SOUTH AFRICAN COMMITTEE OF MEDICAL DEANS

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28 November 2019

Parliamentary Portfolio Committee on Health

Dear Honourable Chair

Invitation to provide comments on the NHI Bill by 29 November 2019

The South African Committee of Medical Deans takes pleasure in submitting the following comments on the NHI Bill. We had a workshop on 6 November 2019 and the workshop discussion is captured into this written submission.

Please note that the South African Committee of Medical Deans would appreciate the opportunity to make a verbal presentation to the Portfolio Committee.

We look forward to your favourable engagements on the matter.

Sincerely

Prof Ncoza Dlova
Acting Chair

A. General, overview comments on the NHI Bill

This submission constitutes a consensus statement amongst the leadership of health sciences faculties in public universities in South Africa on the recently published National Health Insurance (NHI) Bill.

According to the Deans, the implementation of the National Health Insurance in South Africa is an important vehicle and indispensable milestone in transforming the national health system towards Universal Health Coverage. According to the NHI White Paper, existing legislation has fallen short in meeting the imperatives of the Reconstruction and Development Programme and the Constitutional obligation to 'take reasonable legislative measures.'

The 1997 White Paper for the Transformation of the Health System in South Africa provided a framework for the country to develop healthcare financing policies that promote equity, accessibility and utilization of health services, to ensure greater equity between people living in rural and urban areas and between people served by the public and private health sectors within a single unified national health system. However, the South African national health system continues to be divided into the under-resourced public health sector and over-resourced private health sector as well as over-resourced urban areas and under-resourced rural areas. This defies South Africa's constitutional mission of a single unified national health system. The NHI White Paper further asserts that the National Health Act 61 of 2003 and amendments thereof, as well as the development of regulations to effect the National Health Act (NHA), have not gone far enough to establish a single unified national health system.

It is the firm view of the South African Committee of Medical Deans that the current version of the National Health Insurance Bill provides an inadequate framework for the infrastructure and capability needed to achieve the desired outcome of universal health coverage. According to the NHI Bill, the objective is to establish a Fund that aims to achieve sustainable and affordable universal access to health care services by:

- Establishing and maintaining an efficient Fund through the consolidation of revenue so as to protect users against financial risk;
- Serving as the single public purchaser of health services in terms of this Act so as to ensure the equitable and fair distribution and use of health care services;
- Ensuring the sustainability of funding for health care services; and
- Providing for equity and efficiency in funding by actively purchasing health care services, medicines, health goods and health related products from certified, accredited and contracted service providers.

However, the current version does not go far enough to establish a single unified national health system that will promote equity, social justice, quality and access in health care. It leans more towards

being an “NHI Fund Bill” than being a National Health Insurance Bill. The Deans would expect the NHI Bill to address critical health system issues that will ensure successful realization of the mandate of the NHI Fund and the NHI as a financing mechanism for health care in South Africa. These include, inter alia, the following:

- Locating the National Health Insurance Fund in the broader public healthcare delivery system
- Locating the National Health Insurance Fund in the context of a two-tiered national healthcare system with particular reference to the private health sector
- Defining the design and governance of an integrated healthcare service delivery system
- Locating academia and the health professional training platform in the National Health Insurance context
- The governance of the National Health Insurance Fund

The Deans recommend that, in addition to the NHI Fund, the NHI Bill should broaden its strategic objectives to clarify and include the abovementioned areas in the final version.

The remainder of our comments are contained below in three sections:

- Comments on the National Health Bill as distributed
- Issues of concern not addressed in the NHI Bill
- Positive issues dealt with in the NHI Bill

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B. Comments on the National Health Bill as distributed

