Hospital Association South Africa
Advancing Healthcare

NHI Bill Submission to Portfolio Committee on Health

PRESENTERS

Dr Dumisani Bomela …. HASA Chief Executive Officer
Ms Melanie Da Costa …. HASA Board member; chairs the Health Policy & Research Sub-Committee; past chair of HASA

ACCOMPANIED BY 3 OTHER HASA BOARD MEMBERS

Mr Neil Nair …. HASA Deputy Chair
Dr Nceba Ndzwayiba …. HASA Board Member
Ms Clara Findlay …. Chair of Legal Sub-Committee

Agenda

- The Private Hospital Sector - and the NHI Bill
- The Human-Centred Approach to Health Care – general comments and specific comments on the purchasing and the funding system
- Proposed Recommendations to Strengthen the National Health Insurance Bill
- Specific Provisions Tabled for Noting
- Conclusion

The Private Hospital Sector - and the NHI Bill

Dr Dumisani Bomela

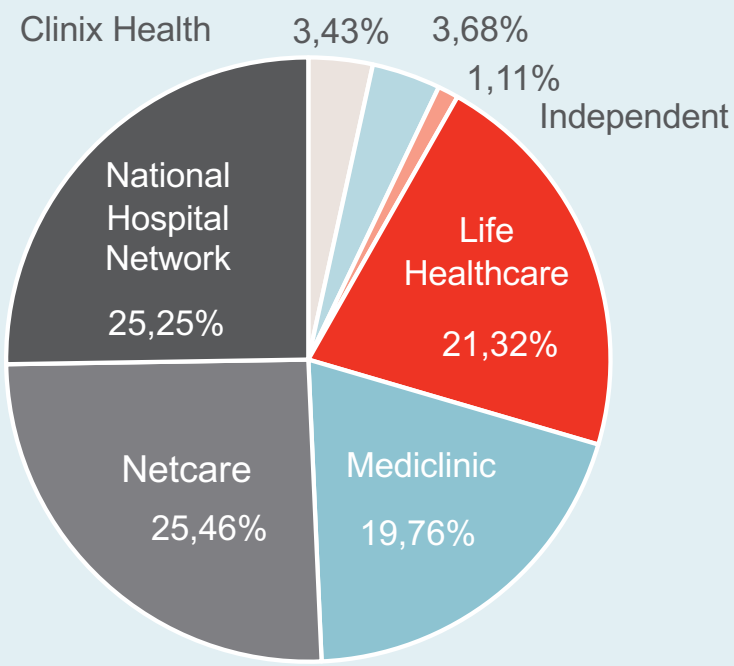
Our presentation aims to assist in crafting a Bill that enables a successfully implemented national policy

The Private Hospital Sector

About us

TYPE OF FACILITY	FACILITIES	BEDS
Acute hospital	226	34 021
Day clinic	88	1 279
Drug and alcohol rehab	54	664
Mental health institutions	44	2 160
Ophthalmology hospitals	20	272
Private rehab hospital	9	356
Sub-acute facilities	80	1 761
Unattached operating theatres	4	1
TOTAL	**525**	**40 514**

MARKET SHARE BY NUMBER OF BEDS



- In 2016, 67% of private hospitals - owned by smaller groups or independent players
- The National Hospital Networks (NHN) comprises independent hospitals and hospitals belonging to some smaller groups. The NHN negotiates collectively with healthcare funders. In 2018, the NHN is the largest hospital grouping in SA

Source: Econex 2017 “Private hospital’s business activities impact on the South African Economy”

The Private Hospital Sector - and the NHI Bill

HASA's Position on the Bill

We agree:

- With the Bill's objective of achieving universal healthcare coverage (UHC)
- We must improve equity and access to quality healthcare and health system performance
- With an iterative NHI expansion
- With the Bill's alignment with the social solidarity principle - and that all participate in a common risk pool and contribute according to their means

However:

- The NHI Socio-Economic Impact Assessment's (SEIS) in our view fails to correctly articulate the problem statement – there is a consequential narrow definition on the financing system as the main obstacle to the achievement of universal health care and a limited focus on the bottlenecks to access.

As a result, we:

- Highlight various underlying issues in the system that address access and inequity for instance, health infrastructure and healthcare worker constraints
- Advocate for:
  - An iterative approach that features clearly defined, transparent, measurable milestones (rather than dates).
  - Avoiding unintended consequences of implementing the Schedule of Amendments to other Acts upfront rather than through a phased approach.
  - Employing the approach above to mitigate against the inherent concentrated operational risk of the NHI.
  - Mitigating against the systemic and financial risk inherent in a single-fund system through incorporating a flexible and integrated multi-funder approach - including self-funding.

Towards the Achievement of a Human-Centred Approach to Healthcare and Long-term Sustainability:

General Comments on Policy

Melanie Da Costa

A Human-Centred Approach to Healthcare and Sustainability
General Comments on Policy

HASA unequivocally supports addressing inequity in health access

As healthcare professionals
we believe in a human-centred approach in which no one needing healthcare is left behind.

We believe in healthy
and sustainable working conditions for healthcare workers, who are currently overstretched.

