NARRATIVE OF MEDICLINIC'S ORAL SUBMISSION TO PARLIAMENT'S PORTFOLIO COMMITTEE ON HEALTH IN RESPECT OF THE NATIONAL HEALTH INSURANCE BILL, 2019

This document should be read in conjunction with Mediclinic's PowerPoint presentation dated 26 January 2022 and contains references to Mediclinic's comprehensive written submission to the Committee dated 29 November 2019 ("**Mediclinic's Written Submission**"), where more detailed information in respect of particular issues may be found.

SLIDES 1 AND 2

NO NARRATIVE REQUIRED

SLIDE 3:

NARRATIVE:

AGENDA

- The agenda reflects the most critical aspects of our presentation.
- We will reflect on Mediclinic’s role in health care and our position on Universal Health Coverage (“UHC”).
- Then we will raise potential concerns with the NHI Bill and provide proposals to address these concerns, for the assistance of this Committee in its deliberations on the Bill.

SLIDES 4 AND 5

NO NARRATIVE REQUIRED

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NARRATIVE:

MEDICLINIC INTERNATIONAL OVERVIEW

- Mediclinic Southern Africa is the South African and Namibian division of Mediclinic International, a diversified international private health care services group.
- The Group is focused on providing specialist-orientated, multi-disciplinary services across the continuum of care.
- Mediclinic International has experience in operating within a range of health care systems with varying economic and regulatory dynamics.
- Our purpose is to enhance the quality of life.
- Our vision is to be the partner of choice that people trust for all their health care needs.

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NARRATIVE:

MEDICLINIC SOUTHERN AFRICA OVERVIEW

The Southern African operations of Mediclinic consist of:
50 Acute hospitals
13 Day Clinics
5 Sub-acute and Specialised Hospitals
2 Mental Health Facilities
8,600 Beds
303 Theatres
2,860 Admitting Doctors
15,049 Employees

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NO NARRATIVE REQUIRED

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NARRATIVE:

POSITION ON UNIVERSAL HEALTH COVERAGE

- Universal access to quality health care for all South Africans is an imperative to which Mediclinic is fully committed.
- The World Health Organisation, a leading proponent of UHC, has pointed out that there is no single way to achieve UHC, and every country must make choices and trade-offs.
- How UHC is achieved in South Africa should be informed by our context, our existing resources, and the available financing mechanisms. Importantly, we say, existing private resources should be fully utilised.
- The NHI Bill lays down some of the essential components of UHC:
    - Strategic purchasing principles
    - A purchaser-provider split
    - A primary healthcare-centered package

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NARRATIVE:

COVID-19 COLLABORATION: LESSONS FOR NHI

- Covid-19 enabled various public and private sector stakeholders across various industries to collaborate.
- The private hospital sector participated in Business-4-South Africa work streams.
- Public and private sectors engaged in developing agreements around processes and fees for the admission of public sector Covid-19 patients at private facilities.
- Collaboration in the roll-out of Covid-19 vaccinations created opportunities for public sector users to receive vaccinations at private sector sites.
- We would welcome engagement with public sector stakeholders to develop the components of a sustainable health care system that will be required under NHI.

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NO NARRATIVE REQUIRED

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NARRATIVE:

CONSTITUTIONAL STANDARDS

- The key concerns which we wish to highlight today are constitutional. *[Refer to clause 5.2 of Mediclinic's Written Submission, which sets out the constitutional principles and provisions applicable to the Bill]*
- This Committee must be satisfied that the Bill can achieve its objectives in a manner which complies with the Constitution.
- The risk, if it does not, is that the resulting legislation, or sections of it, may be set aside by the Constitutional Court.
- There are three main grounds on which the Bill may infringe the Constitution:
    - First, it may breach the constitutional right of access to health care services.
    - Second, the Bill does not indicate with reasonable certainty what the nature and scope of the NHI scheme will be.
    - Third, the provisions for the NHI to procure health care services do not comply with the procurement standards in section 217 of the Constitution.

