"), is tax funded, co-existing with a parallel private sector. This system allows for greater cross-subsidisation from rich to poor, as resources within the SUS are targeted towards those unable to afford to opt out the public system. However, since the SUS is plagued by long waiting lists and poor access to care, private insurance is a necessary component of the healthcare system giving Brazilians greater freedom of choice and access to care. It was estimated in 2013 that approximately 25% of the population had private health insurance.

Similarly, in China, the national and provincial governments are rolling out progressively expanding Social Health Insurance ("SHI") cover for all citizens, but at the same time, actively encouraging the development of private health insurance both as a top up to the SHI, but also to provide full replacement cover where citizens elect to do so.

There are examples of health systems where the role of voluntary health insurance is limited to complementary cover, but these tend to be as a consequence of the design of the public system, and not due to legislative prohibitions. Examples include the Netherlands and France, where the NHI systems offer the world's most extensive benefits and accessibility, as well as patient choice in selecting healthcare providers; and where private insurance companies act as the funders of the mandatory insurance package, leading to competition between these insurers based on quality of service and provision of additional benefits.

In terms of the rights of individuals to purchase additional cover if they choose to, the only country in the world that has attempted to restrict it citizens' rights to in this regard is Canada, where provincial legislation was promulgated by the government of Quebec province to prohibit citizens from having private health insurance in respect of medical and health services that are already insured by the State. The lawfulness of this legislation was tested in the Supreme Court of Canada in *Chaoulli v Quebec*[6] ("*Chaoulli*"). The decision of the Court was to overturn the prohibition of private medical insurance in Quebec.

For all of these reasons, we firmly recommend that medical schemes be allowed to continue offering parallel, as opposed to "complementary" cover to the NHI, and that once citizens have contributed to the NHI, they should remain free to elect to purchase additional medical scheme cover. This requires that Section 9(o) of the Bill is amended to remove the word "complementary" in reference to medical scheme cover.

[4] www.privatehealth.gov.au

[5] www.privatehealthcareaustralia.org.au

[6] *Chaoulli v Quebec (Attorney General)* [2005] 1 S.C.R. 791, 2005 SCC 35.

The National Development Plan ("NDP") considers a combination of public and private insurance to achieve UHC (Chapter 10 pages 342 to 344). In the South African context, allowing citizens to purchase medical scheme cover will support, rather than undermine the proposed NHI. It will mean that there will be a portion of the population that will be contributing to the NHI, but will use only some of its services, thus freeing up significant additional resources to serve those who cannot afford to purchase medical scheme cover. This is consistent with the policy objective of allowing those with the means to provide for themselves and this is consistent with Section 26(2) of the Constitution per the *Grootboom* judgement[7].

A model similar to the above has been proposed by the High Level Panel on the Assessment of Key Legislation and the Acceleration of Fundamental Change in November 2017[8]. This proposal is captured in Annexure A of these comments.

The proposed amendment to the Section 34 of the Medical Schemes Act in the MSAB should therefore be removed, and the Act should make it clear that citizens are free to purchase duplicative medical scheme cover in addition to their membership of the NHI Fund.

The NHI Bill requires a similar amendment of section 9(0) on "Rights of Users" in order to preserve this important choice that should remain available to all citizens, as is currently the case. The provision should be amended to state that users retain the right to purchase any health service benefits through a voluntary medical insurance scheme, any other private health insurance scheme or out of pocket payments, as the case may be.

For all of the reasons described in Section 1(3), Discovery recommends that medical schemes be allowed to continue offering parallel cover to the NHI, and that once citizens have contributed to the NHI, they should remain free to elect to purchase additional medical scheme cover. It will mean that there will be a portion of the population that will be contributing to the NHI, but will use only some of its services, thus freeing up significant additional resources to serve those who cannot afford to purchase medical scheme cover. This is consistent with the policy objective of allowing those with the means to provide for themselves and this is consistent with Section 26(2) of the Constitution per the *Grootboom* judgement[9].

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7 *Government of the Republic of South Africa and Others v Grootboom and Others* [2000] ZACC 19, 2001 (1) SA 46 (CC), 2000 (11) BCLR 1169 (CC), Constitutional Court

8 https://www.parliament.gov.za/high-level-panel

9 *Government of the Republic of South Africa and Others v Grootboom and Others* [2000] ZACC 19, 2001 (1) SA 46 (CC), 2000 (11) BCLR 1169 (CC), Constitutional Court

Should a user prefer to have more flexible access to any level of care, the right to purchase cover that provides for such access must not be limited. It should be noted that since an individual cannot opt out of the NHI Fund there is a benefit to the Fund if they choose to fund their own healthcare requirements.

In our view, it is critical that the final NHI Bill should take into account the important role played by medical schemes in providing cover to part of the country's population. It should therefore clearly acknowledge the ongoing role of medical schemes within the UHC system, and should ensure that schemes are able to provide both parallel and complimentary cover to those offered within the NHI system itself.

4. FINANCING

The NHI Bill does not address the extremely complex issues regarding consolidation of all current health financing flows into the proposed NHI Fund. Under the current system of provincial allocations, over 87% of national health expenditure flows to provinces. These flows are not addressed at all in the NHI Bill. The NHI Bill is also silent on how the health population needs as determined by the contracting units (CUPCs) will be consolidated into the budget prioritisation process to inform the fiscal allocations by National Treasury. The NHI Bill only requires the Benefits Advisory Committee to recommend the NHI benefit package on the basis of available resources.

The provisional report of the Health Market Inquiry includes the analysis that the tax expenditure subsidy per capita in 2013/14 was R2 517 compared to the per capita public health allocation of R3 052[10]. This means that it would be a greater fiscal cost to cover medical scheme members in the public sector than to encourage them to remain on medical scheme cover. This difference will have increased subsequently due to the lower rate of escalation in the tax expenditure subsidy and the higher levels of medical cost inflation. This highlights the importance of the health policy objective of encouraging those who can afford it to provide for themselves (while still contributing to the fiscus through taxes).

It is not possible to comment fully on the financing approach, nor its sustainability, without substantially more information than is contained in the Bill. Although there is international concurrence that costing the NHI benefit package will have little impact on resource allocation decisions; there is also consensus that the unfortunate consequence of avoiding a costing projection is that benefits are not made explicit to the public, nor does it become clear what the realisation of UHC will actually look like.

[10] Table 3.1 on page 36 of the Provisional Report of the Health Market Inquiry published in July 2018

5. SUPPLY OF HEALTHCARE SERVICES AND PROFESSIONALS

The WHO provides a useful framework for evaluating health systems, which comprises six separate but interrelated building blocks:

i. Service delivery
ii. Health workforce
iii. Information
iv. Medical products, vaccines and technologies
v. Financing
vi. Leadership/governance

However, the NHI Bill focuses only on financing and the governance of the Fund, and provides no detail on these other vital issues.

In particular, the NHI Bill does not appear to recognise the numerous and serious current limitations in the supply of healthcare providers in South Africa, and simply assumes that the creation of a single payer NHI Fund will somehow address these major issues. The problems in delivery of accessible, adequate healthcare services for the majority of the population are well known and well documented. While financing and purchasing are essential elements of reform towards UHC, there is a material risk that the situation will become worse, rather than better, if most if not all, of government's focus in the next decades is dedicated to the development of a vast new financing infrastructure, rather than the improvement of the current delivery system.

The Bill is severely lacking in details on the development of a truly effective strategic purchasing function. Some of the key deficiencies include:

- A key dimension of the strategic purchasing function is the ability to collect quality data and to ensure value purchasing in order to improve the quality of services available to all NHI beneficiaries. Although the Bill refers to collecting servicing data from providers, it is not explicit about the interim remedies available to the Fund to avoid poor quality care, what institutional arrangements there will be to ensure quality improvements, and how such improvements will be funded. The NHI Bill should specify the institutional and accountability mechanisms for ensuring good quality of healthcare.

- The Bill envisages that providers will have to meet defined quality standards, and that it will not contract with those providers who do not meet the required standards. However, the Bill does not indicate how shortfalls in delivery capacity will be dealt with should many providers fail to meet quality standards (as would surely be the case at present).

- The Bill provides no enabling legislation for the establishment of supply side regulation to improve the efficiency of healthcare delivery. The provisional HMI report made many recommendations along these lines, and these should be taken into account and included in the final NHI Bill.

- The NHI Bill also fails to address the current severe shortages of healthcare professionals which is a key contributor to the problems in healthcare delivery. While financing reforms are critical for UHC, they are not enough to deliver high-quality health care services ([1]Cotlear et al). The health care delivery system has to be able to deliver the needed health care services in the right location in an affordable way as coverage expands.

- It is critical to assure healthcare providers the regulatory space to voluntarily participate in NHI. This means that the combined regulatory impact of licencing, certification of need, accreditation and NHI Fund price regulation for NHI benefits should not result in the adverse unintended consequence of forcing doctors to opt out of the system.

The current dire shortage and maldistribution of health human resources is captured in the District Health Barometer, 2017 and in a 2018 BHF report[11]. Although HR is not a direct responsibility of the NHIF, there is an opportunity for the NHIF to intervene in growing the national HR for health capacity. This includes addressing the training resources and ensuring adequate capacity to meet future needs.

One suggestion would be for the NHIF to have the regulatory flexibility to invest in modernised, innovative training platforms for healthcare providers and to engage with the private sector in this regard.

Further regulatory change is required for primary care doctors and other health professionals to be allowed to work together in multi-disciplinary primary care teams. This needs to be supported through the incorporation of such team work in health professional training. It also requires extensive revision of the HPCSA regulations as recommended by the HMI. Failure to make these changes poses a material risk that the NHI will not be able to delivery services at the level and quality required.

It is also important to note that the National Development Plan recommends that the health system should produce more and better trained health professionals, who are distributed more equitably (Chp 10, pg 334 & 337). It is also recommended that meaningful public-private partnerships are developed.

The HMI found evidence of supplier induced demand (SID) in the private healthcare market, and proposed that funders should be managing this more effectively. The NHI Fund should acknowledge the potential for SID, and insert an additional duty on the Fund to manage this.

The risk management function of the Fund should explicitly consider the risks to HR supply for the NHI if remuneration and other contracting conditions change. It must be noted that the supply and availability of healthcare professionals is a national asset which could have system-wide ramifications if not managed appropriately.

[11] The provision of healthcare resources in South Africa: An analysis of healthcare professional providers registered on the Practice Code Numbering System. Board of Healthcare Funders, 2018

6. BENEFIT DESIGN AND DETERMINATION

Defining the package of benefits available to contributors is one of the most fundamental aspects of any NHI system. However, the NHI Bill provides very limited detail on the nature of the NHI Benefit package. Global best practice suggests that this is a critical function which must be independent and fully transparent, with a high degree of public participation in order to ensure a rational NHI that is supported by the population. It has been shown that public support grows if UHC starts by providing high-priority services to all beneficiaries so that the entire population benefits.