Our approach is informed by the following observation:

"The strength of health systems can affect the speed and quality of implementation of reforms" *Global Forum for Health Research in collaboration with the World Health Organisation*

*Strengthening health systems, 2004: (https://www.who.int/alliance-hpsr/resources/Strengthening_complet.pdf)

A Human-Centred Approach to Healthcare and Sustainability
General Comments on Policy

To achieve the systemic strength that delivers rapid and quality reforms as per the Global Forum for Health and WHO observation, we must clearly understand the challenges we face.

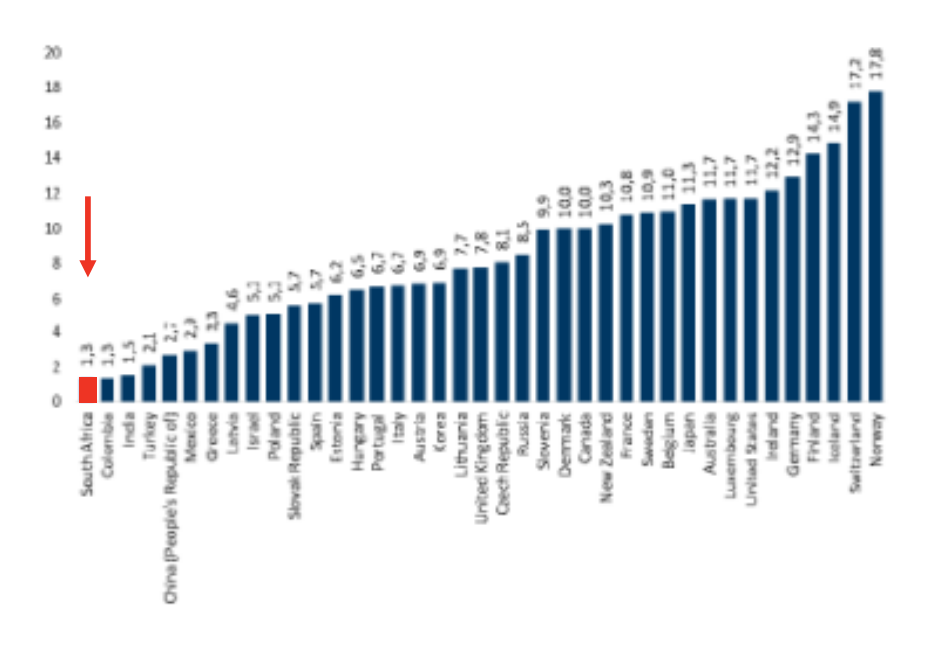
1. The NHI SEIS* stipulates that progress toward healthcare reform has been limited by the existing health financing system structure.
2. While funding structure and public funding is certainly a concern, for example, the current per capita expenditure on health is 27% of the OECD average, so is:
    - physical access,
    - healthcare system performance,
    - service delivery challenges, and
    - Shortage of healthcare workers. South Africa has less than 10% of the OECD average specialists per 100,000 citizens.
3. The Development Bank of South Africa* similarly recognised the depth of our health problems and questioned the capacity of the healthcare system to respond to our changing healthcare needs.
4. It is critical that we adequately manage risks as we tackle these challenges

- We need to ensure that as some elements of NHI go live, be they benefits coming on stream or other legislative changes, that the steps enhance rather than impede on access (that is currently available)
- We also need to be pragmatic and wise about concentrating funder risks be it operational or placing further funding burdens on the State.
- We note, in addition, that the delivery burden might also transfer to the state if the removal of medical scheme tax credits are not aligned to the phase-in of NHI benefits.

*Development Bank of SA in 2008 “A Roadmap for the Reform of the SA Health System”

Shortages of Doctors and Nurses

Nurses per 1,000 inhabitants, 2018
(or latest available)



Doctors per 1,000 inhabitants, 2018
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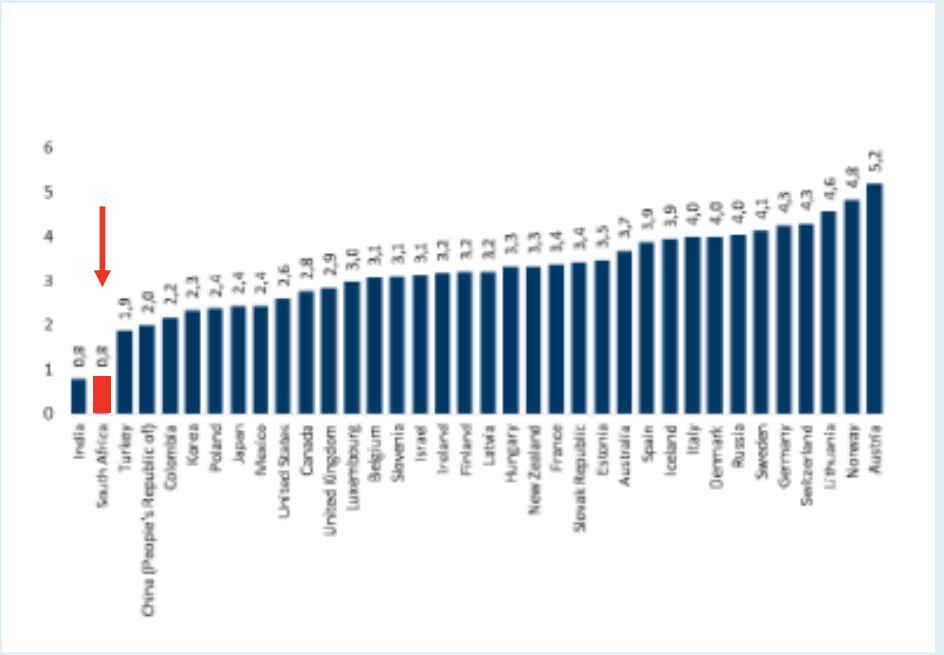