No	Section of Bill	Issue to raise	Motivation including some suggested solution
Preamble			
	Page 3, "**AND IN ORDER TO-"**	After "achieve the progressive realisation of the right to access to quality personal health care services" **add** "within a strengthened public and private health system" Add a clause 'address the social and economic determinants of health to promote health and disease prevention through inter-sectoral collaboration and strengthening non-personal health care'	Although a strengthened health system is implied in the statement "quality personal health care services" it should be emphasised as a separate point. Addressing the social and economic determinants of disease, which will include cooperation with and action by other sectors, is paramount to reducing the burden of disease, and the overall burden on the health system. A coordinated, whole of government approach which links with the NHI objectives is required.
Chapter 1: Purpose and Application of Act			
	Page 7, "Purpose of Act"	2(a) states "serving as the single purchaser and single payer of health care services……" - after "…use of" **add** 'quality'	The purchaser and payer should not be considered as one structure until clarity on the single strategic purchaser and payer roles is provided. Furthermore, strategic purchasing by one structure without consideration for the role of the provinces and

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			the importance of decentralised purchasing creates financial and administrative risks amongst others. Clarity is required regarding which institutional arrangements are to be put in place, and how this will be implemented to support the implementation of NHI, as significant restructuring and strengthening of the system is required. It is proposed that these be developed concurrently with the Bill.
Chapter 2: Access to Health Care Services			
	Page 8, Population coverage	4(1) add 'Asylum seekers, undocumented migrant, students and all children' Remove 4(2) Refrain from using the term "illegal foreigners". Replace with 'undocumented immigrants' 5(b) should include those on student visas.	The proposed changes are in line with the current National Health and Refugee Acts. The Bill should also consider foreigners who reside in SA for purposes of studies. The suggestion for them to get private medical aid may not be feasible or they will only be able to receive emergency care or treatment for notifiable medical conditions. Students on visa should have access to 4(1).
	Page 8, Registration as users	When applying for registration as a user, the person concerned must provide an identification document and an original birth certificate. What will the implications be if a person cannot provide an original birth certificate? Will this person forfeit the benefits of the Health Insurance Plan?	Add to 5 'passport, drivers licence' as another option for registration. The implications of not having any documents as stipulated in this section on registration of the user should be discussed in the Bill.

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		Add to 5 'asylum seekers'. If it not clear whether the details regarding this category will be covered in 4(1)(e) or (6) (5) Regarding 'proof of habitual place of residence'. Not all residences have proof of habitual residence. How this will impact the registration of the user to be made explicit. (7) Details of the management and maintenance of the register, as well as registration of users at unaccredited facilities, are required. (8) What will happen if the user does not have proof of registration? A user seeking health care services must present proof of registration to that health care service provider or health establishment when seeking those health care services. Does this imply that a user may only visit a specific hospital or clinic? What will the implications be if users travel to another province and health care services are needed?	The nature of the registration system (namely, paper-based or electronic, interoperability within health and with other sectors), and the readiness of the government sectors and the health system to implement such a registration system should be carefully considered. Furthermore, significant investment and time will be required to establish a streamlined, effective and efficient system. This will be best implemented in a phased approach. Appropriately trained staff will be required to ensure that smooth-running from data input, hard-and software support and central database and data warehousing levels.
	Pages 9-10, Health care services coverage	With regards to user access to accredited facilities as presented in this section, there is a risk for limited coverage of services and/or increased costs for users who have to travel to other facilities should the facility they are	

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		meant to access not be/no longer be accredited. Furthermore, the implications for rural areas is that there may be insufficient service providers or that users have to incur costs to travel to the accredited facilities that may be out of their geographical areas. Another consideration is the registration of the user who is on vacation or not within their geographical are (eg for work purposes). **7**(2)(d) lists the referral pathway and (iii) states that failure to adhere will mean that the user does not require services. What happens should there be a medical emergency?	Add a clause on how this will be managed. Thus add an additional clause that addresses management of the user should they present with a medical emergency.
Chapter 3: National Health Insurance Fund			
	Pages 11-13, Functions of Fund; Powers of Fund	The functions and powers of the Fund are broad and it covers a wide range of activities and actions. It requires a range of health, financial, legal, business and other technical staff, including administrative staff and strong operational and strategic managers. Strong and well-functioning administration systems are also required. Furthermore, there are about 4,000 public health facilities in South Africa (excluding the private sector facilities). Thus for the Fund to execute its functions and powers, strong, efficient and quality operations must be in place,	Greater clarity is therefore required regarding the administrative and technical support that will be required to support the Fund, and the structure and arrangements of the Fund both centrally and within decentralised structures to effect the

