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Parliamentary Portfolio Committee on Health

Comments by Life Healthcare Group

in respect of

The National Health Insurance Bill [B11-2019]

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1. Introduction

1.1. The Parliamentary Portfolio Committee on Health ("**Portfolio Committee"**) has invited stakeholders to provide written submissions on the National Health Insurance Bill ("**the Bill**"), published on 8 August 2019 by the National Department of Health ("**NDoH**") pursuant to which it is contemplated that the National Health Insurance ("**NHI**"), as a form of universal health coverage ("**UHC**"), will be implemented using a single fund ("**Fund**"). As a major participant in the healthcare sector, Life Healthcare Group ("**LHC**") welcomes the opportunity to comment on the abovementioned Bill.

1.2. LHC is a leading private healthcare service provider in the South African healthcare market with a platform of 49 acute hospitals offering comprehensive inpatient care across 7 provinces. LHC's acute hospital offering is complemented by 9 dedicated mental healthcare facilities and 7 acute rehabilitation facilities, a renal dialysis platform consisting of 26 units (of which 23 are dedicated to chronic care) as well as 5 oncology units. In addition to the acute hospital business, which primarily serves the medically insured market, LHC provides healthcare services to state patients in 10 facilities through its wholly owned subsidiary, Life Esidimeni. LHC also includes Life Occupational Health, a leading provider of employer-sponsored occupational and primary healthcare services with a network of over 310 clinics across 9 provinces.

1.3. As a significant stakeholder in the South African private healthcare sector in general, and more specifically in the hospital sector, LHC is deeply committed to playing an active role in continuing to enhance the performance of the health system with respect to delivering quality, cost-effective care in a sustainable way. We look forward to providing healthcare for a greater number of South Africans and expanding quality healthcare services through the NHI. LHC therefore welcomes this opportunity to contribute meaningfully to the dialogue

and the eventual legislation of the proposed NHI Scheme. We hope to make a positive contribution, through our submissions, to the refinement of the Bill.

1.4. LHC fundamentally supports the principle of all South Africans having access to affordable, comprehensive, quality healthcare services irrespective of their socio-economic status and appreciates the complexities involved in realising this objective. We applaud the mammoth task undertaken by the NDoH in trying to achieve the realisation of this objective in the Bill.

1.5. South Africa, like many other developing countries, has both a private and a public health sector that co-exist. South Africa's journey towards attaining universal healthcare coverage started over a decade ago. Since then, the country has engaged in commentary on the Green and White NHI papers as well as the draft Bill.

1.6. The most critical choice confronting many countries on their journey to attaining UHC is design, more specifically, policy makers selecting either a single-payer system or a multi-payer system. The design selected will be based on the objectives that each of the respective countries are attempting to achieve. There can be no doubt that optimum accessibility and quality of healthcare services provided to all South Africans, irrespective of their socio-economic status, is an absolute priority for government. This is especially true given the unique historical context of our country. The NDoH has made a policy-decision to adopt NHI as a form of UHC by way of a single-payer system.

1.7. A paper published by the Congress of the United States in May 2019 states that: "*The transition toward a single-payer system could be complicated, challenging and potentially disruptive. To smooth that transition, features of the single-payer system that would cause*

the largest changes from the current system could be ***phased in gradually*** *to minimize their impact.*"[1]

1.8. The Congress of the U.S. Congressional Budget Office succinctly lists key design components and considerations for establishing a single-payer health care system[2]:

1.8.1. administration;

1.8.2. eligibility and enrolment;

1.8.3. covered services and cost sharing;

1.8.4. role of current systems;

1.8.5. provider roles and rules;

1.8.6. payment rates; and

1.8.7. cost containment and financing.

1.9. Based on the design components and considerations listed above, the Bill should specify in greater detail the various critical design components of the single-payer system it envisages implementing, which is essential for sustainable implementation.

1.10. Despite the many obstacles to be overcome from design, human resource and implementation perspectives, seeking to improve the nation's health outcomes through addressing the significant challenges within the healthcare sector is a significant undertaking. We believe this undertaking should not fall on the shoulders of the government alone. Instead, all stakeholders in the sector should work together, drawing on our collective expertise and capabilities, in charting a way forward. LHC remains supportive of working

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[1] Congress of the Unites States, Congressional Budget Office, "Key design components and considerations for establishing a single-payer health care system.", Published in May 2019. Available on : https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf , last accessed 22 November 2019

[2] Published May 2019

with government on a reform of the healthcare system which will result in improved access to quality affordable care for all South Africans.

1.11. Through this submission, LHC would like to ensure that constructive and practical recommendations are put forward in order to ensure that UHC is successfully implemented in a **sustainable** manner as the South African healthcare sector evolves through the various policy reforms.

1.12. Our submission below is structured in such a manner as to focus on the following specific considerations that require clarity or would assist in achieving sustainable implementation of UHC:

1.12.1. implementation of the Bill;

1.12.2. pricing and tariff increases;

1.12.3. accreditation;

1.12.4. composition of advisory committees;

1.12.5. ministerial power and governance of the Fund;

1.12.6. value-added tax considerations;

1.12.7. education and training of health workers;

1.12.8. purchaser/provider split; and

1.12.9. funding.

2. Implementation of the Bill

2.1. Fundamental to achieving the objectives of the Bill is the effective progressive implementation of the various phases of the NHI. The transitional arrangements, set out in section 57 (*Transitional arrangements*) of the Bill, acknowledge this premise.

2.2. Broadly, section 57 contemplates the implementation of the NHI in two phases, namely phase 1 and phase 2. Full details of which are set out in sections 57(2), 57(3) and 57(4).

2.3. The Bill proposes that both phase 1 and phase 2 be completed within specific time frames, namely:

2.3.1. phase 1 is to be completed between the period 2017 to 2022; and

2.3.2. phase 2 is to be completed between the period 2022 to 2026.

2.4. Section 57 is silent on the consequences of positive outcomes linked to the stated phase 1 and phase 2 activities (as listed in section 57(2)(a) and (b) respectively) not being achieved before 2026, and whether the further implementation of the NHI will be suspended pending the achievement of these outcomes. By way of example, if the health strengthening initiatives contemplated in section 57(2)(a)(i) and (b)(i) have not resulted in most public health establishments obtaining certification by the Office of Health Standards Compliance ("**OHSC**") by the end of phase 2, then the ability for the NHI to effectively operate from 1 January 2026 will be hindered (as these uncertified health establishments would not be able to be accredited by the Fund in terms of section 39 of the Bill).

2.5. Consequently, there is a risk that the NHI will become fully operational prematurely (i.e. prior to the positive and enabling outcomes of phase 1 and phase 2 activities being achieved). Given that the steps in phase 1 and phase 2 have been identified as necessary for the full operation of the NHI as contemplated in the Bill, it is recommended that instead

of rendering the operation of NHI dependent on the lapse of the fixed time-period contemplated for phase 2 (i.e. 2026), it should be dependent on the actual achievement of **concrete milestones** resulting from phase 1 and phase 2 activities which will enable an effective roll-out of NHI.