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NARRATIVE:

FIRST CONSTITUTIONAL GROUND: ACCESS TO HEALTH CARE

- Section 27 of the Constitution protects everyone's right to have access to health care services.
- It imposes two kinds of obligations on the State
  - First, a positive obligation to protect and progressively realise this right within the State's available resources
  - Second, a negative obligation not to take steps which are retrogressive.
- If the Bill is unable to achieve its objectives (for example, due to inadequate funding or insufficient doctors or nurses), the State would fail in its positive obligation.
- If the Bill results in reduced access to health care services (for example by taking away private services which cannot be accessed in the NHI) the State would fail in its negative obligation.
- The White Paper describes the NHI as a "*substantial policy shift that will necessitate massive reorganisation of the current healthcare system*".
- The risks posed by such a far-reaching upheaval are enormous.

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NARRATIVE:

THREATS TO ACCESS TO HEALTH CARE SERVICES

- There are three key threats to access to health care services:

  1. The first is that there are inadequate resources for the effective implementation of the NHI scheme.
  2. The second is that the Bill offers virtually no role to private sector hospital providers.
  3. The third is that the Bill erodes existing medical scheme cover.

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NARRATIVE:

THREAT 1: INADEQUATE RESOURCES FOR EFFECTIVE IMPLEMENTATION

- There are legitimate concerns regarding the availability of the financial and human resources required to implement the NHI scheme effectively. *[Refer to clauses 7.6.1 and 7.7 of Mediclinic's Written Submission]*

- South Africa’s health care system is currently faced with a range of challenges and constraints. These include:
    - A weak economic outlook, high levels of poverty and unemployment, a narrow tax base underpinning the multiple social spending requirements. The Davis Tax Committee Report observed in 2017 that
      “*...the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth*.”
    - A critical shortage of human resources for health and a complex underlying disease burden *[Refer to Annexure 1 hereto]*
        - South Africa’s doctor- and nurse-to-population ratios are low compared to peer countries. Specialist-to-population ratios are currently 10% of OECD average.
        - Extreme deficits exist in the projected number of specialists by 2040 when accounting for disease burden.
- An overburdened public health care system.
- Everyone’s right of access to health care services would be threatened if the existing health care delivery system (comprising public and private providers) is uprooted and the NHI scheme envisaged in the Bill cannot be effectively implemented.

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NARRATIVE:

THREAT 2: ROLE AND VIABILITY OF PRIVATE SECTOR HOSPITAL PROVIDERS

- The private sector currently plays a significant role in the provision and financing of health care services *[Refer to clause 9 of Mediclinic's Written Submission]*. Private hospitals:
    - provide facilities:
        - 534 private facilities with 40,514 licensed beds
        - 30% of total hospital beds in the country are in private facilities *[Refer to Annexure 2 hereto]*
    - train nurses:
        - More than 50% of output from nurse training programmes in the country is from private institutions
        - Between 4,300 and 4,500 nursing students were enrolled in training programmes offered by private hospital groups during 2014 and 2015.
- The private hospital sector also makes a significant contribution to the South African economy. Private hospitals in 2016/17:
    - contributed R55.5bn to the national economy (1.3% of GDP)
    - supported 248,504 jobs (1.57% of national employment)
    - contributed R16,4 bn in tax (1.5% of total tax revenues)
- *[Refer to clause 5.3 of Mediclinic's Written Submissions, setting out how the Bill would limit access to health care services]*

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NARRATIVE:

Key components of the Bill threaten the viability and role of the private hospital sector.

1. The contracting and reimbursement frameworks in the Bill do not accommodate private hospital participation *[Refer to clause 7.2 of Mediclinic's Written Submission]*
   - The referral networks and service delivery models do not take account of the role and structure of private providers (for example, the language used to describe health care provision in the Bill reflects the current classification of public health care provision (including central, tertiary, regional, specialised, district, clinics and community health centres). This classification gives rise to two principal concerns, first, a limitation on the procurement of services from private hospitals and other private providers that do not fall neatly into this classification, and second, insufficient flexibility to accommodate new service delivery models.)
   - The criteria for provider accreditation do not take account of the structural features of private health care provision (such as the ethical rules on sharing of fees, business models and subcontracting)
   - The Bill provides no reasonable certainty that private providers will be reimbursed at a commercially viable level, i.e. that prices will (a) exceed the provider's total cost of delivering the service and thereby support provider sustainability; and (b) bring about parity between public and private providers by accounting for the differences in their cost structures (e.g., taxation; cost of capital; cost of labour; public financial mechanisms available to the public sector)
2. The exemption of the NHI Fund from the Competition Act exposes providers to risks that the Fund, as the single purchaser of health care services in South Africa, will be in a position to cause harm to competition, and thus erode private sector resources, by:
   - using its dominant power or monopsony power to force prices for health care services below the competitive level
   - concluding exclusive dealing agreements with particular providers