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		and service provision must be high-quality, acceptable, appropriate and timely.	abovementioned. How the Fund will engage with provinces and district-based structures should be made explicit.
	Page 12, Powers of Fund	11(1)(h) We propose that an independent entity investigate complaints against the Fund.	
Chapter 4: Board of Fund			
	Pages 13-14, Establishment of the Board; Constitution and composition of Board	Taking into consideration the function and powers of the Board, the inherent requirements for Board members are too vague. The inherent requirements for the members must fit the responsibilities of these committees. The Board is said to be accountable to the Minister. This chapter establishes the NHI Fund as a Schedule 3A autonomous public entity. We propose that the Fund reports to Parliament and that the Minister's powers are reduced, as the Minister has enormous power as per the current Bill (eg sections 8 and 9 of this section). This may undermine the purpose and effective implementation and independent functioning of the Fund. We propose the Board be allowed to have some of the powers that has been assigned to the Minister in this Bill to manage. 13(3): details on who will comprise the ad hoc advisory panel must be made explicit. It is not clear what the shortlisting procedure will be.	Propose that it be stated that the person should not have a criminal record, should not have been convicted for fraud or corruption.

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		13(5)(a): details on what "a fit and proper person" constitutes should be provided. 13(5)(b): **add** 'public service administration, business management' Given the importance of community participation, someone who represents civil society should also be on the Board. 13(5)(e): More details should be included such as shares or stakes in insurance industries, pharmaceutical companies, involvement in tobacco or sugar industries, etc.	
	Page 14, Functions and powers of Board	Section 15(3)(b) states that the Board is to advise the Minister on "the development of comprehensive health care services to be funded by the Fund through the Benefits Advisory Committee"; (c) "the pricing of health care services to be purchased by the Fund through the Health Care Benefits Pricing Committee of the Board"; (d) "the improvement of efficiency and performance of the Fund in terms of strategic purchasing and provision of health care services".	Sufficient expertise should be on the Board to ensure that all these functions can be fulfilled. Furthermore, it is not clear whether the Board can co-opt or contract advisors to assist with this activity.

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Chapter 5: Chief Executive officer			
	Page 15, Appointment	Clarity regarding the appointment is required. Section 19(1) states that the COE will be appointed through a transparent and competitive process. However, in Section 2 it states that the decision will be made by the Minister who must approve the recommendation of the Board.	
	Pages 15-16, Responsibilities	Section 20 (2) (e) (ii): **add** 'Provinces' before 'District Health Management Office'	
Chapter 6: Committees established by Board			
	Page 17, Technical committees	The inherent requirements for the Technical committees are too vague. The inherent requirements for the members must fit the responsibilities of these committees. It is not clear if the Technical Committees are comprised of members of the Board. It is assumed that these are not given that the following is included in Section 24(3) [the person much be "fit and proper", "have appropriate expertise or experience", etc]. It should be stated whether additional expertise can be bought in, or an expert can be co-opted into the Committee.	If outside members are to be appointed then the appointment criteria should be similar to those of the Board members (see above section), including having proven expertise in the area, and not having a criminal record, etc.

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		Civil society should be represented on Committees as far as is reasonable.	
Chapter 7: Advisory Committees established by Minister			
	General comments on Chapter 7	Clarity and details regarding the powers, roles and capacities of the various members of the Advisory Committees is required. Transparency regarding selection and appointment for all committees are required. The role, including powers, roles and capacity of the persons appointed by the Minister on each Committee should be stipulated. Civil society should be represented on all the Committees.	
	Page 17, Benefits Advisory Committee	Education and prevention should be part of the primary prevention package (**oral health should be part of such a package**).	In this regard, fissure sealing of the first permanent molars in order to prevent carious lesions developing should be part of the package.
	Page 18, Stakeholder Advisory Committee	The Stakeholder Committee should have adequate representation from civil society.	
Chapter 8: General Provisions Applicable to Operation of Fund			
	Page 19, Role of Department	Section 32(1)(c) **add** 'non-personal health services' after 'health services' Section 32(2)(a): The role of the provinces is presented as that of management agents. Provinces should be playing a	