2.6. The document titled "*South African Government: Strengthening the South African health system towards an integrated and unified health system, Presidential Health Summit Compact, 25 July 2019*" ("**Health Compact**") identifies nine pillars ("**Pillars**") in relation to which the existing healthcare system needs to be improved or strengthened, before we can move towards UHC. These are:

2.6.1. Pillar 1 – augment health resources for Health Operational Plan;

2.6.2. Pillar 2 – ensure improved access to essential medicines, vaccine and medical products through better management of supply chain equipment and machinery;

2.6.3. Pillar 3 – execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities;

2.6.4. Pillar 4 - engage the private sector in improving the access, coverage and quality of health services;

2.6.5. Pillar 5 – improve the quality, safety and quantity of health services provided with a focus on to primary health care;

2.6.6. Pillar 6 – improve the efficiency of public sector financial management systems and processes;

2.6.7. Pillar 7 – strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels;

2.6.8. Pillar 8 – engage and empower the community to ensure adequate and appropriate community based care; and

2.6.9. Pillar 9 - develop an Information System that will guide the health system policies, strategies and investments.

2.7. The Health Compact sets out in respect of each Pillar the interventions (or activities) that need to be taken in order to achieve the outcomes of the Pillars. We submit that the implementation of the Fund should be linked to the completion of the interventions set out in the Health Compact, in respect of each Pillar, and not the fixed dates as specified in paragraph 2.3 above. As such, the Bill should target the achievement of these established implementation milestones instead of the aforesaid fixed dates.

In addition to the full implementation of the NHI being linked to the interventions corresponding to each Pillar, we recommend that it be contingent upon users of the healthcare system being able to access services within a reasonable time. We respectfully submit that the power of the Minister to determine the Bill to be fully implemented through regulation, must be linked to meeting this requirement.

2.8. Section 2 (*Purpose of Act*) sets out the purposes of the Bill, and broadly contemplates the achievement of "*sustainable and affordable universal access to quality health care services*". To promote quality and sustainability of health care services that will be covered by the Fund, we recommend that the implementation of the activities for phase 1 and phase 2 be subject to a quality-control system. To this end, we consider it of vital importance that before there can be a transition from phase 1 to phase 2 and thereafter the full operation of NHI, there must be an independent approval or sign-off process that: (i) assesses whether the milestones have been met; and (ii) assesses whether the milestones have been met satisfactorily so as to enable the roll out of NHI.

2.9. In August 2019, PricewaterhouseCoopers Advisory and Genesis Analytics issued a report titled "*Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa, Evaluation Report, Final. NDOH10/2017-2018*" *("**Pilot Project Report**"),* evaluating the implementation of various pilot projects under the NHI policy in a number of districts in South Africa, and their success. It is stated as follows on page 13 of the Pilot Project Report:

"Overall, the implementation of the pilot interventions had mixed success across the pilot districts. Where successful, we identified a few common factors: strong political will, adequate human and financial resources for implementation, good coordination and communication, and good monitoring systems put in place at the time of implementation. However, the interventions also faced a number of challenges, and to varying degrees, these factors hindered their success. The challenges included inadequate planning, a lack of resources, inconsistent communication, a lack of coordination where necessary and insufficient mechanisms to monitor progress and thereby ensure course correction."

2.10. This excerpt from the Pilot Project Report notes that *"good monitoring systems"* must be put in place to ensure that the implementation of the phases under the Bill are successful. These findings support our recommendation that implementation of the Bill requires a monitored, milestone and metric based-approach.

2.11. In conclusion, we respectfully submit that in order to avoid full implementation of the Fund prematurely (i.e. prior to: (i) the underlying health system strengthening initiatives being completed; and (ii) the healthcare system being ready to support this scheme); a milestone-based approach to implementation, as opposed to a time-based approach, should be adopted. We recommend that the interventions set out in the Health Compact in respect of each Pillar be considered for inclusion as pre-conditions for full implementation of NHI. We further recommend that an approval/sign-off process between the phases, and before the subsequent full roll-out of NHI be incorporated into the Bill, in order to ensure monitoring of the quality of the health system strengthening initiatives being implemented in terms of section 57.

3. Pricing

3.1. LHC endeavours to engage positively with the Portfolio Committee in an effort to identify sustainable mechanisms of implementing the Fund. An issue of fundamental importance to

the sustainability of the Fund and of concern to potential providers of healthcare services as participants in the Fund is the pricing of healthcare services.

3.2. Our submissions regarding pricing are made under the following sub-headings:

3.2.1. price-setting or negotiating prices;

3.2.2. pricing parameters;

3.2.3. preferred pricing mechanism; and

3.2.4. tariff increases.

3.3. **Price-setting or negotiated prices:**

3.3.1. Although we recognise that the Bill operates as the framework for the implementation and operation of the Fund, we believe that this framework must clearly outline the key features of the Fund, including how prices for the acquisition of healthcare services will be determined.

3.3.2. There are a number of provisions in the Bill that relate to price-determination for healthcare services, but which collectively are unclear on whether prices will either be set or negotiated. We refer to the following sections in the Bill in this regard:

3.3.2.1. section 11(2)(e) of the Bill, which provides that the "*Fund…must… 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.*" (emphasis added). This provision in the Bill suggests that there will be some kind of negotiation process, before prices will be agreed;

3.3.2.2. section 26(3), which provides that the Health Care Benefits Pricing Committee "*must recommend the prices of health service benefits to the Fund*",

3.3.2.3. section 39(1)(vi), which provides that accreditation will only be awarded to a healthcare service provider if (*inter alia*) that healthcare service provider adheres to the "*national pricing regimen for services delivered*"; and

3.3.2.4. section 55(1)(t), which empowers the Minister to make regulations on "*all fees payable by or to the Fund*".

3.3.3. The last three of these provisions imply price-setting, as opposed to the first which refers to negotiated prices in respect of healthcare services.

3.3.4. In order to ensure transparency in the pricing of healthcare services and to encourage stakeholder support of the Fund, we recommend that the Bill clarify the process that will be used for determining/agreeing prices for healthcare services – i.e. price-setting, or negotiation.

3.3.5. In addition to ambiguity on price determination in the current draft of the Bill, we request the drafters to take into account the procurement obligations on organs of state entrenched in section 217 of the Constitution of the Republic of South Africa, 1996 ("**Constitution**").

3.3.6. Section 217 of the Constitution, broadly requires that all organs of state when contracting for goods and services, do so in terms of a system which is **"*fair, equitable, transparent, competitive and cost-effective.*"**

3.3.7. National and provincial departments, as well all public entities listed in schedules 2 and 3 to the Public Finance Management Act No. 1 of 1999 ("**PFMA**"), are organs of state in the national and provincial levels of government, and are therefore required to contract for "goods" and "services" in accordance with the principles of section 217 of the Constitution.

3.3.8. Section 51(1)(a)(iii) of the PFMA echoes the procurement principles set out in the Constitution, and requires that public entities implement a supply chain management policy which is **"*fair, equitable, transparent, competitive and cost-effective*".**

3.3.9. The general rule, therefore, is that public entities are obliged to follow some form of competitive bidding (or "tendering") procedure before procuring goods or services.

3.3.10. We point out that the Bill appears to confer on the Fund the power to negotiate prices for the procurement of healthcare services and goods (we refer to section 10(2)(k) in this regard). However, the Fund will be an organ of state and, as such, subject to section 217 of the Constitution read with relevant provisions of the PFMA and other procurement-related legislation including the Preferential Procurement Policy Framework Act 5 of 2000 ("**PPPFA**").

3.3.11. The Preferential Procurement Regulations, 2017[3] issued in terms of the PPPFA ("**PPPFA Regulations**") which, in terms of section 3(3) of the Bill, remain applicable to procurement carried out by the Fund, limits the circumstances in which an organ of state can negotiate prices in respect of procurement contracts.

[3] GNR.32 of 20 January 2017: Preferential Procurement Regulations, 2017 (*Government Gazette* No. 40553).

3.3.12. Regulations 6(9)(b) and 7(9)(b) of the PPPFA state that an organ of state may only negotiate prices with a tenderer in circumstances where the price offered by the highest-scoring tenderer is not market-related. If the price tendered is not market-related, then the organ of state may negotiate a market-related price with the highest scoring tenderer. These provisions of the PPPFA Regulations appear to conflict with the powers of the Fund to freely negotiate "lowest possible prices" with healthcare service providers.