   [Refer to clause 5.5 of Mediclinic's Written Submission, dealing with concerns relating to the exclusion of the operation of the Competition Act]
3. The Bill limits medical cover to "complementary cover". *[Refer to clause 7.3 of Mediclinic's Written Submission, dealing with the role of medical schemes under the Bill]*

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THREAT 3: EROSION OF MEDICAL SCHEME COVER

- Approximately 9 million South Africans currently belong to medical schemes:
    - Cover is concentrated in economically active segments of the population
    - Those who are currently insured enjoy guaranteed cover for Prescribed Minimum Benefits (treatment for over 270 medical conditions and 25 chronic conditions, for example, diabetes and asthma)
- Section 8(2) allows for medical scheme cover where there is divergence from the prescribed referral pathway or formulary.
- Sections 6(o) and 33 of the Bill limit the role of medical schemes to “complementary cover” only. What complementary cover means is not clear from the Bill.

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NARRATIVE:

NHI Services

Category A		Category B
Category A1	Category A2	
Covered Paid Services	Covered Unpaid Services	Precluded Services

- If we consider the three categories of services under the Bill, set out in the table, we see that there are:
    - Covered Paid Services: services which are in principle covered by the NHI Fund, and in fact paid for in a particular case
    - Covered Unpaid Services: services which are in principle covered by the NHI Fund, but not paid for in particular case (e.g. because the user did not follow the prescribed referral pathway)
    - Precluded Services: services which are in principle not covered by the NHI Fund.
- If “complementary cover” means that schemes can provide cover only for Precluded Services, leaving out Covered Unpaid Services, the Bill will be retrogressive.

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NARRATIVE:

- Consider Patient A with chronic renal failure receiving life-sustaining haemodialysis treatment currently covered by a medical scheme:
  - If NHI is implemented, it is anticipated that it would cover this treatment in principle:
  - As an expensive treatment, the NHI Fund may not be able to provide cover to all patients who need it;
  - Patient A cannot obtain medical scheme cover due to restrictions on medical schemes and cannot access haemodialysis due to rationing. Patient A finds themself on a long waiting list;
  - Accordingly, existing access to life-saving treatment has been removed.
- Court decisions illustrating possible constitutional challenges to the Bill:
  - There will be an infringement of rights if a patient is limited to the public sector where required specialized care is only available in the private sector – *Law Society of South Africa v Minister of Transport*
  - A patient's right to life and security will be infringed where the patient is prohibited from purchasing private medical insurance and the public health system is not able to provide adequate care within a reasonable time – *Chaoulli v Attorney General Quebec*

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- Almost all Countries in pursuit of UHC make use of hybrid financing models
  - Hybrid UHC financing models have varying degrees of duplication between public and private insurance coverage.
  - Hybrid financing models facilitate explicit income cross-subsidies and introduce a degree of competition to the system.
  - No low- or middle-income country has successfully implemented a single-payer model that provides comprehensive coverage for the whole population, free at point of care.
  - The prohibition or material limitation of the role of voluntary private health care insurance is not required to achieve UHC.
  - There is limited evidence that a single payer model is effective in controlling health care expenditure and ensuring coverage.
- *[Refer to Annexure 3, to illustrate South Africa's score on UHC Index of Service Coverage]*

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- Hybrid Financing
    - o Upper middle-income countries such as Russia, China, Romania, Bulgaria and Malaysia allow a combination of supplementary (duplicative) and complementary private insurance.
    - o Almost every country in Europe allows for supplementary private insurance coverage which may be sold in combination with some form of complementary cover.
    - o Financing models in France, Thailand and Chile, where distinct pools cater for specific populations, may be efficient while responsive to local population needs.
- Single Payer
    - o Canada's total health care expenditure increased from 8.7% to 10.5% of GDP between 2000 and 2015, with 15% of spend paid out of pocket ("OOP").
    - o High OOP spend in lower income countries like Brazil and Ghana (27% and 38% of total health care spend, respectively), both initially embarking on a single-payer model, raises questions around the degree of progressivity of this model in terms of financing and financial protection.
- *[<u>Refer to clauses 4 and 10.2 of Mediclinic's Written Submission</u>, for more details in respect of the international experiences in the pursuit of UHC]*