Additionally, there is evidence that restricting the initial UHC package to a narrower set of conditions can reduce the number of avertible deaths as quality is improved through targeted interventions. [12]

This vagueness on benefit determination hampers the process of public consultation as it is not possible to comment on institutional arrangements without a clearer understanding of what the proposed NHI will actually cover and what services citizens will have access to. In addition, in the absence of a clear definition of the benefit package and the process for determining it, it is impossible to assess the costs of the proposed system and this lack of clarity on costs makes meaningful public debate very difficult and essentially meaningless.

One specific aspect of benefits that requires more explicit focus is coverage of wellness and preventative measures, as well as intersectoral strategies to reduce preventable health needs. One example could be to champion a strategy to reduce injury, accidents and trauma. The NDP recommends the implementation of stronger prevention measures and the establishment of greater inter-sectoral and inter-ministerial collaboration (Chp 10, pg 335).

7. DEMAND MANAGEMENT & RATIONING

The NHI Bill also makes no mention of the benefit prioritisation process, which is absolutely critical in a resource-constrained setting. A clear and transparent prioritisation framework must be applied in order to optimise the use of limited resources, such as the current prioritisation of maternal and child health services.

The NHI Fund should develop a rationing framework for public comment. This will allow citizens to choose between being subject to the NHI rationing constraints, or accessing the needed care through private means; a common option in other UHC systems, as noted above.

The Contracting Unit for Primary Health Care (CUPC) is tasked with identifying healthcare needs in each sub-district. The function of actually managing demand is however not allocated anywhere, yet this remains a critical element of servicing healthcare needs. Segmentation of local populations by health need would enable better allocative efficiency. This should be part of the NHIF functions.

8. STRUCTURAL ARRANGEMENTS

Many of the functions that the NHI Bill allocates to the Fund are currently performed elsewhere, and neither the White Papers, the Bill or the SEIAS provide any detail on what will happen to the current institutions and their employees (for example, the provincial health administrations), nor is there any detail at all on the critical transitional arrangements. It is also not clear which institutions will be retained, which will merge with the NHIF, and which will be phased out. There is also no detail at all on the skills mix that the NHI Fund will require, nor does it appear that any research has been done on whether these skills are available in sufficient quantities. A simple extrapolation from Discovery Health's workforce would suggest that a fully functional NHI Fund operation would require approximately 69,000 employees to manage all aspects of a fully functional NHI for the entire population. The absence of any analysis of what resources are required and how these will be recruited, trained and retained, and their likely costs, clearly indicates that no real feasibility assessment of the NHI has or can be done at this stage.

The NDP emphasizes the importance of meaningful public-private partnerships, which is not limited to contracting for services with the private sector (Chp 10, pg 336). The NHI Bill however entirely ignores this important opportunity for strengthening the capacity of the NHI Fund in both delivery and management.

The capacity of the District Health Management Office must be realistically assessed by establishing clear criteria for effective capacity to be evaluated externally before the Office is accredited to function in the role envisaged in the NHI Bill.

A similar evaluation should be done for the CUPC - to establish the effective capacity at this level, and to confirm whether it has the requisite skills and systems to purchase healthcare, before the Contracting Unit is accredited to function in the role envisaged in the NHI Bill. We recommend that the transitional arrangements should be clearly set out to capture the criteria for the evaluation of these units into fully credible purchasing entities.

9. ACCOUNTABILITY

An important consideration for ensuring system credibility is much clearer definition of roles and competencies for each component of the NHI system, together with effective accountability measures that include community accountability. Even if these criteria are to be defined in future regulations, it is imperative that the Bill enables the NHIF to define accountability criteria for itself and for related structures.

The World Bank[1] conceptualises accountability as a relationship between actors that has five themes: delegation, finance, performance, information about performance, and enforceability. In the NHI Bill, the principal in this relationship is the Minister of Heath while the NHI Fund is the agent.

The strongest accountability happens when all five of the above relationships are working well, but at the heart of these relationships is performance. Ultimately the key relationship of accountability is between policy makers, providers and citizens, and performance drives this relationship.

Provider autonomy has been identified as a key mechanism to ensure system accountability and responsiveness. The extent of this autonomy is not captured in the NHI Bill, although the NHI White Paper refers to increasing autonomy for central hospitals only. Decentralization of powers to district level structures may be a positive move towards ensuring accountability, provided these structures have adequate capacity.

In Chile, the establishment of AUGE not only made the benefit package explicit, it also provided guarantees for waiting times, clinical pathways and drug availability. In Argentina, annual performance agreements between national and provincial governments form a strong part of the accountability mechanism.

Other examples are Brazil and China where specific responsibilities, programme indicators and targets are captured in explicit performance agreements.

For many UHC programmes, financing accountability entails a shift from input-based financing to output and results-based approaches. Provider payment and provider autonomy must be closely linked in order to drive system improvements.

Verifiable targets should include the following criteria, which would help to strengthen the NHI Bill:

- Better access
- Quality healthcare and reduced amenable mortality
- Improved affordability
- Improved health outcomes
- Increased productivity
- More economically active years
- Poor to benefit the most

The NDP cautions against centralised control due to lack of accountability at local level (Chp 10, pg 332). It also cautions against a blurring of accountability lines due to Ministerial prerogative on key appointments for statutory bodies in the health sector (pg 411).

The HMI strongly cautions against a lack of transparency and accountability to medical scheme members, which may be extrapolated to include all citizens who have health insurance. The HMI recommends that there be targeted system incentives to protect transparency and ensure that citizens know what they are entitled to and how to hold funding structures accountable.

Overall health system accountability expressed as quality of healthcare measures must form a key aspect of phase progression as NHI is implemented.

10. PHASED IMPLEMENTATION

The phased implementation approach is prudent and welcome, although current economic and system performance constraints strongly suggest that the current timetable may be too ambitious.

Given the magnitude and complexity of the reforms planned, it is advisable to have parliamentary and/or judicial oversight of the reform process in order to protect the right to healthcare (similar to the oversight process established for the SASSA migration from CPS). The Inter-Ministerial Committee for NHI as established by the President in August 2018 may fulfil this role.

Neither the policy documents nor the NHI Bill establish what system changes will indicate that the reform process is ready to move into the next phase. While time targets are useful, these are wholly insufficient and inappropriate to indicate system readiness to progress into a more advanced phase. In our view, it is critical that there are clear processes of evaluation of the current phase prior to initiation of the next phase. In the absence of this rational approach, the entire system will be at risk if a new phase is initiated prior to clear evidence that the prior phase has been successfully implemented. This is a basic requirement of effective planning and implementation and provisions along these lines should be included in the NHI Bill.

One of the key constraints on the expansion of funding to the NHI will be the ability of the fiscus to afford additional allocations to the health budget. The NHI Bill is however silent on the role of affordability on the planned roll-out. Affordability should be included as a key component of any plans to launch planned expansion phases of the NHI.

Phase 1 (2012 to 2017) entailed health system strengthening initiatives. A comprehensive report evaluating the impact, successes and failures of Phase 1 should be provided, and there should be a direct relationship between what has been achieved in Phase 1 and what will be rolled out nationwide in Phase 2. There should be distinct opportunities for public comment as each phase is evaluated and the next phase is planned. This implies affording the public an opportunity to comment on phase 2 plans once the evaluation report on Phase 1 is released. A similar exercise will be necessary before transitioning to Phase 3.

We recommend that the Office of Health Standards Compliance (OHSC) forms part of the team that assesses whether facilities are ready to participate in rendering NHI services. We understand that the OHSC currently has resource challenges and these need to be urgently addressed to ensure that it can play the pivotal role envisaged in the Bill. These serious capacity limitations affect other regulatory bodies such as the South African Health Products Regulatory Authority (SAHPRA), ultimately compromising access to quality healthcare. The confirmation of adequate capacity in these structures must form part of the evaluation process.

A related and essential assessment for Phase 1 is to assess whether the financial and managerial competence of District Management Offices is sufficient to play the role allocated to them in the NHI Bill.

The NHI Bill has the following clause: *This Act does not in any way amend, change or affect the funding and functions of organs of state in respect of health services until legislation contemplated in sections 77 and 214, read with section 227, of the Constitution and any other relevant legislation have been enacted.*

These fundamental changes to current legislation will determine the funding flows of the NHI, yet it is not clear when these will be effected, nor has any impact assessment been carried out on the potential risks that may arise from the proposed changes in financing flows. The Phase 2 plan should include these changes with clear timelines and interim steps.

There are further references to legislation that will be changed during Phase 2 on pages 65 and page 67 onwards. It is important that the proposed changes are executed in accordance with universally accepted Principles for Good Regulation[12], namely:

- Regulations should have clarity of purpose, and serve clearly identified policy goals.
- Regulations should be proportionate, in that they are appropriate to the risk posed.
- Regulations should be effective and efficient.
- Regulation need to be consistent, certain and predictable.
- Regulations should be adaptable / flexible.
- The development, implementation and enforcement of regulations should be transparent.
- Regulations should have a sound legal and empirical basis and should be reviewed regularly.
- Regulations and regulatory decisions should be impartial.
- Regulators should be fit for purpose.
- Regulators should be accountable.

Phase 2 (2017 to 2022) requires the establishment of four Ministerial Committees which will ensure the following:

- Planned migration of central hospitals
- Structuring of the Contracting Unit for Primary Healthcare Services
- Establishment of the Fund
- Implementation of a Health Patient Registration System
- Initiation of accreditation of health care providers
- Purchasing of health care services at all levels of care
- Initiation of legislative reforms to ten Acts and all Provincial Health Acts

It is crucial to establish a baseline of current health outcomes, and then commission two-yearly assessments of measures that include the following indicators: better access; quality healthcare; improved affordability; improved health outcomes; increased productivity.

[12] OECD (2005) OECD Guiding Principles for Regulatory Quality and Performance p2.

This will ensure that the institutional reforms itemised in the NHI Bill will indeed improve the availability and quality of healthcare as intended. This will also allow for course-correction should the institutional reforms have unintended consequences.

Phase 3 (2022 to 2026) assumes a system readiness that will justify the "mobilisation of additional resources as approved by Cabinet". This phase, which can only be funded through additional fiscal allocations, should only be triggered when a detailed set of key metrics are met which verify that the healthcare system is ready to effectively absorb additional resources to provide good quality services to all citizens. This process must be transparent and open to public participation. Launching Phases 2 and 3 without this type of meticulous planning and ongoing evaluation risks failure of the entire NHI reform and also creates the risk of a substantial increase in use of scarce fiscal resources for healthcare without material gains in the quality and accessibility of health services for our country's citizens.