3.3.13. Furthermore, the contemplation of a price-setting mechanism in the Bill would also be inconsistent with the use of a competitive tender process, which is underpinned by competition on price.

3.3.14. It is because of these conflicts between the provisions of the Bill and the procurement framework that the process that the Fund will use to procure healthcare services remains unclear. The Bill must expressly exclude the Fund from the procurement rules set out in the PFMA and the PPPFA to the extent that the tender process contemplated therein will not be utilised by the Fund to procure healthcare services. However, we point out that notwithstanding any exclusions to the relevant procurement legislation, the Fund will remain bound to the provisions of section 217 of the Constitution, and as such, any process used by the Fund to procure healthcare services must accord with the principles set out in section 217 of the Constitution (i.e. the process must be fair, transparent, cost-effective, competitive and equitable).

3.4. **Pricing parameters:**

3.4.1. It is our submission that pricing for healthcare services must take account of the realities inherent to both the public and private healthcare sectors. For example, costs are, more often than not, higher in the private sector than the in public sector due to the fact that private health establishments have higher expenditure than public

health establishments. This is in part due to the fact that private health establishments are responsible for covering all expenses incurred in running a healthcare establishment, whereas public hospitals are often able to subsidise their costs by free or discounted services provided by other organs of state. As such, "lowest possible prices" or any pricing standard must be determined without compromising the ability of private health establishments to sustain their operations whilst offering healthcare services at the determined/agreed prices.

3.4.2. We submit that value for money, which would include elements such as quality, efficacy, fitness for purpose and cost-effectiveness, and the sustainability of healthcare service providers and establishments must be weighed against "lowest possible prices" when the Fund negotiates or sets prices for healthcare services.

3.4.3. We refer to the Health Market Inquiry, Final Findings and Recommendations Report issued in September 2019 ("**HMI Report**") which, in the context of health establishments, supports a shift towards value-based purchasing of healthcare services.

3.4.4. Currently, the healthcare market is characterised by a general absence of value-based purchasing.[4] This is, according to the HMI Report, a barrier to competition in the market. It is noted in this report that the market will be more effective if there is competition on value (including cost and quality) of healthcare services.[5]

3.4.5. These findings in the HMI Report support the position that having a model for the purchasing of healthcare services that is purely based on "lowest possible prices" is

[4] Paragraph 2 of the Executive Summary of the HMI Report.

[5] Paragraph 7 of the Executive Summary of the HMI Report.

inappropriate. Instead, the purchasing model in respect of healthcare services should be value-based.

3.4.6. For this reason, we recommend that the Bill, as recommended in the HMI Report, adopt a value-based purchasing model as opposed to one that solely concentrates on "lowest possible prices".

3.4.7. In terms of section 10(1)(k) of the Bill, the Fund "*must ensure that health care service providers, health establishments and suppliers are paid in accordance with the quality and value of the service provided at every level of care.*"

3.4.8. Although we commend the Bill for incentivising quality service provision, we request clarity as to how "*quality*" and "*value*" of services will be factored into the prices paid for the acquisition of healthcare services by the Fund, how these values compare to "lowest possible prices" referred to in 11 (2)(e) of the Bill elsewhere, and who or which body/ies will be responsible for measuring or determining quality and value of healthcare services.

3.4.9. The legislature, when delegating powers to a functionary in terms of the Bill, must ensure that it provides sufficient guidance to functionaries on how broad discretionary powers must be exercised.[6]

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[6] In Affordable Medicines Trust and Others v Minister of Health of RSA and Another (2006 (3) SA 247 (CC).) ("**Affordable Medicines**"), the court made the following statement about delegation of powers by the legislature:

"the delegation must not be so broad or vague that the authority to whom the power is delegated is unable to determine the nature and the scope of the powers conferred. For this may well lead to the arbitrary exercise of the delegated power. Where broad discretionary powers are conferred, there must be some constraints on the exercise of such power so that those who are affected by the exercise of the broad discretionary powers will know what is relevant to the exercise of those powers or in what circumstances they are entitled to seek relief from an adverse decision. These constraints will generally appear from the provisions of the empowering statute as well as the policies and objectives of the empowering statute;" (Affordable Medicines at para 34.)

3.4.10. As the Bill stands, it lacks guidance for the Fund on how: (i) to exercise its power to determine/negotiate prices, (ii) the recommendations on price by the Health Care Benefits Pricing Committee relate to the exercise of this power, and (iii) quality and value factor into price determinations/negotiations.

3.4.11. The Fund should be provided with guidance as to what constrains its powers to determine or negotiate prices, and how this power must be exercised. Having this guidance will prevent arbitrary or inconsistent exercises of power by the Fund when determining or agreeing prices for healthcare services. In order to mitigate this risk, we respectfully submit that the Bill should:

3.4.11.1. clarify within what parameters the Fund is required to negotiate or set prices for healthcare services;

3.4.11.2. provide guidance on how the power of the Fund to determine or agree prices must be exercised (for example, is it constrained by the recommendations made by the Health Care Benefits Pricing Committee); and

3.4.11.3. clarify the meaning of the terms "quality" and "value" and how these factors relate to lowest possible prices, and ultimately factor into price determinations or negotiations by the Fund.

3.4.12. The significance of these submissions pertaining to "*quality*" and "*value*" is heightened by the findings in the HMI Report. It is a recurrent theme in the HMI Report that there is currently no clear measure of quality across health establishments, and no clear mechanism for collecting data on whether quality healthcare services are in fact being provided by health establishments. This is to a large extent a result of the absence of

a standardised publicly shared measure of quality and healthcare outcomes.[7] This can be precarious, in that: (i) patients and funders of healthcare services are unable to exercise a choice based on value (quality and price); and (ii) scrutiny over healthcare services is minimal.

3.4.13. To remedy this, the HMI Report recommends that quality be measured in accordance with outcomes and that a standard set of outcomes be developed for application across all health establishments.

3.4.14. To achieve this, the HMI Report recommends that an Outcomes Monitoring and Reporting Organisation ("**OMRO**") be established. This body will operate as a platform for stakeholders to engage and generate *"patient-centred and scientifically robust information on outcomes of healthcare*", which can be used to identify relevant and standardised outcomes for health establishments and for evaluating if a health establishment is in fact achieving these outcomes.[8]

3.4.15. We advocate for a similar approach to the determination of quality under the NHI. Although we recognise and acknowledge that an accreditation process will be adopted under the NHI, and will contribute to standardising of quality of services across health establishments, we, in light of the HMI Report, acknowledge the need for an outcomes-based approach to measuring and monitoring quality alongside the accreditation process.

[7] Paragraph 12 of the Executive Summary to the HMI Report.

[8] Paragraph 52 of the Executive Summary to the HMI Report.

3.5. **Preferred pricing mechanism**

3.5.1. As described in the WHO Price setting and Price regulation in healthcare:

"*When setting prices at an appropriate level, elements that should be factored in include the unit costs of providing services, economies of scale and scope, high entry and capital costs, and marginal benefits of quality.*" [9]

3.5.2. LHC is of the view that prices for private hospitals be established at levels that take all costs involved in the provision of services into consideration and encourage investment in the sector.

3.5.3. The rationale for this proposition is that there is currently no spare capacity in the public sector and there is limited spare capacity in the private sector.