Source: OECD21; Note: South Africa data is from 2015

A Human-Centred Approach to Healthcare and Sustainability
General Comments on Policy

Shortage of Medical Schools

Number of active medical school (2020) per 1,000,000 of population*

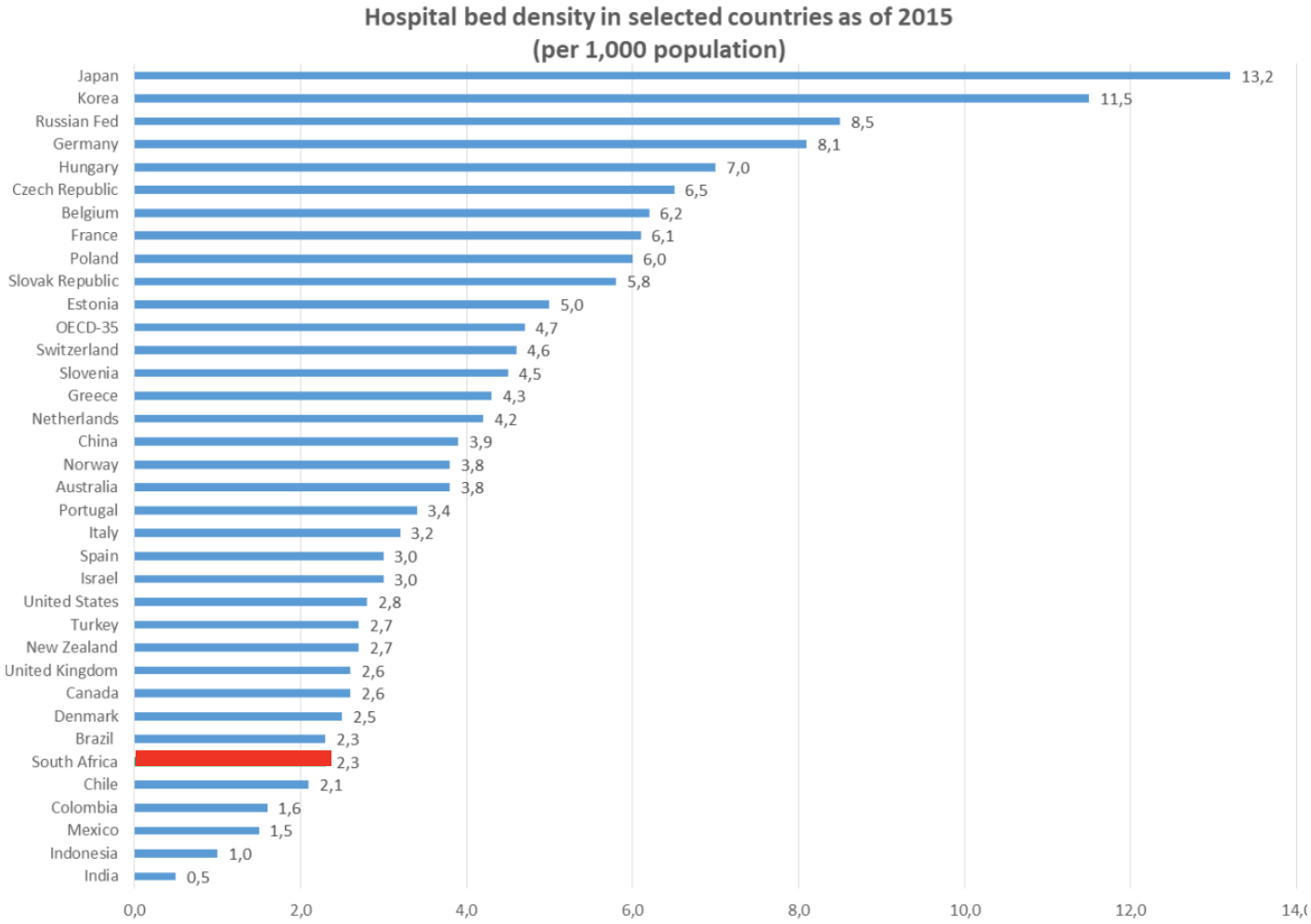
	Active Medical Schools	Active Medical Schools per million population
Libya	13	1.88
Brazil	322	1.50
Colombia	59	1.15
Mexico	118	0.91
UK and Ireland and territories	61	0.83
France	54	0.82
Russia	95	0.65
USA	197	0.59
India	498	0.36
South Africa	10	0.16
China	186	0.13