The WHO recommends that governments should establish robust public accountability and participation mechanisms which are institutionalised, to enable citizen engagement in the reform process. This includes the review of inter-sectoral policies and laws.

The NDP refers to mechanisms such as providing access to physical activity areas and proper nutrition; establishing patient information systems that support decentralised and home-based care; initiating public-private partnerships (PPPs) for purchasing, provisioning, procuring, and sound financial management and even the review of the HPCSA ban on doctor employment (Chp 10, pg 345). All of these measures need to be included in the proposed phases.

11. SYSTEM RISKS

This section highlights some, but not all, of the key risks inherent in the NHI White Paper, which are not addressed in the NHI Bill, 2018. These are therefore key risks of the Bill and the overall NHI reform as well.

11.1 Risks of the single payer model

The proposed single payer model poses numerous substantial risks including, but not limited to:

- Imposing a massive strain on the central fiscus, putting the country's financial sustainability at risk.
- Potential for substantial increases in public expenditures without commensurate improvements in the quantity and quality of health services available to citizens.
- The creation of a massive centralised bureaucracy, with risks of it becoming inefficient and unresponsive, as well as the potential for corruption.
- Risk of undersupply of health services due to shortages of funding and the resulting inability to pay providers at levels required to ensure participation and sustainability.
- Failure to leverage the skills, capacity, assets and capital available in the private sector.
- Potential to result in a net loss of health professionals and health management skills.

- Potential for damage to the current private healthcare funding and delivery system, which could result in large job losses, substantial losses of tax revenues, as well as substantial political resistance from the 9 million citizens who currently utilise the private healthcare system.

Many, if not most, of these risks could be avoided through the adoption of a multi-payer model as proposed in the 2017 Report of the High Level Panel on the Assessment of Key Legislation and the Acceleration of Fundamental Change. This report proposed an alternative trajectory towards UHC in South Africa, which was referred to above. Such an approach would be entirely consistent with the provisions of the NHI Bill, provided that the Bill be amended to clarify that medical schemes will play a parallel role in the provision of cover to those who can afford additional contributions (while still participating in the mandatory NHI Fund).
A key argument made by proponents of the single payer approach is that this is the only method of achieving effective risk pooling. However, as noted above, neither the White Paper nor the Bill have shown why risk pooling cannot be achieved on a virtual basis, with an NHI Fund and medical schemes all carrying the NHI benefits. Not only is this approach likely to be more effective, but it is also far less risky than the current approach proposed in the NHI Bill.

11.2 Risks of strategic purchasing by a single payer

There is no evidence that a single purchaser will necessarily be able to reduce costs within the system. A large bureaucratic purchaser is more likely to suffer from inefficiencies and a lack of responsiveness. Mismanagement and the potential for corruption is higher, with a resultant deterioration in the quality of services available to citizens.

There is also a risk of inappropriate health service pricing. Prices that are too high will not be sustainable within the funding resources likely to be available, while prices that are too low will not support provider contracting, with the result that access to services could be severely restricted. This is a key risk to the system as it affects the scope of the benefit package, public support for NHI and the overall sustainability of the system.

Inappropriate provider restrictions through related regulations such as the certificate of need and accreditation could ultimately compromise access to care through unintended coercion of healthcare providers and the adverse consequences thereof.

There are major potential risks in shifting from the current government flows of funds, which have been well established for decades, to a system in which a newly established organisation is required to contract individually with thousands of individual providers of care, including hospitals, clinics, tens of thousands of health professionals, as well as suppliers of medicines and devices. There has been no assessment of the requirements for establishing the expertise required to contract in this way, nor any assessment of the risks involved should this approach fail. Nor has there been any assessment of the massive increase in transaction costs that will be required to implement this system compared to the current system.

11.3 Demand management

There is no indication in the NHI Bill of the rationing tools that will be applied, nor how urgent cases will be dealt with outside the NHI capacity, nor how more general demand and supply side utilisation pressures will be managed. Rising utilisation is a key driver of medical inflation in the private sector as shown by the HMI provisional report, as well as in healthcare systems all over the world. Simply implementing a single payer NHI Fund will not automatically lead to solutions to these problems. The NHI Fund needs explicit strategies to manage utilisation, failing which its costs will rise rapidly, as many healthcare systems globally are currently experiencing.

11.4 Benefit package

Failure to adequately define and adapt the NHI benefit package over time will pose major risks including failure to meet pressing healthcare needs related to demographic and epidemiologic transitions, and consequently changes in burden of disease over time, as well as advancements in health technology and lack of public support. The benefit package needs to be developed in an incremental way within a transparent framework; and must be sustainable and address priority health needs, ideally with some flexibility at regional level. Much more clarity is needed on how this process will work in terms of criteria to be applied and the inclusion of input from stakeholders.

12. CONCLUDING REMARKS

Discovery acknowledges the important role that an interim NHI Fund structure can play in addressing specific projects associated with backlogs and addressing the needs of vulnerable groups.
We also believe that a significant improvement in the challenges the health system faces can be dealt with by implementing some of the provisions not yet implemented in current legislation e.g. the coordination of national health information systems by the national department as contemplated in section 74 of the National Health Act No. 61, 2003, without waiting for the NHI Act. We suggest a collaborative and consultative process for addressing the risks identified above and developing a sustainable framework for achieving UHC in South Africa.

Discovery Health Medical Scheme

Discovery Health

SECTION 2: COMMENTS ON SPECIFIC SECTIONS OF THE NATIONAL HEALTH INSURANCE BILL
Government Gazette 41725 of 21 June 2018

	General comment applicable to the entire NHI Bill	
	The publication of the NHI Bill without an accompanying Explanatory Memorandum is a significant hindrance to public consultation, as it is difficult to harmonise the contents of Bill with the existing National Health Act, the NHI White Paper, Provincial Health Acts, and related legislative developments such as the Medical Schemes Amendment Bill and the Health Market Inquiry provisional report. It is essential that the public be provided with more clarity on the legislative harmonisation that will develop, in order to establish the context in which the NHI Bill will be implemented. This section provides comments and recommendations on some specific sections of the Bill.	
S2	Application of the Act	
S2(1)	*Extract from Bill*	This Act applies to public and private health establishments but does not apply to military health establishments.
	Comment	The Act is also applicable public and private healthcare providers and to public health administrative organisations or organs of state.
	Recommendation	Amend section 2(1) to include the broader applicability of the Act. There are high levels of anxiety amongst individual health professionals regarding the implications of NHI on their practices and livelihoods. We strongly recommend that there is more effective communication with this constituency to highlight their importance in the proposed Fund and to engage with them in the developments. This is vital to retaining skills in this sector and also encouraging young people to consider entering the profession. Added to this is the need to implement a comprehensive strategy for training and development to ensure that there are adequately skilled human resources to deliver quality health services that are accessible throughout the country.
S2(2)	*Extract from Bill*	This Act does not in any way amend, change or affect the funding and functions of organs of state in respect of health services until legislation contemplated in sections 77 and 214, read with section 227, of the Constitution and any other relevant legislation have been enacted.

	Comment	<u>The Constitution provides as follows:</u> <u>Section77:</u> A Bill is a money Bill if it – a) appropriates money; b) imposes national taxes, levies, duties or surcharges; c) abolishes or reduces, or grants exemptions from, any national taxes, levies, duties or surcharges; or d) authorises direct charges against the National Revenue Fund, except a Bill envisaged in section 214 authorising direct charges. <u>Section 214:</u> Equitable shares and allocations of revenue 1) An Act of Parliament must provide for - a) the equitable division of revenue raised nationally among the national, provincial and local spheres of government; b) the determination of each province's equitable share of the provincial share of that revenue; and c) any other allocations to provinces, local government or municipalities from the national government's share of that revenue, and any conditions on which those allocations may be made. Requires consultation of provinces, organised local government and the FFC. <u>Section 227:</u> National sources of provincial and local government funding 1) Local government and each province - a) is entitled to an equitable share of revenue raised nationally to enable it to provide basic services and perform the functions allocated to it; and b) may receive other allocations from national government revenue, either conditionally or unconditionally. The inference is that there will be changes to the National Health Act as well as changes to all nine provincial Health Acts, and changes to related regulations; and that these changes must be enacted before this Act is promulgated.
	Recommendation	Given that Sections 77 and 214 of the Constitution have a bearing on the NHI Bill, there is insufficient clarity on what other legislative amendments are required; and on how this Bill will be sequenced and synchronized with such legislation to ensure that the NHI Bill passes constitutional muster. The NHI Bill also does not address the flow of funds to the provincial health departments. Without such a change, many of the provisions in the Bill cannot be implemented. In our view, it is

		premature and misleading to include these provisions in the Bill without the critical issue of the flow of funds being addressed. An Explanatory Memorandum is required to clearly outline the sequence of legislative changes envisaged.
S1	Definitions	
	Extract from Bill	"dependant" means – a) a spouse b) a child; or c) any other person who is legally entitled to support from a person who is eligible to support from a person who is eligible to become a beneficiary of the Fund and who is registered as a user
	Comment	It is unclear why this is definition is necessary if the enrolment mandate applies to all citizens. Although enrolment of the population has been a popular feature of developing UHC systems, a clear strategy is required to respond to this enrolment with effective demand- and supply-side management programmes. An Explanatory Memorandum should explain these strategies. If the policy intention is to enrol citizens as part of empowering them to be aware of their NHI rights and responsibilities, this should also be made explicit. Regulations determined under section 52(1)(t) on all fees payable to the Fund will define how payments for families will be calculated. Similarly section 8 requires the registration of beneficiaries and their dependents, yet anyone older than 12 years may register as an independent beneficiary. The rationale for the delineation between beneficiary and dependent is unclear. If all beneficiaries will have the same rights, the additional bureaucracy of registering dependents who will later have to re-register themselves as independent beneficiaries is an unnecessary obstacle. The requirement to register as an independent beneficiary until age 18, deregister, then immediately re-register as an adult beneficiary is an unnecessary bureaucratic obstacle that may result in the person losing cover in that period. Finally, this requirement may in fact exclude the most vulnerable in our population, who often do not have the requisite documentation to access social services.

	Recommendation	Remove this definition as it is unnecessary. Remove section 8(2) as it is unnecessary.
	Definition of Contracting Unit for Primary Health Care	
S37(1)	*Extract from Bill*	37. (1) The Contracting Unit for Primary Health Care is the organisational unit with which the Fund contracts for the provision of primary healthcare services within a specified geographical sub -district area.
	Comment	This unit does not yet exist as a juristic entity, nor does it have PFMA standing. This means its ability to receive funds and to contract for healthcare services is unresolved. It is not possible to comment adequately on this Unit at this stage.
	Recommendation	Further detail is required in section 37 regarding how these units will be established and organised and what discretionary authority they have. This section also needs to be clarified in terms of funding flows, as highlighted in comments on section 2(2).
	Establishment	
S3(2)	*Extract from the Bill*	The Fund is a national public entity as defined in section 1 of the Public Finance Management Act.
	Comment	"national public entity" means— a) a national government business enterprise; or b) board, commission, company, corporation, fund or other entity (other than a national government business enterprise) which is— i. established in terms of national legislation; ii. fully or substantially funded either from the National Revenue Fund, or by way of a tax, levy or other money imposed in terms of national legislation; and iii. accountable to Parliament; This definition means the Fund is a Schedule 3 entity in terms of the PFMA. This is not sufficient to afford the Fund adequate protection and transparency as a major funding entity.