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		stewardship role. Clarity regarding the role of the provinces is required. Section 32(2)(c) states that Minister will 'establish District Health Management Offices as government components'. The role of the province is once again not clear. This should be the role of the Provinces in terms of establishment and oversight.	
	Page 19, Role of medical schemes	In terms of Section 33, clarity is required in terms of what is meant by medical schemes may only offer complementary cover to services not reimbursable by the Fund."	
	Pages 19-20, Purchasing of health care services	If facilities did not receive accreditation due to factors related to funding or support (eg infrastructure etc), what will the funding/financing arrangement be to ensure that these facilities can be improved to meet accreditation standards?	
	Page 20, Role of District Health Management Office	Evidence shows that current district level services are not sufficient in terms of resources of technical capacity to manage additional financial, technical and operational functions. Clarity is required on how this level will be strengthened. Furthermore, who district level structures are accountable to is not clear. The provinces are completely excluded from this section and chapter.	
	Page 20, Contracting Unit for Primary Health Care	Furthermore, the relationship between the CUPs and the district, the Fund and province is not clear, given that	

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		Section 37(1)(b) states that it "is the preferred organisational unit with which the Fund contracts for the provision of primary health care services within a specified geographical area."	
	Pages 21-23, Accreditation of service providers	Reliance on accreditation and certification without a clear plan on how public sector health facilities will be strengthened to be able to meet the requisite standard, and provide services on par with some private sector facilities, would disadvantage public sector facilities. The Bill should state the process of assessment of each facility to ensure that it has sufficient financing to meet certification and accreditation standards. Will the Fund provide finances 'upfront'? How will this impact on or affect the certification and accreditation processes? This section of the Bill is a vitally important one and is critical to the Fund and NDOH meeting their objectives. Substantial resources, activities, processes and policy direction is required to not only ensure that certification and accreditation is seamless, but also that services are adequately and efficiently delivered by these facilities. Detailed plans on how the health system will be strengthened to support what is proposed in this section is required. Failure of the Office of Health Standards Compliance, the NDOH, the Fund and the various other levels of care in the health system to efficiently organise	

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		themselves and deliver care will have major consequences. It is proposed that this be piloted and phased in during implementation. Provincial stewardship will be vital for seamless and coordinated service delivery.	
	Page 23, Information platform of Fund	The current Health Management Information System is primarily paper-based, is not interoperable and is not able to provide real-time information. Finance and human resource information systems require revision, and to a degree fall within the ambit of other ministries (eg Treasury). Statutory bodies' databases require strengthening. Our data elements and indicators are not in line with the information requirements, and district-level staff are not proficient at using computers and other technology. A major concurrent overhaul of the HMIS is required. Current strategies should be fast-tracked and piloted. Legislation to ensure that the private sector complies is also required. Clarity is required on how the Fund will support the overhaul of the system.	
Chapter 9: Complaints and Appeals			
	Complaints	Section 42(2) states "The Investigating Unit established by the Chief Executive Officer in terms of section 20(2)(e) must launch an investigation to establish the facts of the incident reported and must make recommendations to the Chief Executive Officer as to the way in which the matter may be resolved within 30 days of receipt of the complaint."	We propose that a mechanism for addressing certain types of complaints at a local level be instituted as these should be best managed at that level.