- Additional supply:
  - Nelson Mandela Fidel Castro (NMFC) medical collaboration programme
  - Consider private medical schools
- Other developing countries have encouraged the expansion of private medical training:
  - **India:** private medical colleges produce equal numbers of medical graduates to public universities
  - **Brazil:** by 1983 more than half medical schools were private institutions

Sources: World Directory of Medical Schools at World Federation for Medical Education: https://www.wdoms.org
World population Review: https://worldpopulationreview.com

A Human-Centred Approach to Healthcare and Sustainability
General Comments on Policy

Shortage of Hospital Beds



Source: https://www.statista.com/statistics/283273/oecd-countries--hospital-bed-density/

Hospital Association South Africa
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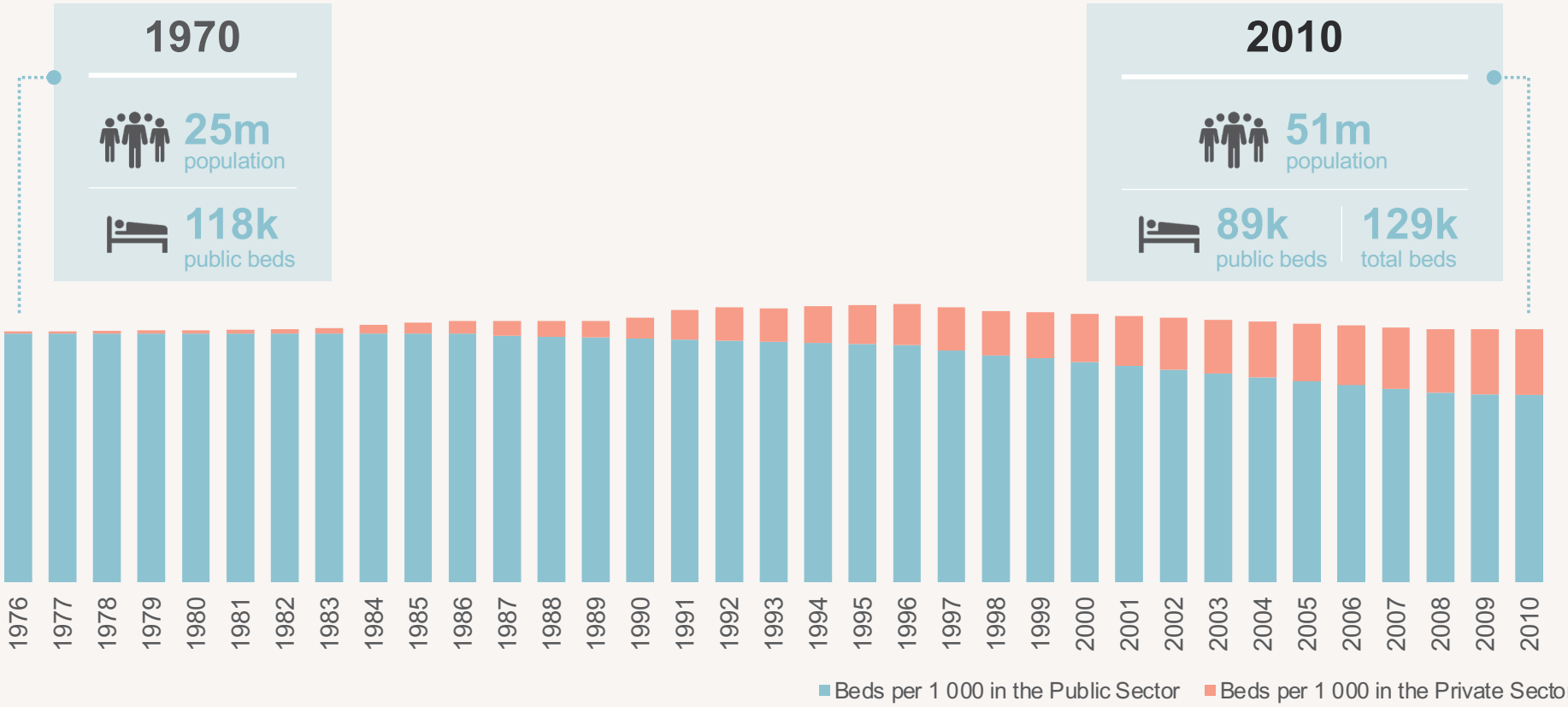
A Human-Centred Approach to Healthcare and Sustainability
General Comments on Policy

Since the 1970's, our population has doubled but the number of beds in the public sector has reduced by 25% and medical training expansion is muted.