	Recommendation	The Fund should be defined as a Major Public Entity, as per Schedule 2 entities of the PFMA. This would afford the Fund a higher level of public accountability, in accordance with section 52 of the PFMA.
	Duties of the Fund	
S5(1)(f)	*Extract from the Bill*	The Fund must determine prices annually after consultation with health care providers, health establishment and suppliers.
	Comment	The Pricing Committee will be an independent body that should include the necessary technical expertise to assess appropriate pricing and make recommendations to the NHIF. This Committee should be free of political influence and ensure remuneration levels are reasonable and affordable. There are systemic risks associated with premature determination of a pricing strategy before the system dynamics are better understood. These risks are even more serious if the policy principle of "voluntary participation" by health providers is effectively removed through controls (certification and accreditation) and prices set by one institution, the NHI Fund. Ultimately, the combination of these restrictive powers within one structure could reduce access to healthcare, as well as damage the current private healthcare system.
	Recommendation	The impact of NHI Fund powers and duties on health professional availability must be periodically assessed as the transition proceeds. Detailed technical work will be required to assess the reasonability of pricing; and adequate capacity for such work is required.
	Duties of the Fund	
S5(1)(o)	*Extract from the Bill*	The Fund must undertake research on, the monitoring of and the evaluation of the impact of the Fund on national health outcomes.
	Comment	It is not appropriate for the Fund to rely on its own monitoring to determine its effectiveness and efficiency in improving national health outcomes. The Fund should have an obligation to provide data and information to an independent organisation that monitors healthcare quality and outcomes.

		Note that there is enhanced system credibility if quality monitoring is performed by a dedicated external body; which would also serve as the national data source for monitoring progress towards health-related Sustainable Development Goals; and for tracking health improvements to due universal health coverage.
	Recommendation	Revise this duty so that it is performed in consultation with an external quality monitoring body. The provisional report of the HMI recommends the establishment of an independent quality assurance body, whose primary function would be to collect health outcomes information across the entire national health system. It is recommended that the NHI Fund does not self-monitor, but rather defers to an external organisation whose sole purpose is to conduct this monitoring and evaluation.
	Functions of the Fund	
S6(l)	*Extract from the Bill*	The Fund must take all reasonable steps to prevent and discourage corruption, unethical or unprofessional conduct, or fraud, or abuse of users or of the Fund.
	Comment	While we agree that the Fund must "prevent and discourage" corruption, these duties are insufficient, and should be broadened to include investigation, possibly through third parties, and referral to prosecuting agencies.
	Recommendation	This obligation should be strengthened to include the requirement to investigate and act upon abuse identified and to refer for prosecution where necessary.
	Rights of Users	
S9(o)	*Extract from the Bill*	Right to purchase complementary health service benefits that are not covered by the Fund through a voluntary medical insurance scheme, any other private health insurance scheme or out of pocket payments, as the case may be.
	Comment	No justification has been provided to limit the rights of citizens to purchase only "complementary health services". The vast majority of current Universal Health Coverage (UHC) systems, including those structured as a NHI (defined as systems financed via explicit health insurance contributions) and those structured as a National Health System (NHS) (defined as systems financed by allocations from the fiscus), allow citizens the option of purchasing both parallel and complementary private cover.

		The experience of Quebec in implementing this type of prohibition in its legislation relating to the implementation of the Canadian national health policy, is informative on how this type of prohibition can limit fundamental rights. In *Chaoulli* there was debate between the judges presiding over the matter as to whether the prohibition on private health insurance in respect of medical services that will be or are funded by the state in terms of its national health insurance plan, is an unreasonable limitation on the rights of Quebeckers to life and security of person. Three of the 6 judges, concluded that the means used to achieve the object is disproportionate to the object itself. Given that alternative, less onerous measures exist in terms of which the public healthcare system can be protected, it was held by these judges that the prohibition is disproportionate to the objective it seeks and is therefore unreasonable. International experience therefore supports the retention of the right to purchase healthcare benefits. The Medical Schemes Amendment Bill refers to "limiting scheme benefits to avoid duplicative costs for benefits". This limitation should also be removed. An additional consideration is that the ability to exercise the right is heavily dependent on prior knowledge about what services will not be available through the NHI Fund, hence there is a responsibility on the NHI Fund to make this information known well in advance, in order to enable the purchase of adequate cover. Since there are several possible circumstances where a health service may be unavailable to the user at the time of need, eg unavailability of equipment, drugs and health professionals, the ability to purchase health services must not be constrained to "complementary" health services. Furthermore, the extent of the service available through the NHI Fund may be limited. Should a user prefer to have additional treatments of the same service beyond the NHIF entitlement, it should be possible to access these services from the same provider, but paid for through private means. Finally, access to higher levels of care through the NHI Fund will be strictly controlled [see also section 10(2)(c) and 11(2)(b)].
	Recommendation	The provision should be amended to state that users retain the right to purchase health service benefits through a voluntary medical insurance scheme, any other private health insurance scheme or out of pocket payments, as the case may be. For all of the reasons described in Section 1(2), Discovery recommends that medical schemes be allowed to continue offering parallel cover to the NHI, and that once citizens have contributed to the NHI, they should remain free to elect to

		purchase additional medical scheme cover. This is consistent with the policy objective of allowing those with the means to provide for themselves and this is consistent with Section 26(2) of the Constitution per the Grootboom judgement[13]. Should a user prefer to have more flexible access to any level of care, the right to purchase cover that provides for such access must not be limited. It should be noted that since a member cannot opt out of the NHI Fund there is a benefit to the Fund if they choose to fund their own healthcare requirements.
	Reimbursement for services rendered	
S10(3)	*Extract from the Bill*	Treatment will not be funded if a health care professional can demonstrate that there is no medical necessity for it; or there is no cost-effective intervention for the service.
	Comment	There also needs to be a peer review and/or appeals process to ensure that decision making is consistent for all members of the Fund. It is unclear as to how the health care professional will not submit a claim for treatment not rendered. However, the healthcare professional will have incurred the expense of consultation time, which should be fairly reimbursed. The clause refers to only one possible cause for withholding treatment, yet it is possible that providers withhold treatment for malicious or negligent reasons. The Bill is silent on the recourse available to the user in this circumstance.
	Recommendation	This section should be revised for clarity. It needs to take into account the various reasons why certain treatments will not be funded, as well as transparent processes for establishing and periodically reviewing the relevant policies that will determine these decisions.
	Benefits Advisory Committee	
S25(2)	*Extract from the Bill*	List section 25(2)(a) to section 25(2)(e).

13 *Government of the Republic of South Africa and Others v Grootboom and Others* [2000] ZACC 19, 2001 (1) SA 46 (CC), 2000 (11) BCLR 1169 (CC), Constitutional Court

	Comment	The tasks of the Benefits Advisory Committee are technical in nature. Representational composition, (especially of provinces) is not appropriate for a technical body. The committee should have more technical competence, to include medical, actuarial, legal and health technology expertise. Such technical expertise will avoid the unnecessary expense of hiring additional technical consultants that will otherwise be needed by a large non-technical committee. It is concerning that there is no participation from those directly involved in care delivery. Political and societal accountability could be achieved through quarterly/annual reporting to existing political and civil society structures. The Committee size of 23 people is unworkable as a technical body; the Bill should aim for no more than 12 people. This would imply that deans of medical schools should be allocated a smaller number of seats, balanced by a mechanism to rotate participation. Similarly, WHO may advise the Board but need not be represented on this Committee. The NHI benefits are offered as guaranteed benefits, free of charge, and it is therefore important that this Committee is in close dialogue with existing structures that have influence on the distribution of healthcare resources. These include structures for facility licensing, pharmacy licensing, certificate of need approvals, etc. An Explanatory Memorandum should address the coordination/ liaison that will be required between all these structures. The NHI Bill should include an obligation to function in a consultative manner with other NHI advisory and technical committees.
	Recommendation	Section 25(2) (a) to (e) should be revised to reconfigure the Benefits Advisory Committee as a technical working committee that can provide the requisite technical support to the NHIF and the Minister; and not as a large non-technical committee made up of representatives of various interests. • A formal sub-committee should be established to assess the appropriateness and feasibility of interventions proposed by the Benefits Advisory Committee. To this end, we propose the establishment of a Health Professions/ Healthcare Provider Management Sub-Committee. • The recommendation of the above sub-committee should be considered by the Benefits Advisory Committee before being forwarded to the NHI Fund.

		• It is important that alignment and co-ordination over the different expert and clinical Committees is established. This includes the identification and allocation of the important function of clinical governance within a co-ordinating structure. An Explanatory Memorandum should be published to clarify how this Committee will replace or interact with the Ministerial Advisory Committee on Health Care Benefits for NHI, as published in Government Gazette 40969 dated 7th July 2017. This is a key part of achieving regulatory harmonisation.
	Health Benefits Pricing Committee	
S 26	*Extract from the Bill*	Section 26 (1) to (3)
	Comment	The size of the Committee should be minimised for optimal efficiency. The technical expertise listed in section 26(2)(c) is necessary for such a Committee.
	Recommendation	Consistent with International best practice, the Health Benefits Pricing Committee should not be subject to political influence and should work closely with entities such as the Supply Side Regulator for Health (SSRH) proposed by the HMI to determine the processes and criteria for the negotiation of prices for health services. The Pricing Committee should also evaluate and prioritise the NHIF benefits that may reasonably be guaranteed at the negotiated price, within the available resources. An Explanatory Memorandum should be published to clarify how this Committee will replace or interact with the National Health Pricing Advisory Committee as published in Government Gazette 40969 dated 7th July 2017. Furthermore there should be explicit checks and balances built into the phased implementation plan, to minimise the risks of unintended consequences of implementation. This should be in accordance with recommendations from WHO, the World Bank and the Lancet Commission.
	Stakeholder Advisory Committee	
S 27	*Extract from the Bill*	Section 27 (1) and (2)

	Comment	It is appropriate that this Committee is structured as a consultation platform for major stakeholders, hence the size of the Committee and representative nature of participants. The regulations should provide detail on how regular user feedback will be obtained and how this Committee will prioritise appropriate responses. The omission of professional associations of health providers is very concerning. Their interests will not be adequately represented by the regulators. Representation from bodies such as SAMA, the SAPPF etc is far more appropriate. Similarly, the Council for Medical Schemes is represented, but medical schemes and administrators are not. This omission needs to be rectified.
	Recommendation	It is crucial that an Explanatory Memorandum captures how these Ministerial Committees will either replace existing forums or whether the committees will work in collaboration and consultation with existing bodies. Currently the National Consultative Health Forum is a multi-stakeholder consultative body for the Minister of Health. The NHI Bill needs to clarify if this National Consultative Health Forum will be disbanded. If it is retained, there needs to be clear articulation of how the input of multiple stakeholder forums will be balanced. All relevant stakeholder groupings should be adequately and appropriately represented. Providers should be represented by their own representative bodies. Similarly medical scheme and administrator representative bodies must be included in this Advisory Committee.
	Technical Committees	
S 28	*Extract from the Bill*	Section 28 (1) to (4)
	Comment	The intention that the Minister receives advice from Technical Committees is welcome.
	Recommendation	Again, the relationship between these Technical Committees, the Minister, the NHIF, and NHI Statutory Advisory Committees as published in Government Gazette 40969 dated 7th July 2017, existing Committees, and statutory bodies proposed by the Health Market Inquiry, must be clearly mapped and articulated in an Explanatory Memorandum.