3.5.4. The former health minister, Aaron Motsoaledi, stated at the nurses' summit on 14 November 2018 that "*South Africa's health system was "overburdened" by having to care for more people than it could afford.*" This is further affirmed in the HMI report which states that "*the public sector is generally overburdened.*"[10]

3.5.5. Insight Actuaries & Consultants undertook an analysis on the South African private hospital occupancy trends and patterns for hospital admission from the years 2014 to 2017. Information was independently requested from Netcare, Mediclinic, LHC and the National Hospital Network on a confidential basis.

3.5.6. The analysis demonstrates that current hospital occupancy is at an average of 65%, with occupancy being higher during the week than over the weekend (doctors tend to undertake procedures more during the week than over the weekend). The occupancy

[9] https://www.oecd.org/health/health-systems/OECD-WHO-Price-Setting-Summary-Report.pdf , P 40

[10] HMI Final Report, page 101, paragraph 229.3

levels do not account for the geographic distribution of hospitals in more densely populated areas, where occupancy levels are much higher and therefore an increase in occupancy would be difficult in these areas.[11]

3.5.7. The recommended appropriate capacity is up to 80% as provision should be made for the admission of emergency patients. Occupancy levels that are above 80% result in inefficiencies and will adversely impact patient care.[12] The analysis therefore highlights limited spare capacity in the private hospital sector to absorb more patients based on these occupancy trends. Given the inherent demand, capacity will need to be increased by the private hospital sector. This increase in capacity would need to be matched by an increase in clinical staff as well as hospital support services such as cleaning, linen, catering, administration and security. The principle of competition in the hospital market relies on the fact that there is a certain degree of excess capacity within a market.

3.5.8. On this basis, our view is that there should be an established price for the country for the provision of hospital services. The creation of this price needs to take into account a fair return on investment factoring the asset-intensive nature of the hospital environment.

3.5.9. An extensive profitability analysis was undertaken by the HMI using 10 years' worth of data wherein it set out the methodology for estimating an appropriate cost of capital

[11] Private Hospital Review, HASA, 2009

[12] Eurostat (2016) reports that the majority of European countries operate on 75% hospital occupancy, across the public and private sectors.

for entities providing hospital services in South Africa (the Weighted Average Cost of Capital ("**WACC**")). The asset pricing model was applied to the hospital groups (LHC, Netcare and Mediclinic),to arrive at an appropriate WACC estimation.[13]

3.5.10. A fair return on investment in the private sector is fundamental to its sustainability. LHC is a for profit, Johannesburg Stock Exchange listed organisation and we believe that this should enable our effective and efficient delivery of services rather than be an impediment to the delivery of healthcare services to the population.

3.5.11. A significant portion of the existing cost base stems from operating within the current regulatory requirements. In order to significantly decrease the cost of the delivery of services, there may be significant changes required to be made to the existing legislative framework under which hospitals operate. Should such changes be made and costs reduced, LHC would welcome the opportunity to adapt its operating model to reduce costs within a refined regulatory environment that enables this reduction in cost.

3.5.12. The HMI report, which has established a fair cost of capital with the extensive analysis undertaken, in our view is a good starting point to establish a fair return that should be added on the investment that needs to be covered through tariff. We request that the NDoH lend some credence to the methodology utilised by the HMI in establishing the appropriate cost of capital and in the establishment of a fair return on investment for the purposes of establishing a pricing level for the hospital industry. We recommend that the pricing of NHI encourage investment and take into account the full cost of provision of services.

[13] HMI Final Report, page 98, paragraph 213

3.6. **Tariff increases**

3.6.1. In terms of section 10(1)(g) of the Bill, the Fund must "*determine payment rates annually for healthcare service providers, health establishments and suppliers in the prescribed manner and in accordance with the provisions of this Act*".

3.6.2. Section 10(1)(g) is silent on the mechanism that will be used to determine increases in "*payment* rates". We recommend that the Bill make provision for such a mechanism.

3.6.3. We also point out that the Bill is silent on the relationship between section 10(1)(g), the price recommendations made by the Health Care Benefits Pricing Committee in terms of section 26(3), and the negotiation of pricing by the Fund in terms of clause 11(2)(e) of the Bill.

3.6.4. Clarity is sought as to how these provisions in the Bill relate to each other and whether the annual increase in rates will be (i) set by the Fund, (ii) on the recommendation of the Health Care Benefits Pricing Committee or (iii) agreed through a negotiated process with healthcare service providers.

4. **Accreditation**

4.1. **Criteria**

4.1.1. LHC welcomes the requirement for health establishments and healthcare service providers to obtain accreditation before being able to participate in the Fund. We request that the accreditation requirements as currently provided for in section 39 (*Accreditation of service providers*), be set out with greater clarity and detail.

4.1.2. Although it is clear from section 39 that the Fund will accredit health establishments and healthcare service providers, the Bill remains silent on how and when these accreditation processes will be undertaken. Clarity is required on how the Fund will carry out these accreditations, for example:

4.1.2.1. Will the accreditation unit established by the Chief Executive Officer of the Fund in terms of section 20(3)(d) of the Bill carry out this function? If so, it is requested that the powers and functions of this unit be set out in the Bill.

4.1.2.2. Will fees be payable for accreditation and if so, how will these be determined?

4.1.2.3. How will the Fund know in advance (i.e. at the time of first accreditation) that a health care service provider or health establishment "*meet[s] the needs of users and [complies] with prescribed performance criteria*" as contemplated in section 39(2)(b)? We point out that these criteria must take into account the fact that both public and private health establishments will need to be able to comply with these criteria and must therefore accommodate the complexities of both kinds of health establishment. For example, it is important that criteria used for determining accreditation take account of the fact that private health establishments currently do not employ doctors, who are governed by a separate regulatory body, the Health Professions Council of South Africa ("**HPCSA**").

4.1.2.4. Section 39(3) appears to establish an obligation on the Fund to contract with any health establishment certified by the OHSC and with any other "prescribed health care service provider" that satisfies the requirements listed in subsection 39(2) to provide the services listed therein. However, contracting requires agreement on the part of all the parties thereto, therefore the nature of the obligation, and the extent to which the parties may negotiate the terms of such contract, is unclear.

4.1.3. Linked to the points raised in paragraph 4.1.2.3 above, we point out that in terms of section 39(2)(a) of the Bill, accreditation of a health establishment or healthcare service provider depends on certification by the OHSC. We request clarity on the assessment criteria that will be used by the OHSC for certification. To date, the OHSC

uses the National Core Standards for Health Establishments in South Africa as a reference point when rating health establishments, which standards are better suited to measuring standards in the public sector as opposed to the private sector. This is because these standards do not take into account the fact that, unlike public health establishments, private health establishments do not employ various classes of the healthcare service providers carrying out healthcare services on their premises, such as doctors.

4.1.4. It is essential that the assessment criteria used by the Fund and the OHSC to assess accreditation take account of the complexities in both public and private health establishments, in order to ensure that private health establishments are not inadvertently precluded from accreditation, and participation in the Fund.

4.1.5. We further recommend that since the Bill envisages contracting with both the private and the public sector in providing services to NHI, that there is comparability and a level playing field between these two service provision platforms. In order to do that and to enable private sector to manage and influence the clinical outcome of the services that are provided, we recommend that the employment of doctors be enabled. This would allow the private and public sectors to compete for NHI patients on the basis of value.

4.2. **Referral Pathways**

4.2.1. In terms of section 39(2)(b)(iv), a healthcare service provider and health establishment must adhere to the healthcare referral pathways before it can be accredited, and in terms of section 39(8)(e), the Fund may withdraw or refuse to renew the accreditation of a healthcare service provider or health establishment if it has failed or is unable to comply with healthcare referral pathways.