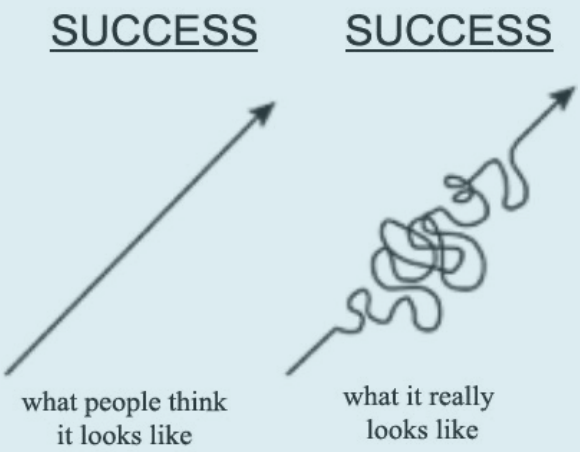
Source: Data 1976-2010 Alex Van Den Heever; Review of Competition in the South African Health System produced for the Competition Commission (19 June 2012) page 31. Latest data source Health Systems Trust together with HASA data

A Human-Centred Approach to Healthcare and Sustainability
General Comments on Policy – In Summary

The challenge we face is to build a health system that can deliver reforms at both the speed and the quality future generations deserve and require

We need:

- a clear understanding of the interdependent, multi-faceted nature of healthcare as well as the complex challenges we face, and in addition, we need to manage the risks inherent in attempting to overcome these challenges.
- appropriate numbers of qualified doctors, nurses, and allied workers,
- appropriate and well-maintained health infrastructure and functioning medical equipment,
- access to medication, medical & surgical consumables and medical technologies,
- a stable and reliable supply chain,
- strong administration,
- a well-run, efficient, data-rich, and information technology-run system.



Towards the Achievement of a Human-Centred Approach to Healthcare and Long-term Sustainability:

Specific Comments on purchasing and funding the system.

Melanie Da Costa

A Human-Centred Approach to Healthcare and Sustainability
Comments on Purchasing of Health Services

HASA supports purchasing of services from private sector as a means to improve access and equity

PRIMARY HEALTHCARE

‘Funds for primary health care services must be transferred to Contracting Units for Primary Health Care at the sub-district level as outlined in section 37’.

EMERGENCY SERVICES

(a) Emergency medical services provided by accredited and contracted public and private health care service providers must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary.

(b) Public ambulance services must be reimbursed through the provincial equitable allocation.

HOSPITALS

The Fund must transfer funds directly to accredited and contracted central, provincial, regional, specialised and district hospitals based on a global budget or Diagnosis Related Groups.

Which is the contracting body for private hospitals or perhaps this will come later?

We notice that public health systems around the world embrace the services of private hospitals.

A Human-Centred Approach to Healthcare and Sustainability
Comments on Purchasing of Health Services

Alignment to the proposed changes to the Medical Scheme Act in the Bill?

S55.1 (m) The Minister may…make regulations regarding—the relationship between public and private health establishments, and the **optional contracting** in of private health care service providers;

- Purchasing from **public hospitals** is considered in the Bill in Phase 1 (S7.4(g)

S33. Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund.

- If private hospitals are not reimbursable during certain periods of NHI phasing, S33 interpreted such that benefits can be covered under voluntary private insurance until the Bill is 'fully implemented'….
- ….does the proposed amendment to the Medical Scheme Act in Schedule 58 cater for this?
- Will removal of medical scheme tax credits align the phasing of private hospital benefits?

A Human-Centred Approach to Healthcare and Sustainability
Comments on Purchasing of Health Services

Hospital cover and the impact of tax credits

- The 2017 version of the NHI White Paper calls for tax revenue currently paid to medical scheme
- beneficiaries in the form of medical scheme tax credits to be reallocated towards funding the NHI

- Some recommending that only R30 billion is required for NHI and much speculation funding this through a total withdrawal of the tax credit for medical schemes.

- The primary purpose for the tax credit is to “reimburse” taxpayers making use of the private healthcare sector.

- The removal of medical scheme tax credits will affect poorer medical scheme beneficiaries disproportionately and medical scheme membership would become unaffordable and would need to access public healthcare for services potentially still to be phased in by NHI.

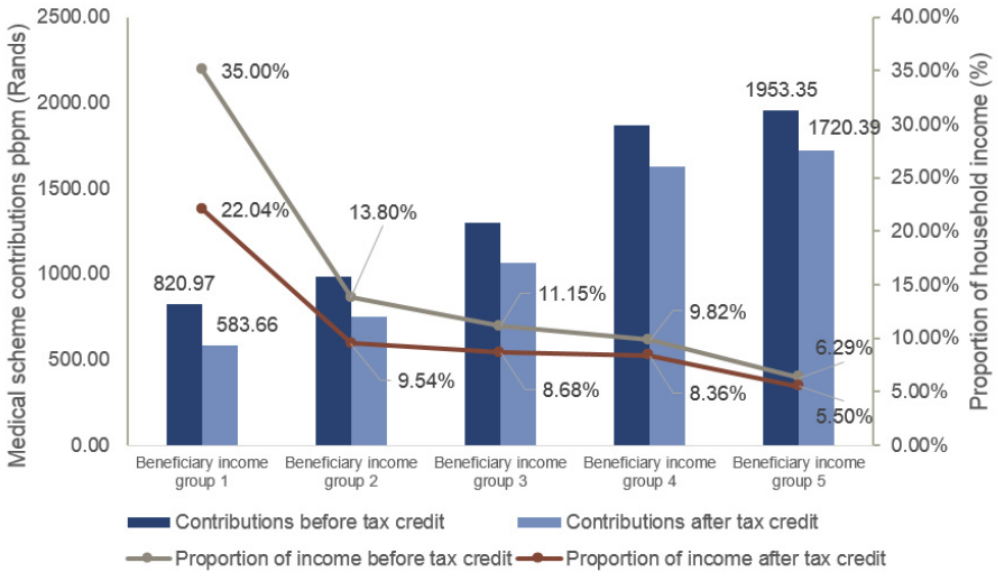
- It is one thing to remove this once NHI is ‘*Fully implemented’* but has its unintended risks in the phasing in period.