		Alternatively, the clauses proposing various Committees must be revised to simply allow the Minister to establish Technical Committees as necessary, without prescribing the types of Committees to be established as this prescription is premature and inappropriately constrains the Minister in future, when circumstances may be very different from today. A general recommendation is that technical committee members are appointed on the basis of their technical expertise, not as stakeholder representatives.
	Functions of National, Provincial and Municipal Departments of Health	
S 33	*Extract from the Bill*	Provincial health departments will be the main providers of health services for purchasing by the NHIF. Municipalities retain responsibility for water, food and waste services as well as control of communicable diseases amongst other functions. They will no longer provide personal health services.
	Comment	The Bill does not explain the mechanisms for protecting provincial investments in health care if the procurement of their services by the NHIF is not guaranteed. Much more detail on actual funding flows is required to demonstrate how these reforms will protect the public from poor or inadequate provincial funding for health service provision.
	Recommendation	The Implementation Phases need to be explicit about when the functions of provincial departments and municipal health services will change; and what guiding criteria will indicate that they are ready for the changes. This is a critical part of the implementation phases and it should be available for public comment through an Explanatory Memorandum.
	National Health Information Repository and Data System	
S 34	*Extract from the Bill*	3) In order to be accredited and reimbursed by the Fund, a health care provider or health establishment must submit such information as may be prescribed to include: b) procedure codes using the prescribed coding systems; c) details of treatment administered including medicines dispensed and equipment used; d) diagnostic tests ordered
	Comment	The Medical Schemes Amendment Bill proposes the establishment of a Central Beneficiary Register and a Healthcare Provider Register, and the provisional report of the Health Market Inquiry recommends the establishment of provider and population databases for the purposes of capacity planning and to ensure continuity and portability of care.

		There is real risk of duplication of these various registers, which should be rationalised. There must also be appropriate safeguards for the collection, collation and storage of sensitive information.
	Recommendation	There needs to be co-ordination to ensure that the scarce resources in the health system are used efficiently. There also needs to be co-ordination of information which needs to be appropriately collected, stored, processed, transmitted and reported to reflect the sensitive nature. These functions should be rationalised and located at the appropriate positions within the health system. The NHI Bill should be amended to reflect these requirements.
	Purchasing of healthcare services	
S 35	*Extract from the Bill*	• At national level the Fund must transfer funds directly to all certified, accredited and contracted hospitals excluding district hospitals based on Diagnostic Related Groups. • At provincial level the Fund must transfer funds directly to certified, accredited and contracted provincial, regional, specialised and district hospitals based on a global budget or Diagnostic Related Groups. • At the sub -district level funds for primary health care services must be transferred to Contracting Units for Primary Health Care contemplated in section 37. • Emergency Medical Services provided by accredited and contracted public and private providers must be funded on a capped case -based fee with adjustments made for case severity where necessary.
	Comment	The actual flow of information and related flow of funds is not clear in the Bill. There are four different flows of funds reflected in Section 35 of the Bill, but only two NHIF structures, the national NHI Fund and the district level Contracting Unit for Primary Healthcare. Clarity is required about which of these two units will reimburse the four levels of contracting as above. Clarity is also required about the submission of utilisation information and how this will be aligned with reimbursement flows. The SEIAS should clearly outline the financial, social and legal ramifications of the NHIF possibly choosing not to purchase services from selected providers at any level (particularly if they do not meet accreditation standards). This clarification is

		similarly required where specific parties in a CUPC (such as the district hospital) could lose their accreditation, and therefore be suspended from providing primary care services. Can the CUPC appoint a different district hospital and what are the implications for the local population? As stated in section 1(11.2), there are major potential risks in shifting from the current government flows of funds, which have been well established for decades, to a system in which a newly established organisation is required to contract individually with thousands of individual providers of care, including hospitals, clinics, tens of thousands of health professionals, as well as suppliers of medicines and devices.
	Recommendations	A detailed assessment should be carried out on the feasibility, costs and risks of shifting from the current model of government funds flows to a system of procurement based on contracting between the NHI Fund and each individual provider. It is not at all clear that the proposed model is feasible, or that it is the most cost effective approach to building a UHC system. Until such an assessment has been performed, this approach to contracting should be removed and this element of the NHI system should be left open for later determination, based on emerging evidence.
	Contracting Unit for Primary Health Care	
S 37	*Extract from the Bill*	• The Contracting Unit for Primary Health Care is the organisational unit with which the Fund contracts for the provision of primary health care services within a specified geographical sub -district area. • The Contracting Unit is comprised of a district hospital, clinics and, or community health centres and ward -based outreach teams, private primary service providers.
	Comment	The CUPC plays a role of planning, monitoring and evaluation of primary health care on behalf of the NHIF; but also contracts with the NHIF for the provision of primary healthcare. There is an inherent conflict of interest in these dual roles. Furthermore it is not clear how the CUPC will relate to the District Health Management Office. Clarity is needed on the category of public entity that the CUPC will be and how it will be accountable both financially and operationally to the community it serves. There is no definition of what is meant by “private primary providers organised in horizontal networks”, nor of whether solo-practice providers will be able to join a CUPC.

		It also needs to be clear if and how the NHIF will intervene should the CUPC prove unable to meet its objectives.
	Recommendation	It is too early in the NHI trajectory to determine the role, structure and functions of a district contracting unit. This function should be retained by the NHIF until there is more clarity about the exact role and functions of a more local structure, which can only happen once the requisite legislative changes have been completed, and funding flows are clearly mapped, so as to allow full establishment of the NHIF.
	Role of District Health Management Offices	
S 36	*Extract from the Bill*	1) The District Health Management Office established by section 31A of the National Health Act must facilitate, coordinate and manage the provision of non -personal public health care programmes at district level in compliance with national policy guidelines and applicable law. 2) The District Health Management Office must liaise with and report on a monthly basis to the national office of the Fund concerning .."*difficulties with health services*"
	Comment	The Bill separates the roles of the District Health Management Office and that of the CUPC so that the District Health Management Office is restricted to the provision of non-personal health services. It is therefore contradictory to expect this Office to report to the NHI Fund on difficulties experienced by either users or providers with health services. This function is effectively duplicated within the CUPC. There is no explicit description of the flows of information between these parties nor of the accountability structures that will ensure that such reporting happens. If the intention is that the District Health Management Office performs an oversight role over an NHIF institution, then the legal relationship between the two entities must be explained. There is a risk that these additional layers of bureaucracy actually impede access to care rather than facilitate it. It is noted that District Health Management Offices have existed for over two decades, yet they are still very weak structures with limited authority.
	Recommendation	The functions of the District Health Management Office should be changed to remove duplication with the CUPC and to align its role with the provision of non-personal health services.

		Additionally the District Health Management Office needs to remain accountable to the Provincial Health Department, hence its role and reporting must be within that framework, not directly to the NHI Fund. These relationships should be clearly described in an Explanatory Memorandum. It is also necessary to provide more detail on the criteria that will indicate that District Health Management Offices are ready to play the role envisaged in the Bill before additional NHI duties are thrust on them.
	Accreditation of service providers	
S 38	*Extract from Bill*	Section 38 (1) to (9)
	Comment	Section 38(2) lists six accreditation criteria that are additional requirements to current legislation. Several of these accreditation requirements are not possible to evaluate prospectively, e.g. adherence to treatment protocols and adherence to referral networks. It is an additional and unnecessary bureaucratic step to require providers to be accredited first. These providers are currently subject to strict regulations just to practice or to offer health services. Since all NHIF-related criteria will form part of contract conditions, this pre-contract condition is unnecessary. This accreditation requirement could also become a point of manipulation or even corruption; which should be avoided. The accreditation requirements fail to acknowledge the serious shortages of health professionals in the system which are bound to negatively impact the allocation "of the appropriate number and mix health care professionals to deliver healthcare services".
	Recommendation	The NHIF should be enabled to directly verify professional Council registration and OHSC certification of providers, without creating an additional bureaucratic hurdle for providers. The requirement for accreditation should be removed and replaced by contracting criteria that the NHIF will apply. These criteria should have sufficient flexibility to allow for differing local conditions, including the shortage of health professionals. The comments made with respect to section 5(1)(f) about retaining the regulatory space for the practical expression of "voluntary provider participation" are also relevant to this section.

		The Bill should also make provision for service providers to cancel their accreditation/ contracts if their contract conditions are not met.
	Payment of service providers	
S 39	*Extract from Bill*	S 39(1) requires the Fund to determine the nature of provider payment mechanisms.
	Comment	Sections 39(2) and 39(3) specify the type of payment mechanisms to be used for hospital services and for primary services
	Recommendation	The Bill should refer to a requirement for value based contracting rather than specifying precise reimbursement mechanisms. It is essential to retain flexibility in the payment mechanisms to be used by the NHI Fund. This will not only allow for learning as the reforms are implemented, but also for the dissemination of best practice that is most suited to local conditions. It will also allow flexibility for innovation and changes in payment mechanisms as the environment changes in the future. For example there are areas in the Eastern Cape and the North West that are significant sources of mining labour. Simple capitation agreements will not cater well for highly migrant populations. In order not to be subject to manipulation and arbitrage, risk adjustment mechanisms require extensive data sets and detailed analysis. Sections 39 (2) and 39 (3) should be removed until further work as established appropriate reimbursement models. Section 39 (4) also requires clarity on the flow of funds to CUPCs.
	Complaints	
S 40	*Extract from Bill*	Section 40(2) requires an investigation of a complaint to be finalised within 30 days of receipt.
	Comment	For a population of over 57 million, a commitment to address complaints within 30 days is highly ambitious and unlikely to be realised.
	Recommendation	The 30 day limit should be removed. Appropriate response times can be defined in regulations as capacity is developed.