4.2.2. Clarity is required on whether accredited healthcare service providers will, in terms of sections 39(2)(b)(iv) and 39(8)(e), lose their accreditation if they provide medical healthcare services to persons that approach them directly or without having been referred to them.

5. Composition of Advisory Committees

5.1. The success of the NHI to a large extent depends on collaboration between the public sector and private sector healthcare service providers, which includes collaboration in respect of expertise, skills and knowledge developed by each sector to date.

5.2. In Chapter 7 of the Bill, the Minister is required to establish a number of committees, including the Benefits Advisory Committee, the Healthcare Benefits Pricing Committee and the Stakeholder Advisory Committee, each of which will play an essential role in shaping how the Fund will be implemented.

5.3. As such, we submit that these committees, where its' independence is essential, should be representative of stakeholders across the industry, including private health establishments.

5.4. Any concerns relating to a conflict that may arise from the inclusion of the private hospital sector in such committees, we maintain, is adequately addressed in the "*Conflict of Interest*" provisions included under section 29 (*Disclosure of interests*) of the Bill.

5.5. The Bill provides for the Minister to establish the committees mentioned above. This creates an anomaly as the Board is responsible for the proper functioning of the Fund; to implement, contract and manage the Fund, whilst not having any say in the benefit design or the pricing of same. LHC recommends that the conditions relating to the appointment of the ministerial committees be revisited with a view of giving the Board of the Fund the sole authority in the appointment of these committees. This will ensure that the operation of the Fund is

independent and free from political interference and that the Board can ultimately be held accountable. Formulation of these committees may be guided by the principles underpinned in the King IV Code on Corporate Governance.[14], [15]

5.6. **Benefits Advisory Committee**

5.6.1. In terms of the National Health Insurance Bill, 2018, "*two members nominated by the hospital association or similar body representing the private hospitals*" were to be included as members on the Benefits Advisory Committee. In terms of the Bill, the Benefits Advisory Committee will no longer include representatives of hospitals (public or private).

5.6.2. It is our submission that there should be representatives on the Benefits Advisory Committee from private and public hospitals. This is because a determination as to the benefits package, which will be made by the Benefits Advisory Committee, must take cognisance of the capacity for accredited hospitals or health establishments to accommodate the covered healthcare services and recover the costs involved in so .

5.7. **Health Care Benefits Pricing Committee**

5.7.1. LHC respectfully draws attention to the lack of representation of private health establishments on the Health Care Benefits Pricing Committee (despite the inclusion of persons with "*health management*" and "*labour relations*" experience on this committee). LHC submits that the pricing of hospital services is a complex and specialised science and that persons with skills and experience in hospital

[14] King IV report on Corporate Governance for South Africa 2016. Available at: https://cdn.ymaws.com/www.iodsa.co.za/resource/collection/684B68A7-B768-465C-8214-E3A007F15A5A/IoDSA_King_IV_Report_-_WebVersion.pdf , last accessed 27 November 2019.

[15] "…the recommended practices do not prescribe which committees should be established by the governing body – the governing body should judge what is appropriate for the organization. The practices furthermore recommend that the application of roles and responsibilities, and the composition of committees, should be considered holistically. The aim here is to promote effective collaboration among committees with minimal overlap and fragmentation of duties, as well as a balanced distribution of power."

management will add value to deliberations on issues relating to sustainable pricing of hospital services.

5.8. **Stakeholder Advisory Committee**

5.8.1. At section 27 (*Stakeholder Advisory Committee*) of the Bill, the composition of the Stakeholder Advisory Committee is provided for as follows:

> "***27.*** *The Minister must, after consultation with the Board and by notice in the Gazette, appoint a Stakeholder Advisory Committee comprised of representatives from the statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers as well as patient advocacy groups in such a manner as may be prescribed.*"

5.8.2. We point out that the terms "*health professional*" and "*providers*" are not defined in the Bill, and as such, it is not clear to which groups of healthcare providers and/or health establishments these terms relate.

5.8.3. To the extent that the undefined terms referred to above do not include the private hospital sector, we respectively submit that because the private hospital sector is a stakeholder in the healthcare system and its omission from the Stakeholder Advisory Committee will create a vacuum in the deliberations on stakeholder interests at that forum, provision should be made for its inclusion in this committee.

6. **Ministerial Power and Governance of the Fund**

6.1. We note that a substantial portion of the Bill has been dedicated to the governance and operation of the Fund, and we express our support for this position. The Fund, being fundamental to the roll-out of NHI, must be operated independently and transparently. The Fund should make provisions for accountability and financial sustainability. Accordingly, we

applaud the separation between the Fund, the advisory committees to be set up by the Minister and the board of the Fund ("**Board**").

6.2. We respectfully point out and submit that the effective governance of the Fund, requires the imposition of checks and balances on the extensive powers afforded to the Minister, the Board and the Chief Executive Officer ("**CEO**") under the Bill. To this end, we make submissions on the following areas of the Bill:

6.2.1. the governance of the Fund;

6.2.2. financial control;

6.2.3. fund reserves;

6.2.4. advisory committees contemplated in Chapter 7 of the Bill; and

6.2.5. the extensive powers of the Minister to make regulations in terms of section 55 of the Bill.

6.3. **Fund governance**

6.3.1. The Dullah Omar Institute published an in-depth paper on the legal framework for the SOE board members and executive appointments. The paper succinctly sets out the reasons for the current state of South Africa's SOEs (Eskom, PRASA, SABC) and details how these reasons identified can be addressed only at the level of regulatory framework governing board and executive appointments, dismals and duties. We recommend the NDoH apply the learnings from this guidance when designing the NHI Fund's governance structures.[16]

6.3.2. At the outset, we note that in terms of section 13 (*Constitution and composition of Board*) of the Bill, the Minister will be vested with the power to appoint Board

[16] The Dullah Omar Institute for Constitutional Law, Governance and Human Rights, titled, "Appointment and dismissal of board members an executives of Eskom, PRASA and the SABC." Published in 2018. Available at: https://dullahomarinstitute.org.za/women-and-democracy/board-members-of-state-owned-enterprises-towards-transparent-appointments/reports/wandrag_legal_framework_paper_2_revision_4_04_07_2019.pdf. Last accessed 22 November 2018.

members. Pursuant to the nomination process for Board member appointments, the Minister must appoint an *ad hoc* advisory body to conduct public interviews of the shortlisted candidates and forward its recommendations to the Minister for approval. We point out that the Bill is silent on who is responsible for preparing the shortlist of candidates and on the criteria for selecting members of the *ad hoc* advisory body. We recommend that, for the sake of independence and transparency, the criteria for the persons that may sit on the *ad hoc* committee be included in the Bill, and that it be made express in the Bill who retains the power to shortlist candidates. Distinct steps should be articulated in order to ensure that the *ad hoc advisory body* is not politicised.

6.3.3. We express our support for the Minister to issue in the Gazette a call for public nomination of candidates to serve on the Board in terms of section 13(1) of the Bill, it will allow for an open competitive recruitment process.

6.3.4. Public participation in the appointments and dismissals of board members and executives are critical and must be prescribed. As stated in the Dullah Omar Institute paper, "*public administration must be governed by the democratic values enshrined in our constitution of public participation, accountability and transparency.*" National assembly should also play a role of a public participant in these processes.