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REQUIRED MEASURES

The Bill should:

- Provide for **staggered implementation** based on benefit costing, financial and human resource estimates, with **measurable milestones** to be reached before key aspects of the NHI scheme are implemented *[<u>Refer to clause 7.8.1 of Mediclinic's Written Submission</u>]*
- Remove the limitations on medical scheme cover and ensure a comprehensive and sustainable role for private providers in the NHI scheme
    - o Make provision for sustainable existence of medical schemes and private providers which allows for cross-subsidisation of lower costs to the public sector.
    - o Concurrently optimise the capacity of the medical schemes environment to cover as many members of the population as possible, for example:

- Low Cost Benefit Option (LCBO) framework to provide insurance for lower income households
- Prescribed Minimum Benefit (PMB) review
- A risk equalisation mechanism incentivising schemes to compete on value to members rather than attracting younger/healthier members.

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SECOND CONSTITUTIONAL GROUND: LACK OF REASONABLE CERTAINTY

The Bill fails to provide reasonable certainty on:

- the nature and scope of health care services that will generally be available **under the NHI scheme**;
- the nature and scope of the health care services which will be available **outside the NHI scheme**;
- how registered users of the NHI scheme may **access health care services within or outside** of the NHI scheme;
- the nature and scope of the **role of private health care providers in the NHI scheme**; and
- the permissible **scope of medical scheme cover**.

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REQUIRED MEASURES

The Bill should provide for a fair and transparent methodology for reviewing the scope of services covered by the NHI scheme, including:

- a transparent process of determining the benefit package taking into account access, quality and affordability;
- representation of all health care provider groups on the Benefits Advisory Committee;
- review of treatment guidelines by an **independent committee** of academic and private sector specialists.
- *[Refer to clause 7.4 of Mediclinic's Written Submission]*

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THIRD CONSTITUTIONAL GROUND: PUBLIC PROCUREMENT STANDARDS

- Section 217 of the Constitution requires that when an organ of state contracts for goods or services, it must do so in accordance with a system which is **fair, equitable, transparent, competitive and cost-effective.**
- However, the following sections of the Bill do not allow for a fair, equitable, transparent, competitive and cost-effective procurement framework:
    - The Fund must **determine** payment rates annually (s 10(1)(g)).
    - The Health Care Benefits Pricing Committee must **recommend the prices** of health service benefits (i.e. the prices of specific health services) to the Fund (s 26(3)).
    - The Fund, in consultation with the Minister, must determine the nature of 'provider payment mechanisms' (s 41(1)).
- *[Refer to clause 5.4 of Mediclinic's Written Submission, setting out the constitutional concerns with the procurement provisions of the Bill]*
- In addition, the Bill gives the Minister of Health authority over both the NHI Fund (purchasing) and the provision of services in the public sector which undermines the purchaser-provider split and creates a conflict of interest.

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NARRATIVE

REQUIRED MEASURES

- Existing legislation which governs how an organ of state contracts for goods and services should be reviewed to ensure that the Bill provides for a lawful procurement framework.
- The NHI Bill should provide for a fair, equitable, transparent, competitive and cost-effective procurement model with the following key components:
    - Decision-making by a neutral, independent body
    - Reimbursement of public and private providers in accordance with the different actual average input costs of public and private providers respectively
    - Any tariff evaluation to be conducted in accordance with appropriate coding, comprehensive costing data, and annual inflation
    - *[Refer to clause 7.2.3 of Mediclinic's Written Submission]*

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NO NARRATIVE REQUIRED

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In Summary, three key concerns are raised by the Bill.

- **First Key Concern**: The Bill threatens access to health care services due to –
  - inadequate resources for effective implementation of the NHI scheme;
  - limited role for private sector providers; and
  - erosion of medical scheme cover.
- <u>Proposals to address the concern</u>:
  - Stagger implementation based on costing and human resources estimates, with measurable milestones to be reached before key aspects of the NHI scheme are implemented**;**
  - Ensure a comprehensive and sustainable role for private providers in the NHI scheme; and
  - Remove the limitations on medical scheme cover.