	Lodging of appeals	
S 41	*Extract from Bill*	A user, health care provider, health establishment or supplier aggrieved by a decision of the Fund contemplated in section 40 may, within a period of 60 days after receipt of written notification of the decision, appeal against such decision to the Appeal Tribunal appointed by the Minister in terms of section 42.
	Comment	It is unusual and potentially excessively costly for dissatisfied persons to appeal directly to a Tribunal without the option of an intermediate step. A two-step process as described could result in an accumulation of years-worth of backlog cases. It is also an expensive way of resolving complaints. A better option could be that there be Provincial Appeal Committees with recourse to a National Appeal Tribunal. This would be less costly and would ensure that disputes are resolved at the lowest possible level relative to where they arise. This 'subsidiarity principle' is consistent with good administrative practice. It is noted that the role of the Health Ombudsman is correctly reserved for adjudicating health quality complaints rather than funding complaints.
	Recommendation	The escalation of cases to the national Appeal Tribunal should be a last resort, after exhausting the options available at a more local level.
	Sources of income	
S 46	*Extract from Bill*	(1) The Minister must, in consultation with the Minister of Finance, determine the budget and allocation of revenue to the Fund on an annual basis.
	Comment	Sections 73 and 213-217 of the Constitution of South Africa allocate the tabling of Money Bills exclusively to the Minister of Finance, and the control of government budgets to National Treasury. The Minister of Health can therefore only accept the budget allocation as determined by the Minister of Finance. Such budget allocation cannot be determined jointly with the Minister of Finance.
	Recommendation	Section 46 of the NHI Bill should be amended to read that the Budget should be determined by the Minister of Finance after consultation with the Minister of Health. This would ensure that Treasury is always in final control of the budget,

		but that the Treasury should do so at least after having consulted with the Health Ministry, though it would not be bound by the latter's input. This would also ensure that budgets are passed – ie there in no risk of an impasse as could be the case with *in consultation* processes.
	Annual report	
S 48	*Extract from the Bill*	Section 48 (1) to (4)
	Comment	The list of matters to be reported upon is limited to input factors in terms of users and the financial value of health services. It is imperative that the Fund is able to demonstrate its achievements in strategic purchasing and in achieving improved health outcomes.
	Recommendation	Information on the quality and value of health services purchased, and on the population health outcomes should form part of the Fund's annual report, and be subject to normal audit processes.
	Miscellaneous	
S 49 (a)	*Extract from Bill*	The Minister may assign any duty and delegate any power imposed or conferred upon him or her by this Act, except the power to make regulations, to any person in the employ of the Fund;
	Comment	South Africa has plenty of recent experience with boards and public institutions that are subject to undue political influence. Good governance is compromised if the Minister can directly instruct officers of the Fund, and thereby usurp the role of the Board. The application of good governance principles is that the shareholder is responsible for the mandate, the board is responsible for developing and enforcing the strategy necessary to meet that mandate, and the executive management is responsible for the implementation of that strategy. It is critical that executive management remains directly accountable to the board, not to the Minister.
	Recommendation	This section should be revised to ensure that the responsibility of the Board and its governance integrity is completely protected from undue political influence. The role of the Minister should therefore be to play a defined role in the appointment of the Board and to conclude an annual performance agreement with the Board of the NHIF. Beyond this, the Bill should clarify that the Minister cannot interfere with the Boards duties and oversight functions and also that he cannot interfere with the officers of the Fund in the carrying out of their duties.

S 52	Regulations	
	Extract from Bill	Regulations may be made on the following: a) information to be provided to the Fund for the development and maintenance of the National Health Information Repository and Data System by users,… b) clinical information and diagnostic codes to be submitted and used by service providers…. m) relationship between public and private health establishments, and the optional contracting in of private health care providers; n) relationship between the Fund and medical insurance schemes registered in terms of the Medical Schemes Act and other private health insurance schemes;
	Comment	Information to be submitted by providers should be guided by an overarching health system information strategy that creates a standardised reporting system based on national coding standards. Ideally this should be supported by a national system of electronic health records.
	Recommendation	The NHI transition trajectory should be underpinned by a suitable information system trajectory so that the information-related regulations are developed only when there is a realistic understanding of what is feasible. Similarly, the regulations governing relationships as per paragraphs (m) and (n) should only be developed at a later stage when NHI institutions are established and NHI benefits have been defined. It is estimated that this will be the final phase of implementation, beyond 2022.
	Transitional arrangements	
S54	*Extract from Bill*	S54(2)(b) (iii) includes the undertaking of initiatives which are aimed at establishing institutions that will be the foundation for a fully functional Fund; S54(3)(a) The National Tertiary Health Services Committee which will be responsible for developing the framework governing the tertiary services platform in South Africa. S54(3)(b) The National Governing Body on Training and Development which will, amongst others-…

		S54(3)c) The Ministerial Advisory Committee on Health Care Benefits for National Health Insurance which will be a precursor to the Benefits Advisory Committee … S54(3)(d) The Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance which will be established to advise the Minister on Health Technology Assessment and which will serve as a precursor to the Health Technology Assessment agency.
	Comment	Neither the policy documents nor the NHI Bill establish what system changes will indicate that the reform process is ready to move into the next phase. While time targets are useful, these are wholly insufficient and inappropriate to indicate system readiness to progress into a more advanced phase. In our view, it is critical that there are clear processes of evaluation of the current phase prior to initiation of the next phase. In the absence of this rational approach, the entire system will be at risk if a new phase is initiated prior to clear evidence that the prior phase has been successfully implemented. This is a basic requirement of effective planning and implementation and provisions along these lines should be included in the NHI Bill.
	Recommendation	A comprehensive report evaluating the impact, successes and failures of Phase 1 should be provided, and there should be a direct relationship between what has been achieved in Phase 1 and what will be rolled out nationwide in Phase 2 There need to be key deliverables/measures in a more comprehensive plan for transition that defines when moving from one phase to the next and sections of the Bill can be promulgated only once measures attained. The progressive implementation of NHI must be supported by transparent and accountable reporting. The recommendations made in section 1(10) on Phased Implementation must be considered for this section of the NHI Bill.
	Commentary on Laws Repealed or Amended	
	General comment applicable to the entire section 53 of the NHI Bill	There is a lack of consistency between the list of laws to be amended in section 54(4)(h) and the laws that are actually amended in section 53. The latter includes laws that are not under the jurisdiction of the Minister of Health such as the Competition Act of 1998. Section 55 (2) refers to different provisions of this Act coming into effect on different dates, without any explanation about what criteria will trigger the promulgation of different sections of this Act. It is impossible to comment meaningfully on this Bill without a) an Explanatory Memorandum that explains the intentions behind the proposed legislative amendments

		b) a comprehensive description of the three phases of NHI implementation with regulatory harmonisation of the intended changes and clear steps about which related laws will be changed in accordance specific decision points in the health system reform trajectory.
	General recommendation on section 53.	The entire process of public consultation is seriously compromised when the public is not provided sufficient information to comment meaningfully on the Bill. It is strongly recommended that this section is withdrawn in its entirety until the documents requested in the comments above have been provided.
	Laws repealed or amended: National Health Act	
S 53	*Amendment of NHAct section 25*	(n) assist the District Health Management Office in controlling **[control]** the quality of all health services and facilities;
	Comment	Requiring the District Health Management Office to control all health services and facilities does not comply with existing laws that allocate quality responsibilities to different organisations, including the Office of Health Standards Compliance; and possibly the still-to-be-established OMRO as recommended by the HMI. Also the reference to "all" health services should be changed to refer to only to "NHI benefits and services".
	Recommendation	Remove this new paragraph from section 25 of the National Health Act. Any changes to the National Health Act need to be published in a specific Bill with an accompanying Explanatory Memorandum.
	Laws repealed or amended: National Health Act	
S 53	*Amendment of National Health Act* *Section 31(A)(2)(a)* *Section 31(A)(2)(c)* *Section 31(A)(2)(f)*	a) develop district health care plans in support of the district health system that identify health care service needs in terms of the demographic and epidemiological profile of a particular district; c) identify certified and accredited public and private health care providers at primary care facilities that are suitable to receive funding for services within the relevant district; f) provide information on the disease profile in a particular district that would inform the design of the health service benefits for that district;

	Section 31(A)(2)(g) *Section 31(A)(2)(k)*	g) improve access to health care services in a particular district at appropriate levels of care at health care facilities and in the community; k) receive and resolve complaints from users in the district in relation to the delivery of health care services,
	Comment	The functions allocated to the District Health Management Office in the specific amendments identified are already allocated to the Contracting Unit for Primary Care (CUPC) in a different part of the same NHI Bill. If the intention is that the District Management Office plays only a coordinating role, then this should be clearly stated. The function of complaints management is allocated to the NHI Fund in an earlier part of the same Bill. Not only is there is function duplication, the CUPC is accountable to the NHI Fund, yet the District Management Office is accountable to the Provincial Health Department, which leaves ambiguity about how these duplicative functions will be harmonized and made comprehensible to the public.
	Recommendation	It is not rational to allocate identical functions to different structures at the same level of health care provision; especially since these structures have different reporting lines. The Bill should be revised to ensure regulatory consistency and alignment. The allocation of the function of complaints management should be revised so that users have clear ways of interacting with the NHI system. It is not acceptable for the public to be expected to understand the nuanced differences between the CUPC, the District Health Management Office, the NHI Fund and the Health Ombudsman.
	Laws repealed or amended: National Health Act	
S 53	*Amendment of NHA Act section 36(6)(d)*	d) if the health establishment or the health agency, as the case may be, or a health care provider or health worker, working within the health establishment, persistently violates the constitutional rights of users or obstructs the State in fulfilling its obligations to progressively realise the constitutional right of universal access to health services. "
	Comment	The terms “persistently violates the constitutional rights” or “obstructs the State in fulfilling its obligations” are not defined in any Act.