If the removal of the tax credit results in a structural reduction in medical scheme membership before the phasing in of ‘catastrophic cover’, the additional funds will have to be distributed over an increasing public sector catchment population

A Human-Centred Approach to Healthcare and Sustainability
Comments on Purchasing of Health Services

Hospital cover and the impact of tax credits.

Medical Scheme contributions before and after tax credit



Using an **affordability threshold of 12.85% of household income**, those most affected by the removal of the tax credit will be those that can least afford cover. They could result in a shift of demand to public hospitals, placing more demands on the public hospital resources which might not have seen an injection of additional resources.

"In total, 21.86% of medical scheme beneficiaries will move above the affordability threshold with the removal of tax credits, i.e. **1.9 million beneficiaries** in 2016.

* Poorest 20% Source: IES 2010/2011 (Statistics SA); SARS (2017); Econex calculations

A Human-Centred Approach to Healthcare and Sustainability
Comments on Purchasing of Health Services

Sustainability of providers under purchaser-provider split

SA public hospitals must be self-sustaining in a purchaser provider split.

Risk that a monopsony buyer sets prices too low, while attractive in the short run, erodes the supply chain over time if it is unsustainable.

Continued provision of health services requires fair pricing that is scientifically informed and transparent and efficient payment system.

Important differentiators in comparing private vs public tariffs:

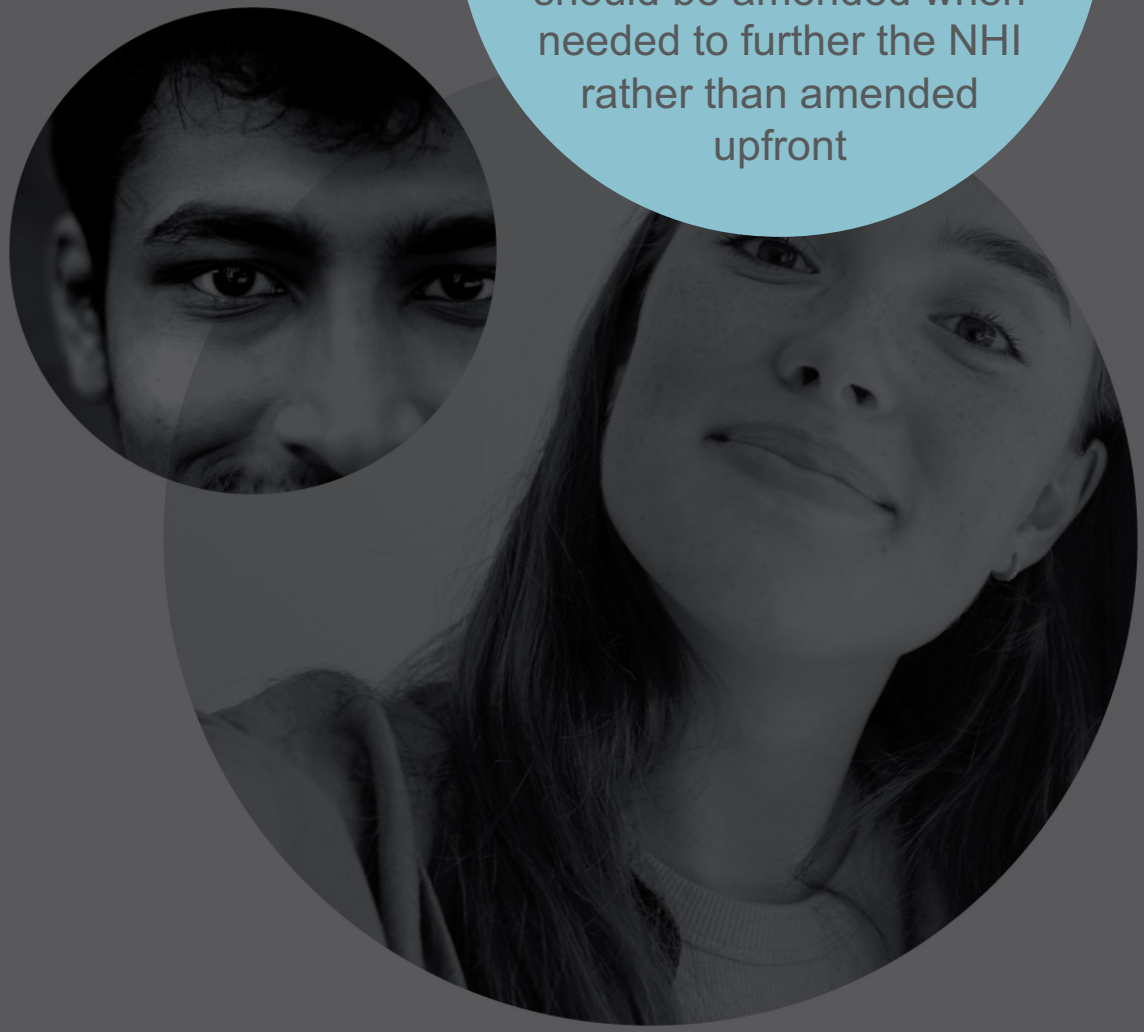
- Doctors are employed in public sector but are independent in the private sector.
- Taxes: VAT (15%) & Corporate (28%).
- SEP and Net Acquisition Price on surgical devices higher than state in order to cross subsidise.
- CAPEX.
- Return on investment to cover weighted average cost of capital.