- **Second Key Concern**: Lack of reasonable certainty
- <u>Proposals to address the concern</u>:
  Amend relevant sections of the Bill to provide clarity on –
  - Nature and scope of services available under and outside the NHI**;**
  - How users access services under and outside the NHI; and
  - Role of private providers and medical schemes.

  Provide for a fair and transparent methodology for reviewing the scope of services covered by the NHI scheme, including
  - a transparent process of determining the benefit package
  - representation of all health care provider groups
  - independent review of treatment guidelines

- **Third Key Concern**: Public procurement standards
- <u>Proposals to address the concern</u>:
  - Provide for a fair, equitable, transparent, competitive and cost-effective procurement model.
  - Establish an independent body to determine appropriate reimbursement models and scientifically calculated tariffs.

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NO NARRATIVE REQUIRED

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CONCLUDING REMARKS

- Universal access to quality health care for all South Africans is an imperative which Mediclinic fully supports.
- In its current form, the Bill is subject to the risk of not meeting its objectives.
- The future of health care for the country and all who live in it will be determined by this Bill.
- It is a golden opportunity to harness the resources of all the role players in all health care sectors and to provide clarity and certainty to all role players.
- As a hospital provider, Mediclinic remains fully committed to being party to the development and delivery of South Africa's future UHC dispensation.

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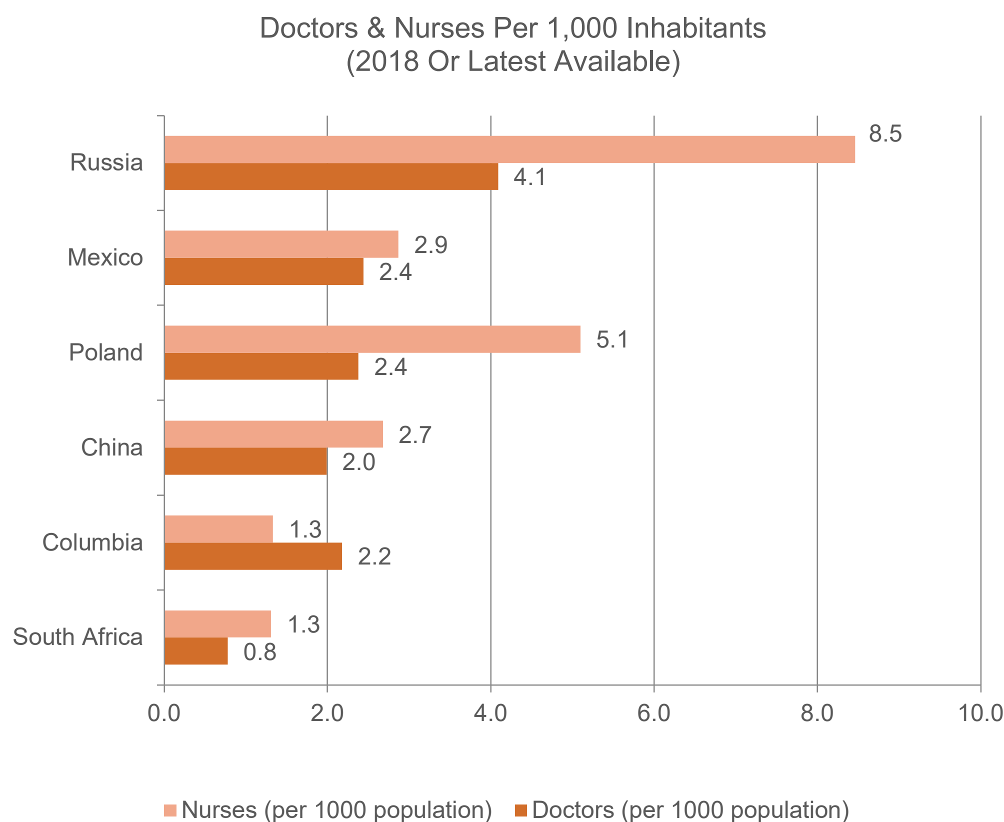
NARRATIVE