		This creates an opportunity for subjective interpretation of what these phrases mean, thus creating regulatory ambiguity.
	Recommendation	This clause should be removed.
	Laws repealed or amended: Allied Health Professions Act	
S53	*Allied Health Professions Act, 1982, section 38A*	"Every practitioner shall, unless the circumstances render it impossible for him to do so, and before rendering any professional services, inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he intends to charge for such complementary services that are not covered by the National Health Insurance Fund Act, 2018"
	Comments	This clause presumes that all registered Allied Health Professional will be accredited for NHI services, which is not a reasonable assumption. It also assumes that any services that may be charged for must be "complementary" services. This is also an unreasonable assumption since NHI benefits have not been defined and there are many circumstances that may lead to the rendering of services that are not immediately available within the NHI system e.g. strikes, equipment breakdown, shortages of staff, etc. A final comment is that an NHI Bill should not concern itself with how providers charge for non-NHI services.
	Recommendation	The wording should rather reflect that any NHI-accredited practitioner shall, unless the circumstances render it impossible for him to do so, and before rendering any professional services, inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he intends to charge for such services that are not covered by the NHI Fund.
	Laws repealed or amended: Compensation for Occupational Injuries and Diseases Act	
S53	*Compensation for Occupational Injuries and Diseases Act, 1993*	By the deletion of the definition of "medical aid" and associated references.

	Comments	There is no clarity about the proposed amendments however it appears that the liability for medical expenses is transferred from the employer (via the Compensation Fund) to the NHI Fund. This is inappropriate as the purpose is to ensure employers are held accountable for occupational related injuries and diseases.
	Recommendations	Remove the proposed amendment to the Compensation for Occupational Injuries and Diseases Act
	Laws repealed or amended: Competition Act	
S53	*Competition Act, 1998, section (3)(b)*	by the insertion in subsection (1) after paragraph (b) of the following paragraph: "(bA) the operations of the National Health Insurance Fund as single public purchaser and single payer of national health care services; and ".
	Comments	There is no clarity about the relevance of this phrase in the Competition Act. It is inappropriate for such an amendment to be promulgated under a Bill published by the Department of Health.
	Recommendations	Remove the proposed amendment to the Competition Act.
	Laws repealed or amended: Health Professions Act	
S53	*Health Professions Act, 1974, section 53 (a) and (b) and (c)*	"Every practitioner shall, unless the circumstances render it impossible for him to do so, and before rendering any professional services, inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he intends to charge for such complementary services that are not covered by the National Health Insurance Fund Act, 2018"
	Comments	This clause presumes that all registered Health Professionals will be accredited for NHI services, which is not a reasonable assumption. It also assumes that any services that may be charged for must be "complementary" services. This is also an unreasonable assumption since NHI benefits have not been defined and there are many circumstances that may lead to the rendering of services that are not immediately available within the NHI system e.g. strikes, equipment breakdown, shortages of staff, etc, etc. A final comment is that an NHI Bill should not concern itself with how providers charge for non-NHI services.

	Recommendation	Change the wording of this clause as follows: "Any NHI-accredited practitioner shall, unless the circumstances render it impossible for him to do so, and before rendering any professional services, inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he intends to charge for such services that are not covered by the National Health Insurance Fund Act, 2018 or are not available through the NHI Fund".
	Laws repealed or amended: Medical Schemes Act	
S53	*Medical Schemes Act, 1998. Section 2(a)(1)*	"(1) If any conflict, relating to the matters dealt with in this Act, arises between this Act and the provisions of any other law save the Constitution, the National Health Insurance Fund Act, 2018, or any Act expressly amending this Act, the provisions of this Act shall prevail. "; and (b) by the deletion of subsection (2).
	Comments	The current wording of Section 2 of the Medical Schemes Act, 1998 is: 2. Application of Act (1) If any conflict, relating to the matters dealt with in this Act, arises between this Act and the provisions of any other law save the Constitution or any Act expressly amending this Act, the provisions of this Act shall prevail. (2) This Act shall also apply to a medical scheme established by any organ of the State including those medical schemes established under section 28(g) of the Labour Relations Act, 1995 (Act No. 66 of 1995). The NHI Bill amendment effectively makes the Medical Schemes Act subsidiary to the NHI Act. This is done without affording full public consultation on a fundamental change to an existing Act that regulates the entire medical schemes industry. Surprisingly, even though the Medical Schemes Amendment Bill was released at the same time as this Bill, this fundamental change was not included in the Medical Schemes Amendment Bill, 2018.
	Recommendation	This clause should be removed from the NHI Bill, and if necessary, a change should be made to the Medical Schemes Amendment Bill to allow for full scrutiny and public engagement with this proposed change.

	 	
	Laws repealed or amended: Prevention of and Treatment for Substance Abuse Act	
S53	*Prevention of and Treatment for Substance Abuse Act, 2008*	The substitution for section 7 of the following section: "**Support for services delivered by service providers.** 7. The Minister may from funds received from the National Health Insurance Fund to provide financial assistance to service providers that provide services in relation to substance abuse. ".
	Comments	There is no legal basis for funds to be transferred from the NHI Fund to the Minister for the funds to be used at his discretion as is suggested by this clause. If the NHI Fund receives money for the purposes of purchasing NHI service benefits, the above diversion of funds is not a lawful use of the money, not is it within the mandate of the NHI Fund.
	Recommendation	Remove the proposed amendment from this Bill.

ANNEXURE A: A hybrid model to achieve universal healthcare coverage

[extract from the Report of the High Level on the Assessment of Key Legislation and the Acceleration of Fundamental Change, November 2017]

While there is consensus amongst all stakeholders regarding the vision and objectives of the NHI as set out in the White Paper, there are differences in how the NHI should be implemented. The Panel received a presentation of what was referred to as the Hybrid Model that proposes a three-tier model of private schemes, government schemes and a new NHI scheme. Broad details of the proposal are as follows:

The proposal seeks to take the best out of current and previous policies and legislation to recommend an alternative approach to the implementation of an NHI model that they believe will be more likely to deliver on the objectives of the White Paper and achieve the constitutional and WHO objectives of universal health coverage (UHC) for all in South Africa. The Private Sector presenters of the Hybrid NHI model maintain that it is more feasible and far less risky to implement, will create less political resistance, and takes advantage of the existing infrastructure, skills and systems within the current health care system. This approach suggests that the employed and wealthy continue to fund themselves with minimal support from the tax payer.

It therefore directs more funding to the poor and unemployed. It is less risky and quicker to operationally implement and co-opts and places obligations on the well-functioning private sector – all in pursuit of the identical constitutional and World Health Organisation objectives of UHC for all South Africans as the White Paper.

The presentation also highlighted the risks that the NHI Model and White Paper will exacerbate inequality and lead to even worse disparities than the current system as wealthy people will opt out. A broad outline of the proposals with supporting data, references and comparisons with the White Paper was set out in a presentation.

Salient details are as follows:

- It combines the learnings and best parts of the White Paper and previous policies (including Social Health Insurance) to create a new NHI Fund in a three-tier model alongside the existing public and private sector funds.
- The healthy and young are introduced into the risk pool by mandatory medical scheme membership to all employed people and used to subsidise the NHI. The wealthy, young and healthy therefore subsidise the poor, old and sick.
- Scarce funds are directed at the poor and unemployed and the wealthy fund themselves largely out of after-tax earnings. The model is therefore much more affordable to the taxpayer than the model in the White Paper.
- The private sector is co-opted and given obligations to become part of the solution rather than being side-lined by a new mega government department (which would dwarf other entities like Eskom, South African Social Security Agency, Road Accident Fund and others).

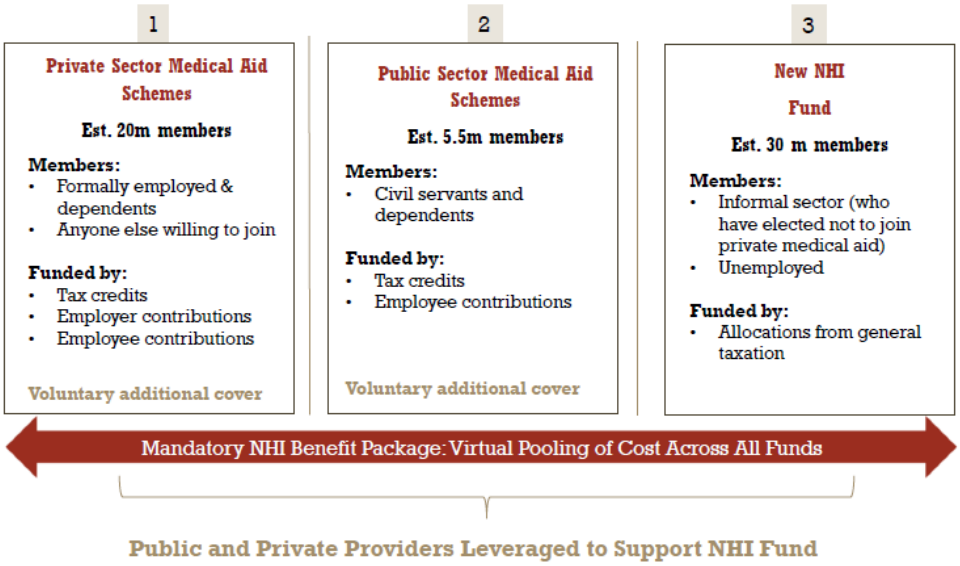
- It leverages existing national healthcare assets in the public and private sector to improve services to all. No low to middle-income country has successfully implemented a single-payer model. The successful low to middle-income countries predominantly have features of the Hybrid Model.
- It provides significantly low transitional and implementation risks and focusses on building the physical infrastructure and institutional infrastructure of the country. The model contemplates a 3-tier system consisting of the private medical schemes with mandatory membership funded by the employed; the existing public sector schemes; and a new NHI fund for the unemployed and low-income employed funded by the state. All three pillars will provide the identical package of Prescribed Minimum Benefits (PMB). Motivations for the recommendations are as follows:

    - This option results in cheaper premiums for the employed poor as it is expected to reduce the cost of cover by as much as 23%.
    - This will also make it cheaper to provide for the balance of the population as the government can allocate the additional resources to the poor.
    - It will lead to a transition to UHC which is far less risky as the cost of any over-runs in the employed population, due to the expected continuation of high utilisation levels and better access to facilities, will not be borne by the state.
    - A regulated private medical scheme mechanism is likely to reduce levels of inequality as risk and income equalisation mechanisms can be applied. A single fund approach with the wealthy purchasing care directly and via private health insurance operating as a completely separate pool will create much greater levels of inequality. This has been evident in other markets with high levels of income disparity.
    - The wealthy are likely to make more claims due to factors such as access and expectations. The Hybrid Model is structured on the basis that they pay for this additional cost rather than drawing from the central pool. Higher utilisation levels mean that there is a risk that the wealthy will squeeze out the poor in terms of benefits.
    - Members that are currently comfortable with the services offered by their schemes will not only have significant cost reduction but also have security of being able to stay with their schemes rather than being forced to join an untested and yet-to-be established single fund controlled by a huge government department. This should address resistance to cross-subsidies as well as continuing to provide an element of choice of cover.
    - In summary, the employed are compelled to pay for themselves and subsidise the poor while the proposed NHI Fund can focus on the poor. This is consistent with the proposed implementation framework that focuses on vulnerable groups (women, children, the elderly and disabled). This will speed up the achievement of UHC for all. The speed of expanding cover can be accelerated by also enabling medical schemes to simultaneously expand access affordably.