6.3.5. As described in the Dullah Omar Institute paper , 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.[17] There ought to be a substantive transparent criteria for the appointment of board members to be

[17] The Dullah Omar Institute for Constitutional Law, Governance and Human Rights, titled, "Appointment and dismissal of board members an executives of Eskom, PRASA and the SABC." Published in 2018. Available at: https://dullahomarinstitute.org.za/women-and-democracy/board-members-of-state-owned-enterprises-towards-transparent-appointments/reports/wandrag_legal_framework_paper_2_revision_4_04_07_2019.pdf. Last accessed 22 November 2018.

stringently applied. The legislative framework should address both the appointment and dismissal of board members and executives with a prescribed process in order to avoid governance challenges and increase accountability. [18] Great thought must be given around the legislative framework on the appointments and dismissal of board members and executives to ensure that there are no contradictions in the legal framework (i.e the PFMA, the Companies Act and the NHI Bill).[19] Any conflict in the legal framework must be addressed in great detail.

6.3.6. It is significant that the appointment of the CEO is subject to Cabinet approval in terms of section 19(1)(b) of the Bill, and that the appointment of the members of the Board and other executives is not. We respectfully submit that Cabinet approval be required in respect of the appointment of Board members and other executives too. The latter acts as a check on the power of the Minister to appoint the members of the Board.

6.3.7. There needs to be a clear separation of responsibilities between the government (who would be the only shareholder of the Fund), the Board and its executives. As stated in the Dullah Omar Institute paper: "… *the shareholder is responsible for the mandate, the board for developing and enforcing the strategy required to meet the mandate, and executive management for the implementation of that strategy*." [20]

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[18] "The governance fiasco at Eskom offers further evidence of the problems that can arise from a convoluted arrangement in which government is shareholder, policy-maker and regulator alike, especially so where its role extends to the appointment and removal of both the CEO and board members and consequently ends up undermining the oversight role the board is mandated to play in exercising control of the affairs of the SOC." The Dullah Omar Institute for Constitutional Law, Governance and Human Rights, titled, "Appointment and dismissal of board members an executives of Eskom, PRASA and the SABC." Published in 2018.

[19] An example of such conflict is the SABC: "The SABC board shambles and continued meddling by various Ministers of Communication are a clear consequence of the conflicting legal framework that govern the appointment and dismissal of board members and executives. In regard to the SABC, these include the Broadcasting Act, the Companies Act and the company's MOI, with the PFMA added to the mix." The Dullah Omar Institute for Constitutional Law, Governance and Human Rights, titled, "Appointment and dismissal of board members an executives of Eskom, PRASA and the SABC." Published in 2018.

[20] The Dullah Omar Institute for Constitutional Law, Governance and Human Rights, titled, "Appointment and dismissal of board members an executives of Eskom, PRASA and the SABC." Published in 2018. Available at: https://dullahomarinstitute.org.za/women-and-democracy/board-members-of-state-owned-enterprises-towards-transparent-appointments/reports/wandrag_legal_framework_paper_2_revision_4_04_07_2019.pdf. Last accessed 22 November 2018.

6.3.8. Section 18 of the Bill sets out the remuneration and reimbursement features for the Board members. In order to strengthen accountability and sustainability of the Fund, we propose that the remuneration framework take into account specific performance metrics of the Fund. These performance metrics must be linked to the Board members' remuneration structure which would result in positive consumer welfare outcomes.

6.3.9. The Bill is silent on sanctions that can be taken against board members for not ensuring the sustainability of the fund or engaging in fraudulent and corrupt activities. We request inclusion of this detail.

6.3.10. The responsibilities of the CEO are set out in section 20 (*Responsibilities*) of the Bill, and include at section 20(4), subject to the direction of the Board, responsibility for: (i) all the income and expenditure of the Fund; (ii) all revenue received from National Treasury; (iii) all assets and liabilities of the Fund; and (iv) the proper and diligent implementation of the financial matters of the Fund. It is recognised at section 51 (*Annual Reports*), that the Board is the accounting authority of the Fund, for purposes of the PFMA. As such, the ultimate responsibility for financial management of the Fund, should be in the hands of the Board and not the CEO of the Fund. Alternatively, the CEO, in carrying out his / her duties should be subject to expressly stated fiduciary duties akin to those provided for in section 50 of the PFMA, as follows:

> *"**50. Fiduciary duties of accounting authorities.** — (1) The accounting authority for a public entity must—*

(a) exercise the duty of utmost care to ensure reasonable protection of the assets and records of the public entity;

(b) act with fidelity, honesty, integrity and in the best interests of the public entity in managing the financial affairs of the public entity;

(c) on request, disclose to the executive authority responsible for that public entity or the legislature to which the public entity is accountable, all material facts, including those reasonably discoverable, which in any way may influence the decisions or actions of the executive authority or that legislature; and

(d) seek, within the sphere of influence of that accounting authority, to prevent any prejudice to the financial interests of the state.

(2) A member of an accounting authority or, if the accounting authority is not a board or other body, the individual who is the accounting authority, may not—

(a) act in a way that is inconsistent with the responsibilities assigned to an accounting authority in terms of this Act; or

(b) use the position or privileges of, or confidential information obtained as, accounting authority or a member of an accounting authority, for personal gain or to improperly benefit another person.

(3) A member of an accounting authority must—

(a) disclose to the accounting authority any direct or indirect personal or private business interest that that member or any spouse, partner or close family member may have in any matter before the accounting authority; and

(b) withdraw from the proceedings of the accounting authority when that matter is considered, unless the accounting authority decides that the member's direct or indirect interest in the matter is trivial or irrelevant."

6.3.11. Section 11 (1) (h) of the Bill states that the Fund may…" *investigate complaints against the Fund, health care service providers, health establishments or suppliers*;". Concern stems from this clause as it essentially provides the Fund the power to investigate itself. This would certainly not be considered a fair and credible process. We therefore recommend that assessments of complaints be undertaken by an independent entity to lend this process credibility.

6.4. **Financial Control:**

6.4.1. The Fund bears similarities to the compensation fund set up in terms of section 15 of the Compensation of Occupational and Injuries and Diseases Act 130 of 1993 ("**COIDA**"), and the Road Accident Fund, established in terms of section 2 of the Road Accident Act 56 of 1996 ("**RAF Act**"). Each of these funds, like the Fund, insure against certain types of risks arising in respect of certain specified beneficiaries.

6.4.2. We note that in terms of the COIDA, as a liquidity protection, a reserve fund is established in terms of section 19. The purpose of which reserve fund is to provide for unforeseen demands on the compensation fund. As will be submitted in paragraph 6.5, a reserve fund, or mandatary cap on reserve levels in respect of the Fund, is advocated by LHC.

6.4.3. Although we do not look to the Road Accident Fund ("**RAF**") as a model for the Fund, given the solvency issues currently experienced by the RAF, we look to it as a model from which the Fund can learn.

6.4.4. We recognise that the Fund will be established as national public entity (and will, as such, be listed as a public entity in schedule 3A to the PFMA), that is: (i) established in terms of the Bill; (ii) fully or substantially funded by taxes; and (iii) accountable to Parliament. The RAF is likewise listed as a schedule 3A public entity to the PFMA, and is therefore subject to the same financial controls and supervision to which the Fund will be, under the PFMA.

6.4.5. Notwithstanding the fact that the RAF is subject to the PFMA, in terms of section 14 of the RAF Act, it is subject to further financial control and supervision by the Financial Services Board established in terms of section 2 of the Financial Services Board Act 97 of 1990 (now the Financial Sector Conduct Authority). The Fund, unlike the RAF, does not have the added benefit of financial supervision of an external body, such as

the Financial Sector Conduct Authority. The Fund's financial management is limited to the controls provided for in the PFMA, and in the Bill. The financial viability of the Fund is of national interest, and as such, we submit that, like the RAF, the Fund requires additional financial controls and supervision, external to the PFMA. For this reason, we respectfully submit that an independent body, like the Financial Sector Conduct Authority, be mandated to regulate and supervise the financial viability of the Fund, and in particular regulate and monitor the solvency and liquidity levels of the Fund.