Summary
Comments on the funding system

International literature is clear that mandatory prepayment is a key ingredient in achieving universal health coverage.

- As private hospital services might be phased in at a later time consider the impact of amendments to the Medical Scheme Act upfront and phasing in of removal of tax credits on the impact of catastrophic cover, with a focus on improving access to the most vulnerable
- Have we sufficiently considered the concentration of risk and the unintended consequences?
- The NHI Fund itself could be national or provincially located with single risk pool through risk equalisation, similarly private administrators could also be considered.
- Alternative NHI approaches need to be engaged with e.g.
    - *Alternative Configurations for the Healthcare System in South Africa, towards achieving Universal Healthcare Coverage. (*A research report by Insight Actuaries for Business Unity South Africa).

Clear legislative framework:
Review for consistent terminology, ambiguity and consider that regulations should be amended when needed to further the NHI rather than amended upfront



Proposed Recommendations to Strengthen the National Health Insurance Bill

Melanie Da Costa

Proposed Recommendations to Strengthen NHI Bill

The Bill requires a clear framework for implementing the NHI Fund so that the scope for uncertainty and unintended consequences is limited.

- S6 of the Bill establishes user rights (within States available/appropriate resources)

- S7 deals with health care service coverage.
- S7.2 (d) a user must first access services at a primary health care ; must adhere to the referral pathways.
- If S7.2 (d) has not been complied with?

- S8 explains that users must pay through voluntary medical insurance scheme when services will not be funded by the Fund
    - S8.(2): *'A person or user… must pay for health care services rendered directly,* ***through a voluntary medical insurance scheme or through any other private insurance scheme'***

Role of medical schemes

- S33. Once National Health Insurance has been ***fully implemented*** as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund.

- How would one measure that the Fund is' ***fully implemented"***?

- S33 appears to seek to rule out the right of persons to purchase additional insurance or insure against risk of rejection/unavailability of State funding of healthcare expenses once the fund is fully implemented.

Proposed Recommendations to Strengthen NHI Bill

Sequence to NHI rollout based on tangible system strengthening.

- Both Phase 1 and Phase 2 are required to be completed within specific time frames, namely between the period 2017 to 2022; and 2022 to 2026, respectively.

It is recommended that:

- S8 should consider **out of pocket payments** too for those that have not self funded (not knowing their claim would be rejected by the Fund)
- S33 The NHI Bill needs to be explicit on what ***'Fully Implemented'*** means.
- Consideration be given to an integrated multi-funder NHI and removing the restrictions on additional funding after contributing to NHI
- S57 To achieve the set objectives, milestones should be defined in dimensions including:
  - Expansion of priority services (towards the package of comprehensive health care services),
  - Population coverage,
  - For example, much learning on such milestones through the collaboration on COVID-19 vaccines

A Human-Centred Approach to Healthcare and Sustainability

Purchasing of health services – sustainability of providers under purchaser-provide split

S35. (1) The Fund must actively and strategically purchase health care services on behalf of users in accordance with need.

It is recommended that:

- S35 (1) be amended as follows: 'The Fund must actively and strategically, with reference to quality and sustainability, purchase health care services on behalf of users in accordance with need…'

S11.2. (e) negotiate the **lowest possible price** for goods and health care services without compromising the interests of users or violating the provisions of this Act or any other applicable law.

- S11.2 (e) – 'negotiate the most efficient possible price for goods and health care services without compromising quality and the interests of users or violating the provisions of this Act or any other applicable law.

A Human-Centred Approach to Healthcare and Sustainability

Purchasing of health services – sustainability of providers under purchaser-provide split

S10 (e) – 'prioritise the timely reimbursement of health care services to achieve equity'

It is recommended that:

- The conditions, timing and guarantee of payment to providers should be clearly set out, as per S59 (2) of the Medical Schemes Act, in order sustain the delivery of health care goods and services

*"S59 (2) A medical scheme shall, in the case where an account has been rendered subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within **30 days** after the day on which the claim in respect of such benefit was received by the medical scheme."*

A Human-Centred Approach to Healthcare and Sustainability

Composition of Health Benefits Pricing Committee: S26 (1) and (2) of the Bill

Pricing is a significant contributor to a stable NHI Fund, and a stable and sustainable local supply chain.

S26.2 “The Health Care Benefits Pricing Committee consists of persons with expertise in actuarial science, medicines, epidemiology, health management, health economics, health financing, labour, and rights of patients, and one member must represent the Minister.”