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Chapter 10: Financial Matters			
	General comment on Chapter 10	Universal health coverage is the only way forward for South Africa. So largely the NHI Bill is sound. No comment on the financial implications, but these will be massive and the Bill probably underestimates the costs.	
Chapter 11: Miscellaneous			
	Page 27, Regulations	Section 55: no mention is made of the Provinces	
	Page 28, Transitional arrangements	In this section, a "progressive and programmatic approach based on financial resource availability" is proposed with two Phases highlighted. The 5 year time frames for the implementation of Phase 1 (2017 – 2022) and 2 (2022 – 2026) respectively are not feasible or realistic taking into consideration all the objectives that must be achieved during each phase. For example, the public health facility infrastructure must be improved within the next 3 years to ensure they meet the requirements of the Office of the Standards Compliance. According to the proposed Health Insurance plan, the primary health care clinics will be the first point of entry for all health care users. The majority of health problems must be diagnosed and treated at this level where there are already critical problems regarding infrastructure, procurement and staffing.	We propose that a monitoring and evaluation framework be established to guide implementation. We also propose that as far as is possible, evidence-based approaches be used to guide and learn from implementation activities. To this end, we propose an additional interim committee that focuses on health systems and services implementation, strengthening, research and evidence generation, synthesis and translation. This committee should provide guidance on the best implementation and research approaches based on local and international evidence. The Committee should provide inputs into key legislative changes to be made to support preparation for and implementation of NHI.

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		The nursing profession is the back bone of the South African primary health care services. There is already a serious shortage of nurses within an overburdened healthcare system with a very high incidence of burnout syndrome due to a high workload. The looming national crisis regarding nursing education will further exacerbate this problem. All existing generic qualifications will phase out at the end of 2019. The majority of nursing departments/schools at universities and colleges have been submitting new curricula for their diplomas and undergraduate programmes since 2016. To date, only a few private colleges and one university were granted provisional approval for their first intake in 2020. In addition, the regulations for the new postgraduate diplomas (specialty areas in nursing, and primary health care is one of them) have not been promulgated. Consequently the curricula cannot be finalised because the approval process by the Council of Higher Education and the South African Nursing Council takes 18 months to complete. The implication thereof is that there will be no further intake from 2020.	

C. Issues of concern not addressed in the NHI Bill:

1. No mention is made of health education or national organisations such as universities and the NHLS. The existing health delivery system is going to split into a myriad of small fragments that then have to be individually glued together into a completely new system with the District Health Management Office as the key role players. If this massive change management process is not undertaken professionally the health care delivery system might not survive it. The primary goal of the entire health system is to promote health and the moment the model of primary health care as an entry point comes in, there will be huge savings. In identifying the role of universities, start with areas of mutual interest which include training and the quality of health services.
   We suggest a full new chapter be included to deal with this.

2. General: This is the first time government and public hospitals will mean two different things. Government is the regulator and the hospitals are service providers. Consider tapping into and funding indigenous health knowledge systems to keep the nation healthy. With respect to rehabilitation services, the Benefits Advisory Committee will be using a disease-based approach and rehabilitation professionals should make inputs outlining the benefits and where those services fit in. Hopefully there will be robust discussion around the evidence of particular rehabilitation services before things are finalised. There needs to be a pragmatic approach to strengthening the governance functions of hospital Boards as they are one of the building blocks. Having Boards on district and regional level will be quite beneficial for the services rendered, particularly if there is buy-in in terms of what they need to do. Dr Pillay noted that remuneration plays a big role in this regard. The Bill needs to be clear on:
   - The oral health services refugees and foreign nationals are entitled to.
   - Excluded oral health services that are to be channelled to private insurance.
   - The role of OHSC in strengthening the Inspectorate for Oral Health in inspecting dental practices and facilities in the hospitals. The Office of Health Standards Compliance also needs to be strengthened.
   - Balancing the model of reimbursement with a more hybrid system to counter the effects of both under- and overserving.

3. Academic medicine as suggested to be a separate Chapter:
   SACOMD feels very strongly about being able, as a collective, to bring submissions to the Portfolio Committee to ensure that (1) the academic health sciences participate in a fundamental and important change in the health care system, and (2) the Bill supports and enables the work of the universities.

   Over and above the fundamental issue of universal access to health care, the emphasis in the iteration of documents between the Green Paper over a decade ago and the gazetted final Bill in July of this year has changed from service to funding. The input of the universities is important for the former, not the latter. We need to ensure that the Bill and all the regulations support the academic institutions, including technical and nursing colleges, in achieving their goal of training health care professionals for a healthy and wealthy society. As the Bill currently stands, it is no longer explicit about access to quality health care. This needs to be put back in as it is a tool to achieve a certain outcome.