6.5. **Fund Reserves**

6.5.1. We are pleased to note that the Minister may, in terms of section 55(1)(u) of the Bill, issue regulations on the "*nature and level of reserves to be kept within the Fund*", subject to the PFMA.

6.5.2. The World Health Organisation has conducted and compiled research on some of the factors that contribute to the success of universal healthcare coverage schemes, one of which is the specification of mandatory reserve levels. The maintenance of a specified level of non-distributable reserves, is not only recognised by the World Health Organisation as necessary to the success of universal healthcare coverage, but is recognised locally in the Medical Schemes Act 131 of 1998 ("**MSA**") as necessary to the success of local medical schemes.

6.5.3. Liquidity and solvency requirements, such as a minimum stated reserve level for a medical scheme, are vital to protecting the interests of the scheme's beneficiaries. Given the recognition of this requirement in the MSA, and its role in protecting the interests of scheme beneficiaries, it is LHC's view that, it would be much more important to have a mandatory reserve level in the case of a medical scheme-equivalent that operates nationally.

6.5.4. We therefore respectfully submit that the setting of "*reserve levels*" for the Fund should not be discretionary, but mandatory. In addition, we submit that the setting and determination of "*reserve levels*" for the Fund, should be based on robust actuarial analysis (signed off by the Actuarial Society of South Africa). The determination of the "*reserve level*" should not only be carried out by the Minister, after consultation with the National Health Council and the Fund, as contemplated in section 55(1) of the Bill, but in consultation with the Minister of Finance on behalf of National Treasury.

6.5.5. We note that in terms of section 53(3) of the PFMA, a public entity listed in schedule 3 to the PFMA may not accumulate surpluses, unless the prior written approval of National Treasury has been obtained. Because the Bill remains subject to the provisions of the PFMA in terms of section 3(3) of the Bill, to give effect to our submission in this regard, the power of the Minister to regulate and impose reserve levels, in consultation with the Minister of Finance, must be expressly excluded from the ambit of the PFMA.

6.6. **Advisory Committees**

6.6.1. The Minister is empowered to establish the Benefits Advisory Committee, the Stakeholder Advisory Committee and the Health Care Benefits Pricing Committee. All appointments to the Benefits Advisory Committee are made by the Minister in terms of section 25(2).

6.6.2. As regards the Health Care Benefits Pricing Committee and the Stakeholder Advisory Committee, the Bill is not clear in sections 26 and 27 respectively, as to which person or body has the power to appoint the members of these committees. Sections 26 and 27 merely empower the Minister, in consultation with the Board, to establish these committees, but do not expressly confer a power thereon to appoint

their members. It is requested that clarity be provided on these elements of sections 26 and 27.

6.6.3. We point out that section 27 fails to set out the powers and functions of the Stakeholder Advisory Committee. We recommend that these powers and functions be set out in the Bill.

6.7. **Regulations**

6.7.1. LHC is concerned that the wide power conferred on the Minister to regulate the affairs of the Fund, and the relationships of stakeholders to the Fund and to each other in terms of section 55, without legislative guidance as to the manner in which such matters should be regulated, is an unlawful delegation of power by the legislature. As noted above, the legislature, when delegating broad discretionary powers to a functionary, such as a Minister, in legislation, must ensure that these powers are constrained, or that the legislation provides adequate guidance to the functionary as to how these powers should be exercised. We are concerned that the Minister's power to regulate the following issues remains unconstrained in the Bill, in terms of:

6.7.1.1. section 55(1)(a), "*the legal relationship between the Fund and the various categories of health establishments, health care service providers or suppliers as provided for in the National Health Act*";

6.7.1.2. section 55(1)(i), "the functions and powers of a District Health Management Office";

6.7.1.3. section 55(1)(j), "*the functions and powers of a Contracting Unit for Primary Health Care Services*";

6.7.1.4. section 55(1)(k), "*the relationship between the Fund and the Office of Health Standards Compliance*";

6.7.1.5. section 55(1)(l), "*the relationship between the Fund and the Department of Correctional Services in order to clarify the mechanisms for purchasing, within available resources, quality needed personal health care services for inmates as is required by the Correctional Services Act, 1998 (Act No. 111 of 1998)*";

6.7.1.6. section 55(1)(m*), "the relationship between public and private health establishments, and the optional contracting in of private health care service providers*"; and

6.7.1.7. section 55(1)*(n), "the relationship between the Fund and medical schemes registered in terms of the Medical Schemes Act and other private health insurance schemes.*"

6.7.2. It is our respectful submission that because of the enormous potential impact of NHI both on individual rights and on the established public and private health care sectors, not to mention the impact of NHI on the fiscus (and therefore on the general public), the nature and parameters of the legal relationships between the various institutions referred to in the sub-sections to section 55 quoted above should be determined by the legislature.

7. Value-Added Tax

7.1. The Bill is silent on the issue of Value Added Tax ("**VAT**") (as defined in the Value-Added Tax Act 89 of 1991). Because private sector healthcare service providers and suppliers are responsible to the South African Revenue Service for VAT (but government departments are generally not), it is important that the Bill clearly delineate how matters relating to VAT will be handled by the Fund, relative to (potentially) standard pricing mechanisms applicable to both public and private sector healthcare service providers and establishments.

7.2. We therefore submit that clarity on this issue be provided in the Bill.

8. The education and training of health workers

8.1. One of the overarching purposes of the health reform agenda is to achieve sustainable and affordable universal access to quality health care services. Needless to say, the realisation of this objective requires a sufficiently large complement of suitably trained healthcare workers of all categories which is appropriately distributed across the country to facilitate access for all. Given the well-documented constraints currently faced by the healthcare sector with respect to both the numbers and the distribution of healthcare workers in the face of our quadruple burden of disease, the lack of skilled resources for health is undoubtedly one of the biggest challenges to the implementation of any healthcare reform agenda in South Africa. We believe that the magnitude of the problem and the impact on the healthcare sector as a whole are too significant for the burden of addressing this challenge to fall on the government alone.

8.2. It is generally recognised that the roll-out of universal health care coverage is largely dependent on a large network of healthcare professionals, and that steps need to be taken to address the human capital constraints to the implementation of the Bill, and more particularly, to increase number of healthcare professionals, and stabilise fluctuations in the number of healthcare providers in our healthcare system.

8.3. This is re-inforced by the findings in the Pilot Project Report, which, as set out in the excerpt referred to at paragraph 9 above, indicate that human resource constraints curtailed the success of a number of the phase 1 pilot projects.

8.4. We welcome section 57(3) of the Bill, which provides as follows:

> "(3) In Phase 1 the Minister may establish the following interim committees to advise him or her on the implementation of the National Health Insurance:

(a) The National Tertiary Health Services Committee which must be responsible for developing the framework governing the tertiary services platform in South Africa.

(b) The National Governing Body on Training and Development which must, amongst others—

(i) be responsible for advising the Minister on the vision for health workforce matters, for recommending policy related to health sciences, student education and training, including a human resource for health development plan;

(ii) be responsible for the determination of the number and placement of (including but not limited to) all categories of interns, community service and registrars;

(iii) oversee and monitor the implementation of the policy and evaluate its impact; and coordinate and align strategy, policy and financing of health sciences education."