Thank you for your attention

Annexure 1

Doctors and nurses per 1,000 inhabitants



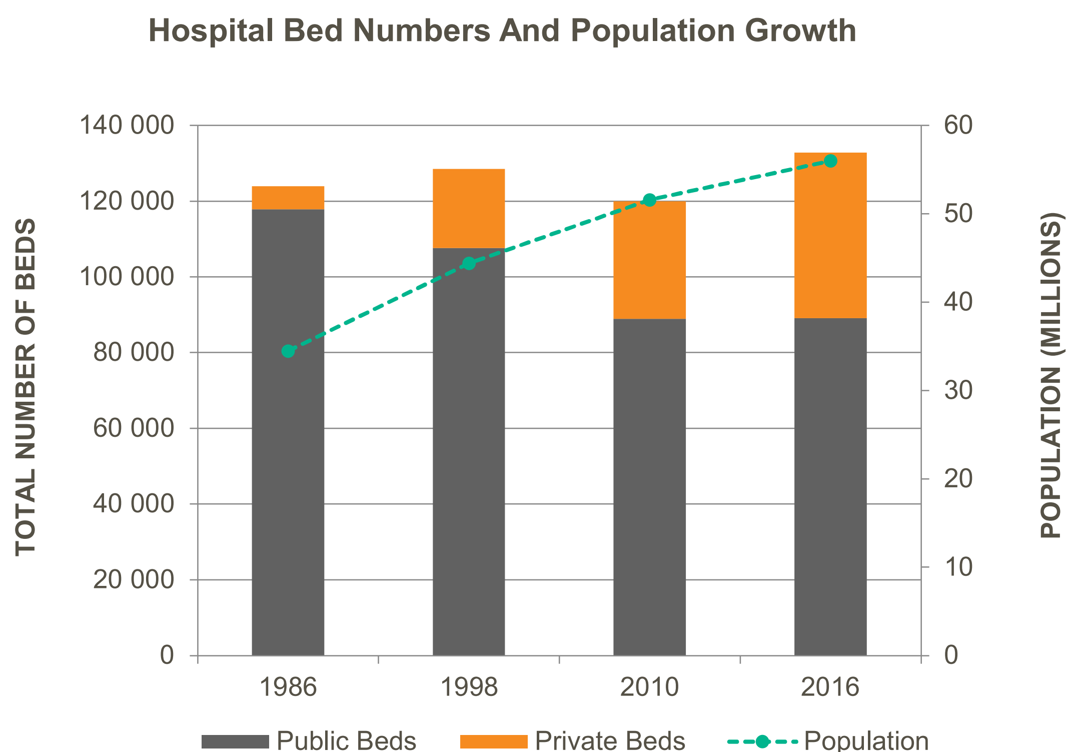
- South Africa's ratio of doctors and nurses per 1,000 population is low when compared to peer countries[1]
- South African specialist staffing ratios are currently **10% of OECD average** specialist-to-population ratio. There exist extreme deficits in the projected number of specialists by 2040 when accounting for disease burden (Percept 2019. The supply of and need for medical specialists in South Africa.)
- An updated HRH strategy is required prior to NHI implementation, including:
  - An audit and forecast of human resource requirements based on population needs
  - Additional initiatives for training and attracting the necessary skills

[1] OECD Data. https://data.oecd.org/

Annexure 2

Hospital bed numbers and population growth

Despite growth in population, the combined number of public and private hospital beds in the country has stagnated between 120,000 and 130,000 beds since 1986.[2]



Source: Competition Commission HMI 2018; World Bank; Econex 2017

- The Bill places emphasis on public health care provision with a limited role for private contracting outside of primary care:
  - Phase 2 *"selective contracting of health care services from private providers"* (section 57(2)(b));
  - Classification of providers is based on public health care provision; i.e. central, tertiary, etc. (section 35(2));
  - DRGs and capitation-based reimbursement models conflict with HPCSA ethical rules.
- The Bill does not allow for effective strategic purchasing from the private sector.

[2] Competition Commission HMI 2018; World Bank; Econex 2017

Annexure 3

UHC Index of Service Coverage

South Africa scores compare favourably to many other upper-middle income countries based on the WHO's service coverage index.