   There is very little reference to research and none to academic research in the Bill. The only way academic principles are addressed is in terms of the rights of users. We need to look at what professionalism means in the professions and start asking for academic components to be included in the Bill. Applying academic principles to medical delivery will provide a better outcome. Every medical encounter should be opportunity to train, innovate and measure.

   Academia must participate in the various advisory committees but these advice provided into the NHC Tech with no mechanism of control. The responsibility of delivery is clearly going to be the Minister's. It is understood that he is responsible to Parliament which is a relatively political environment. We are of the view that the appropriateness of that and whether it has proved to be the best form of control elsewhere in the world, needs to be explored.
   Neither the Department nor the Board include an academic component. There are five academic components that could be of value, namely quality; the supply of health care professionals; the expertise (which needs to be better defined); the independence of the

universities and their ability to do much that government is not in a position to do; and the fact that they innovate, particularly in the health professions.

Some very specific issues are as follows:

- The shape of a health care system depends on the nature of the professionals. That needs to happen today and needs to be done with the universities.
- The sustainability of producing health care professionals depends on the quality and stability of the health care system and it must be recognised that the system is broken across the board, particular the public and private primary health care environment.
- We have to start talking about the funding and management of the academic system, particularly in Health Sciences education. The joint management of this is not written into the Bill but that is essential if it is to have teeth.
- We have to start talking about central hospitals versus academic complexes, including the latter as potential service providers. We want central hospitals to have a very clear academic component in the tertiary environment. We really need to talk about creating within the provinces an academic complex component from CUPs to quaternary services if we are not to overburden the tertiary services. Academics also have to take on our responsibilities in the CUPs if we are to both deliver and train.

One issue that does not separate out well in the Bill is involving the tertiary institutions in monitoring and evaluation. There is a level of independence that can close the loop. There has to be some form of competitive environment and an independent review will be needed for the management of that. We are of the opinion that the NDoH still being the major providers and cannot play both roles. The need to monitor that interface very carefully needs to be recognized.

Further issues for consideration include:

- The management of the health care environment is not very clearly put together and needs to be strengthened, particularly in terms of funding. Public health entities must be strengthened if you want a promotive environment.

- The interim arrangements are one of the things being talked about. It has made it clear when talking to organisations that the implementation will be pragmatic but what interim arrangements will apply before the NHI is fully implemented? The universities have a role to play here as well. How will the CUPs be linked to the public health environment?
- The Bill and White Paper are very different in terms of the commitment to training and the quality of the training platform. Somewhere the universities need to have control over the training platform.
- It is not clear how the HRH fits into the broader environment.
- The poor alignment between the NDoH, DHET and Treasury and the lack of coordination between national and provincial are important issues. What is the future vision for the JHSEC and how it can be improved?
- It needs to measure how much we can integrate the academic institutions into the process while still maintaining their independence. It must also clearly define if universities are coming in as technical partners and what that means. More detail is needed in terms of how universities can add value so as to translate into regulations and funding commitments.
- There is the issue of cost containment and pricing as well, given that the South African health sector is driven by imports and relationships with entities elsewhere in the world that can be guilty of collusion. That is the kind of technical role the academics can play.
- The fact that the universities are massive organisations is an advantage. There are academic facilities within the universities that can be used for monitoring and evaluation to build the capacities.
- An area that is missing is finding ways to expand the platform and the challenges in that regard. There are resource issues that need to be addressed, for example how to ensure that there are Anatomists in place when implementing a platform.
- Another aspect for the universities to think about is moving quite quickly into 4IR and AI, and how all the technologies that are coming in such as teleconsultation can be applied in the health system and how the risks should be managed. This goes further than innovation in the broader sense.

4. The Bill plays down the power of the Provinces. The problem is that our provinces are called “provinces”, but in fact have the power of the “states” in a federal system like the USA. Currently they have the power to disrupt NHI into 9 different versions of an NHI. This system cannot continue to be supported.

5. Training posts: Training posts are not addressed as well as staff of the NHI and their role in training. This can be addressed in the chapter suggested.

D. Positive issues dealt with in the NHI Bill

1. The role of central (quaternary) hospitals is emphasized.