It is recommended that:

That the subsection reads ‘… establish an independent Health Care Benefits Pricing Committee…’.

Pricing is a function of various economic considerations. Some areas of pricing expertise have been omitted:

- The expertise to be included:
  - expertise in coding
  - cost of medical infrastructure
  - regulations and cost of private sector inputs;
  - new health care technologies

That the Committee Chairperson reflects the highly technical and varied range of expertise.

A Human-Centred Approach to Healthcare and Sustainability

S58 covers immediate changes in laws – omnibus approach to legislation amendments – concern is that it does not provide for phasing in.

S58. (1) Subject to this section and section 57 dealing with transitional arrangements, the laws mentioned in the second column of the Schedule **are hereby repealed or amended** to the extent set out in the third column of the Schedule.

- Premature to contemplate all the amendments that will take effect during, or on full, implementation of the Bill
- We suggest that legislative reform should only be considered when necessary once the NHI fund is practically established
- Any legislative amendments should be restricted to those required where the NHI fund objectives cannot be carried out without the changes while ensuring that making changes to the existing legislation will not impact on the continuity of healthcare services available to eligible users during the transitional phases
- All proposed regulations should be subject to a public participation process - contemplated in clause 55(2)

A Human-Centred Approach to Healthcare and Sustainability

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Act No. 13 of 1998
Medical Schemes Act, 1998

The amendment of section 1-

(a) by the **substitution for the definition of "business of a medical scheme"** of the following definition:

" 'business of a medical scheme' means the business of undertaking, in return for a premium or contribution, the liability associated with one or more of the following activities:

a) providing for the obtaining of any relevant healthcare service that is not covered by the provisions of the National Health Insurance Act, 2019
b) granting the assistance in defraying expenditure incurred in connection with the rendering of any relevant healthcare service that is not covered by the the National Health Insurance Act, 2019

A Human-Centred Approach to Healthcare and Sustainability

S58 covers immediate changes in laws – omnibus approach to legislation amendments – concern is that it does not provide for phasing in.

S58. (1) Subject to this section and S57 dealing with transitional arrangements, the laws mentioned in the second column of the Schedule are hereby repealed or amended to the extent set out in the third column of the Schedule.

It is recommended that:

Remove the schedule or make it a draft schedule and reference it in S57 instead, so that there will still be opportunity for public participation per scheduled amendment as and when the NHI Fund and its benefits come on stream.

The NHI should operate on a transparent and independent basis where provision is made for accountability and financial sustainability.

Specific Proposals Tabled for Noting

Dr Dumisani Bomela

Governance

"One of the critical determinants for ensuring the success of an SOE is having a board constituted with the appropriate expertise, the required level of experience and most vital, integrity."

DULLAH OMAR INSTITUTE

- Clear separation of responsibilities.
- Concerns raised around the concentration of powers.
- Clarify the process to dismiss of the CEO.
- Operate transparently and on an independent basis and make strong provision for accountability and financial sustainability.
- A remuneration framework for board members that observes **specific performance metrics of the Fund**.
- **Articulate sanctions** that can be taken against board members for not ensuring the sustainability of the fund or engaging in fraudulent and corrupt activities. HASA requests inclusion of this detail.

Other Comments for Noting

S3(5)	What are the consequences of excluding the Competition Act?
S13(5)	Constitution and composition of the Board should be through a transparent and credible process, with Parliamentary decision making after consultation with the Minister. Additional expertise should be included, with provisions guarding against conflict of interests.
S16	Conflict of interest provisions should be strengthened to include direct and indirect conflicts.
S27	The Stakeholder Advisory Committee should include business.
S39	Time periods for accreditation of service providers should be specified.
S49	Should provide for a transparent and incremental programme for the reallocation of medical tax credits.
S52	Delegation of Ministerial powers should not apply to the appointment of structures and committees.

Concluding Comments

The NHI Bill forms a credible basis to move forward and progressively fund and achieve universal health care but the phasing in, aligned to adjustments to regulations and tax adjustments, in critical and not clear in the Bill.

Health system strengthening is not sufficiently considered in the debate, leading to unintended rationing for longer than expected. Drawing on international evidence there is a clear risk that the NHI could be underfunded relative to pent up demand, leading in turn to unintended rationing - prioritise the most vulnerable.

Insurance, whether statutory or private should not undermine the rights of individuals to physiological autonomy under S12(2) of the Constitution.

Some areas do require consideration in order to best achieve the objectives of the Bill in order to not negatively impact on the sector's sustainability and ability to provide quality care to patients.

- Single Fund vs Multiple Funds within the framework of social solidarity
- S57 – timelines to NHI rollout vs measurable milestones and an explicit definition of 'Fully Implemented"
- S58 and 59 – affects 11 pieces of legislation that should rather be considered when necessary to meet the NHI Fund's objectives and should afforded the appropriate consultation.
- The proposed exclusion of other forms of funding and the limitation on right to access outside of NHI, once fully implemented, should be reconsidered.

Hospital Association South Africa
Advancing Healthcare

HASA reaffirms its commitment to working hand in hand with the State to build the best version of the NHI for the country.

Thank You