Discovery Health Medical Scheme

Discovery Health

Hybrid NHI Model – Three Fund Types Including New NHI Fund



A Virtual Fund Achieves Risk Equalization Without the Large Fund Risk

Virtual Fund: all schemes retain independence but risk subsidies are paid by low risk funds to high risk funds to achieve risk equalisation without physical of cash.

Physical Fund: All funds pooled to achieve risk equalisation.

✓ Benefits of a Virtual Single Fund

- Achieves same **risk equalization** as single fund by **sharing risk across funds**
- Healthy and wealthy **cross subsidise poor and sick**
- Better **accountability** and **transparency**
- More **autonomy** and **incentives** for funds to innovate and deliver high quality services
- **Addresses resistance** from **stakeholders concerned by large state entity** and **associated governance**
- **Eliminate implementation risk** and **systemic risk** of corruption and failure of Single Payer NHI Fund

✗ Risks of a Physical Single Payer NHI Fund

- Funding **risk is borne entirely** by the **State**
- **No direct responsibility** for **cost containment**
- Major **inefficiencies** in central funding
- Risk of **corruption** and **inefficiency** (SASSA, RAF, SABC, Eskom, PRASA) leading to **failure of system** and **systemic risk**
- **Not necessary** to **achieve UHC goals**
- **Risk** of **significant resistance** from **many stakeholders**. Is existing capital that has been built up by members paid into the central fund? Is this confiscation? Litigation a certainty.

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Discovery Health Medical Scheme

Discovery Health

Hybrid NHI vs White Paper NHI

Deliverable	White Paper	Hybrid Model
Provide UHC	✓	✓
Provide universal and standardised benefit package	✓	✓
Access to all doctors and hospitals – public and private	✗ • Private providers not obliged to contract with NHI and may opt out. Citizens may choose to bypass NHI gatekeeper, or seek care and pay OOP	✓ • Each fund will contract with private providers on their own terms, but private providers not obliged. Citizens will have more choice, but will not be able to bypass the system
Differentiation of access	• Citizens may bypass NHI referrals or purchase care OOP	• All citizens receive mandatory NHI Package
Freedom of choice funder	✗ • Single funder – no choice	✓ • All citizens have greater freedom of choice
Freedom of choice provider	✗ • NHI will stipulate providers available based on their willingness to contract	✓ • Funders will have freedom of choice to contract with providers on own terms
Incentive for competition, innovation and efficiency in the funder and provider markets	✗	✓
Financial burden on state	✗ • Any under estimation of costs needs to be covered by tax revenue • Systemic risk of failure • Political resistance	✓ • State's obligation is limited to those belonging to NHI fund. Employed funded by contributions which need to cover costs (risk transferred) and cross subsidy of NHI package (risk shared)
Decentralisation of hospital management	• Under NDoH	• Hospitals compete based on efficiency (first tested at provincial level)
Risk of transition	• Only vulnerable groups covered in first phase, affordability challenges will continue to exclude lower income earners as the private sector funds are squeezed out. Likely to lead to overall loss of cover.	• Parallel process of introducing NHI Fund for vulnerable groups AND expanding access to cover to lower income earners in partnership with private sector. More likely to lead to broader affordable cover.
	Unaffordable and higher risk	**Affordable and lower risk**

Recommendations

1. Consider a **hybrid NHI model as a less risky, more affordable** NHI model
2. **Collaborate** with all players and **National Treasury** to **define budget implications** of all models under consideration
3. Continue to **accelerate public revitalisation** programmes in an effort to **improve efficiencies** and as part of an **operational readiness assessment**
4. Co-opt **private sector** as **part of solution.** E.g. training doctors in private sector and leverage private sector for admin, for partnership to conduct readiness assessment
5. Consider short term **regulatory interventions** in healthcare sector to **improve affordability and efficiency**

Annexure B: Comments on SEIAS: Initial Impact Assessment: National Health Insurance Fund dated July 2017

As compiled by the Department of Planning, Monitoring and Evaluation, July 2017

A general comment on the Socio-Economic Impact Assessment System is that the lack of any research evidence or substantiation of the points made in the SEIAS. There is no quantification or reference to research or analysis included which renders the document a collection of opinions. This is difficult to engage with meaningfully.

According to SEIAS guidelines published by the DPME in May 2015, the aim of a SEIAS is:

- To minimise unintended consequences from policy initiatives, regulations and legislation, including unnecessary costs from implementation and compliance as well as from unanticipated outcomes.
- To anticipate implementation risks and encourage measures to mitigate them.

The SEIAS guidelines state that these aims require that the SEIAS builds on two fundamental approaches to evaluating the impact of a new rule:

1. Technical analysis, where researchers identify from their investigations, published studies and more or less complex simulations how the new rule will likely to affect different groups in society, and

2. Participatory research, mostly through consultation with stakeholders, in order to get an assessment of the impact of a new rule from those most affected and knowledgeable about the context.

There is no evidence of the above analysis or research in the SEIAS report for the NHI Bill.

The table below captures key statements in the SEIAS and provides high-level comments on these statements.

POLICY CHOICE	SEIAS statements	Comments
Role for Medical Schemes	• National Health Insurance is the preferred option to resolve the problem identified. • NHI will involve a single purchaser to drive high quality health services with a high degree of government control over total health expenditure to address inequality. A single payer is administratively more efficient and cost-effective. • The only other possible change from the status quo would be a change to full provider privatisation (privatisation option) • Current cost of medical scheme administration is 20% to 25% of overall private health expenditure. This level is expected to rise.	• Regular SA health system reviews by the Health Systems Trust provide no evidence of an insurance problem in this system. • An alternative hybrid model of NHI has not been considered. The current public sector system has significant centralised purchasing, yet doesn't show efficiency gains. • International experience suggests many more possible options. • CMS annual reports show that non-health expenditure has reduced since 2000, and is now at an average of 8.6% of gross contributions (CMS AR 2016)

POLICY CHOICE	SEIAS statements	Comments
Financing	• Progress towards UHC is hampered by a high degree of fragmentation in funding • The primary concern in SA is highly unequal per capita spending • Substantial OOP expenditure in both private and public sectors, with no mechanism for pre-payment in the public sector. • Multiple schemes and options further fragments the risk pools	• National economic constraints, including slow economic growth and unemployment are the major obstacles to more equal healthcare expenditure. • National OOP is estimated at 8%. For scheme beneficiaries, this is 18.6% (CMS AR 2016) of total expenditure, including copayments. Public sector users experience limited OOP if they use public facilities due to mean testing.
Risk pooling	• The structure of SA financing system limits capacity for cross subsidization. • Risk pools in both sectors are highly fragmented for historical and regulatory reasons. • The young and healthy can opt out of coverage and there is no risk equalisation mechanism.	• The implementation of a risk equalization mechanism has not been implemented by government, despite significant work being done and recommendations made. The provisional HMI report recommends that this is implemented. • Recommendations to mandate scheme coverage for the formally employed have been ignored.
Purchasing	• All stakeholders are responding to incentives which drive higher socio-economic groups away from the public sector due to perceptions of poor quality of care. • Traditional passive relationship between purchasers and providers needs to be replaced by strategic purchasing. • Only government can lead the creation of incentives to drive different behaviour and choices.	• There is a dire need for quality improvement in the public sector (not just a perception) • Health policy has included the need to encourage those who can afford to, to provide for themselves. • There is ample evidence of strategic purchasing in the medical schemes environment. • Schemes have established wellness programmes which have been shown to drive member behaviour.
Benefit coverage	• There is lack of comparable information on quality of care. • Access to public sector services is limited by supply-side constraints. • Private sector administrators develop multiple benefit options because they are profit-driven. This is allowed due to insufficient regulation. • The richest 40% of the population receive 60% of the healthcare benefit; and the richest 20% receive 36% of the benefits. By contrast the poorest 20% receive 13% of healthcare benefits	• An independent organisation dedicated to monitoring quality of care would resolve this. • Multiple benefit options are a response to member preferences. The CMS regulates and approves all benefit options. • Statement ignores the progressive tax regime which funds public sector healthcare; and ignores the voluntary nature of medical scheme membership.

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	despite having a need for 25%. This means the poor suffer at the expense of the non-poor. • Scheme coverage reflects apartheid racial discrimination. This compromises social cohesion.	• This is an inflammatory assertion which ignores the actual racial mix of medical scheme members, including all public sector schemes.
Demand management and rationing	• The referral system is not enforced. • Government will determine tariffs for all health services • Provider payment mechanisms to drive efficiency of provision	• The risks associated with price administration must be explicitly mitigated.
Supply of Health Professionals	• Status quo option implies continued poor quality of care due to maldistribution of financial and human resources	• The inadequate training capacity for health professionals has been a persistent national problem. The NHI Bill offers no solution for this.
Structural arrangements	• The NHI Fund will be established as Schedule 3b public entity. Administrative costs are estimated at a maximum of 3% by 2025/26. • Cost of facility certification by the OHSC is estimated at 10% total health expenditure. • Enforcement of certificate of need for providers. • Schemes to bear cost of aligning minimum service benefits to NHI benefits. • Increased regulation needed to limit the private sector, with increased costs of compliance if "privatisation" option prevails • "Privatisation" option improves access for the wealthy and leads to profit maximization by both funders and private providers.	• Administration costs of other public compensatory funds are consistently above 5%. • No evidence is presented for the 10% estimate. • If such enforcement is done, it must be supported by rigorous risk management. • This phrase is ambiguous, and has no reason advanced for "limiting the private sector". • The CMS already regulates schemes and monitors all expenditure. These two statements are not supported in fact.
Accountability	• The NHI Fund will have a robust governance framework with direct accountability to the Minister of Health	• The highest level of accountability is to Parliament rather than to an individual Minister.
Impacts	• Only NHI will improve social cohesion through decreased health inequalities and improved health outcomes. • Privatisation may lead to social delivery protests and undermine national security • NHI will create strong resilient health systems; and is pro-poor.	• None of the impacts suggested here are based on any evidence.

POLICY CHOICE	SEIAS statements	Comments
	• Failure to implement NHI will leave majority exposed to catastrophic costs for healthcare needs	• The majority already use free care in the public sector.
System Risks	• There may be poor provider uptake and public resistance or apathy to NHI • Risks of constraints to fiscal space for NHI is considered unlikely. • Weak information systems • Lack of intersectoral collaboration • Insufficient capacity at OHSC • Inept or corrupt management • Status quo will lead to increased administrative costs and have a negative impact on national priorities.	• The first six risks are realistic but there is little attempt to propose effective countervailing / mitigation strategies in the NHI Bill. • Evidence from previous years contradicts the assertion that the status quo will lead to increased administrative costs.