8.5. Although section 57(3) is a step in the right direction, we respectfully submit that:

8.5.1. The establishment of the National Governing Body on Training and Development must be mandatory, not discretionary;

8.5.2. Private hospital groups already financially support the training of healthcare professionals. In September 2017, Econex explored "*private hospitals*" contribution to the South African economy (2016/2017)", and pointed out in its report on this issue that private hospitals made financial contributions towards education and training in the 2016/2017 period, and that the three main hospital groups in the private hospital industry were responsible for the training of 2 269 students in 2017. With the increased human resource capacity needs attendant to the increased volumes of users, there will need to be greater focus on the training of healthcare professionals

and support staff. We express concern about how the increased number of staff required for the implementation of the Bill will be trained and made ready within the timeframes contemplated for phase 1 and phase 2;

8.6. The Socio-Economic Impact Assessment System (SEIAS) Revised Impact Assessment: National Health Insurance Bill, 26 June 2019 ("**SEIAS**"), helpfully sets out comments by stakeholders on earlier drafts of the Bill and whether the comments made by these stakeholders have been incorporated into the Bill, and why or why not. At page 25 of the SEIAS, in respect of comments made by stakeholders on issues of human resource constraints, it is stated that these comments were not factored into the revised Bill "*as they are addressed in other Policies and Strategic Documents of the Department*". We express concern about this approach, particularly in respect of the urgent need to prevent healthcare providers from exiting the system.

8.7. Below we detail the implications of the current regulatory landscape on the ability of the private sector to optimally participate in addressing human resource challenges the country is faced with.[21] Despite operating side-by-side within the same political and economic context, there are distinct differences in the treatment of the public and private healthcare sectors from a policy perspective that have a material impact on the ability of the private sector to fully contribute to the country's health reform agenda both in terms of service provision and capacity building. Specific to human resources, differences in regulation of the two sectors that limit the private sector's ability to contribute to the training of resources as well as optimise the utilisation of human resources include the following:

8.7.1. **Prohibition of employment of medical doctors and allied health professionals by private hospital groups** – this limits private hospital groups' ability to influence

[21] Life Healthcare Group's Response to the National Health Insurance in South Africa to the NHI Green paper, 22 December 2011, P22

the effective utilisation of skilled resources, as well as clinical pathways for patient management in pursuit of cost-effective healthcare services.

8.7.2. **Limited accreditation of private nursing colleges** – private sector training colleges continue to face numerous challenges in obtaining accreditation in order to train more nurses.

8.7.3. **Prohibition of private medical schools –** the state is the sole provider of medical training in South Africa, with instruction provided by academic clinicians who primarily work in state hospitals. There is potentially a role for private providers to play with respect to doctor education, particularly given the direct shortage of doctors in this country, as well as the vast clinical expertise that resides in the private sector.

8.7.4. **Provision for foreign recruitment of doctors by the public sector but not the private sector** – the inability of private hospital groups to recruit and employ foreign doctors limits our ability to actively play a role in increasing the number of doctors in South Africa in the short term, as well as provide a more cost-effective clinical service through careful management of clinical pathways.

8.8. We firmly believe that without urgent intervention by all stakeholders, even our ability to maintain current service levels as a nation will be jeopardised. It is critical to address the regulatory impediments mentioned above in order for private sector to optimally assist in addressing the human resource crisis. Therefore, as a significant stakeholder in the healthcare sector, we look forward to working together with the government and other stakeholders to devise and implement appropriate solutions to our human resource crisis.

9. Purchaser/provider split

9.1. The Bill contemplates the separation between the purchasing and provision of healthcare services, LHC fully supports the entrenchment of this principle.

10. Funding

10.1. National Health Insurance system is premised upon a pre-payment, income-subsidisation system, primarily funded from taxation and an additional stream from a dedicated payroll fund. The success and sustainability of such a Fund is therefore dependent on economic growth as well as a stable and growing payroll base.

10.2. In the current recessionary climate and with growing unemployment, the requirement to fund an additional payroll tax for the NHI-Fund may place an increased burden on the already heavily encumbered tax base. An additional risk may be that voluntary medical scheme enrolment becomes unaffordable, creating an unavoidable opt-out of private health insurance and increasing the burden on an already burdened public healthcare system.

10.3. We welcome the provision in the Bill that states that:" *In a favourable economic environment there will be an initiation of the evaluation of new taxation options for the Fund…*" The NHI Fund should be introduced with due diligence, restraint and due regard to the exercise of fiscal discipline.

10.4. We are also cognisant that in order for treasury to address the financing aspect of this critical reform, it will require for benefits to have been clearly defined.

10.5. We therefore look forward to an opportunity to fully engage on the Treasury NHI Financing paper upon its publication.

11. Conclusion

11.1. LHC would like to reiterate its support for the principle of universal healthcare coverage, and its desire to collaborate with the Department of Health, and Parliament, on the process of refining the Bill in order to meet this objective. We trust that our submissions reflect our commitment to this collaborative process, and to identifying sustainable ways for implementing the NHI.

11.2. For the reasons set out above, it is respectfully submitted that, broadly:

11.2.1. There is a risk that NHI will become fully operational prior to the positive and enabling outcomes of phase 1 and phase 2 activities being achieved. Given that the steps identified in phase 1 and phase 2 have been identified as necessary for the full operation of the NHI, it is recommended that instead of rendering the full operation of NHI dependent on the lapse of the time period contemplated for phase 2 (i.e. in 2026), it should be dependent on the actual achievement of concrete milestones resulting from phase 1 and phase 2 activities which will enable a proper roll out of NHI. We recommend that these milestones be linked to the achievement of the interventions stated in the Health Compact in respect of each of the Pillars and to the ability of healthcare service providers to deliver healthcare services in a reasonable time;

11.2.2. The Bill requires clarity on a number of fundamental issues, such as:

11.2.2.1. whether the Bill contemplates a price-setting mechanism or price negotiation between the Fund and healthcare service providers, for the determination of prices for healthcare services;

11.2.2.2. whether a procurement process, as contemplated by section 217 of the Constitution, read with the PFMA and the PPPFA, will be used by the Fund to procure healthcare services;

11.2.2.3. how payment rates in respect of healthcare service providers and health establishments will be determined or increased on an annual basis;

11.2.2.4. how the accreditation process contemplated in section 39 of the Bill will be carried out and by which bodies; and

11.2.2.5. how the Fund will deal with VAT;

11.2.3. To facilitate the financial control and supervision of the Fund, it is recommended that an external body, akin to the Financial Sector Conduct Authority, be mandated to supervise the financial controls of the Fund, and in particular to monitor its liquidity and solvency;

11.2.4. It is a hallmark of successful universal coverage schemes globally that a specified minimum reserve be in place. Although we recognise that the Minister has a discretion to regulate the Fund's reserves, we submit that this should be a mandatory power, and should be exercised in consultation with the Minister of Finance;

11.2.5. The advisory committees to be established in terms of chapter 7 of the Bill, at the date of this submission, do not make provision for representation on these committees by private health establishments. It is recommended that private health establishments be given an opportunity to participate in these committees, through membership, to avoid any vacuum in the discussions and decisions taken at these fora;

11.2.6. A number of the issues provided for in section 55 of the Bill, in respect of which the Minister may regulate, are better suited to inclusion in the Bill, than being set out in regulation.

11.2.7. We believe that without urgent intervention by all stakeholders, even our ability to maintain current service levels as a nation will be jeopardised. It is critical to address the regulatory impediments mentioned above in order for private sector to optimally assist in addressing the human resource crisis. Therefore, as a significant stakeholder in the healthcare sector, we look forward to working together with the government and other stakeholders to devise and implement appropriate solutions to our human resource crisis.

11.2.8. The expansion of quality healthcare services in South Africa represents an opportunity for LHC to contribute to providing healthcare for a greater number of South Africans.

11.3. LHC again thanks the Portfolio Committee for this opportunity to make submissions in respect of the Bill, and would like to re-iterate our interest in making verbal submissions to the Portfolio Committee.