UCT Input on the NHI Bill

Parliamentary Portfolio Committee on Health

Wednesday, 2 June 2021

Proposed approach to the reform

- Protect existing service delivery, while seeking to test new initiatives or interventions within iterative cycles of action and learning.
- Rationalize the legislation
  - Determine essential elements to legislate
  - Incrementally incorporate elements as they get tested and refined with experience during implementation.

The Bill

- **Main Goal is to achieve universal access to quality health care services**
- **The Bill seeks to:**
  - **Establish a National Health Insurance Fund**
  - **set out its powers, functions and governance structures;**
  - **provide a framework for the strategic purchasing of health care services by the Fund on behalf of users;**
  - **create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population;**
  - **to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users;**
  - **to provide for matters connected herewith.**

CHAPTER 2

- Users will have a number of entitlements, including the right to services that are part of the benefit package, if in need.
- Explicit rationing is commendable
- Welcome movement away from implicit rationing e.g. medicine stock outs, differential service availability; poor quality of care; and long waiting times

In theory

- If the size and scope of the benefits
- could be made to ‘fit’ within the current and future health system constraints (including budget, human resource and infrastructure constraints),
- then quality and equity would improve
- quality improvements will also alleviate the current medico-legal claims

But

- Extremely challenging to create a list of explicit benefits that is affordable to all in need as is in Chapter 2
- If we get the benefits wrong, there are likely to be new medico-legal threats.
- Many health systems (including the United Kingdom National Health Service) have 'implicit' benefits, at least for some aspects of care.
- **We therefore propose that part of the benefits need to be implicit**.

Will need

- To be explicit about:
  - health benefits,
  - referral pathways
  - Essential Medicines and Essential Laboratory Lists.
  - **areas of disinvestment**
  - **rationalization of clinical guidelines**

Chapter 4, 5, 6: NHIF Board and CEO

- We are concerned that power is centrally concentrated in the Minister
- Recommend:
  - National Health Insurance Fund (NHIF) Board be accountable to Parliament not the Minister
  - Board and Committees include civil society and user groups
  - The NHIF Board appoint its own chairperson and the CEO of the NHIF
  - Ad hoc advisory panel to appoint (e.g. CEO of the Fund)
    - include user groups, civil society, provider reps & academia
    - have clarity around how transparency is to be achieved

Chapter 7: Advisory Committees

- Benefits Advisory Committee, Stakeholder Advisory Committee, Health Care Benefits Pricing Committee and supported as national bodies.
- Outputs of these bodies are highly technical and also politically contentious
- Suggest an incremental approach to implementation, with clear cycles of feedback and learning.
- Concerned that the Benefits Advisory Committee is too far removed from issues of cost and affordability and that it may be more appropriate for the committee to be the “Benefits and Pricing Advisory Committee” so that issues of affordability can be properly considered.
- Recommend Committees to appoint their own Chairpersons

Chapter 7: Advisory Committees

- We support progressive incorporation of economic evidence into decision-making
- We support a movement towards making benefits transparent and explicit as data and evidence become available
- This inclusion of economic evidence will allow for the consideration of horizontal equity (i.e. equal access to benefits for equal need) as well as for vertical equity (i.e. supporting additional claims for key vulnerable and marginalized groups including disabled, trans and gender diverse people, and those living in rural areas

Chapter 7: Advisory Committees

- We note that the Benefits Advisory Committee will need substantive technical and institutional support to make procedurally fair, evidence based and coherent decisions about which services should be made available under NHI
- This will require a different approach to that used currently for decision making.
- For example, the existing Essential Drugs Programme relies on substantial volunteer resources and donor technical support to produce the Standard Treatment Guidelines and Essential Medicines List.
- The production of the NHI services package will require a fully resourced and competent workforce and mechanisms for producing evidence and analysis.

Chapter 11

- While health technology assessment (HTA) is proposed as a mechanism for assisting in decision making, taking into account affordability, equity and efficiency, more consideration is required as to the nature, remits and form of processes that utilize HTA methods.
- We recommend that the Bill consider explicitly establishing the institutional arrangements for such technical support to the Benefits Advisory Committee as the decision-making processes relating to the NHI services are critical to both early planning and buy-in from stakeholders as well as the longer-term sustainability of the NHI Fund
- High-profile examples of institutional arrangements include the UK's National Institute for Clinical and Care Excellence (NICE) or Thailand's Health Intervention and Technology Assessment Program (HITAP).

Prevention and Promotion

- If the NHI is to move us in the direction of UHC, prevention needs to be foregrounded in how the Bill provides for the funding of the health system
- Primary Health Care was described as the 'heartbeat' of the NHI in earlier White Papers but has almost vanished from the NHI Bill save for a cluster of specific services delivered at primary care level.
- To achieve adequate prevention as a core element of the NHI, and to ensure that Health Promotion is able to prevent diseases and save the health system costs related to the preventable burden of disease swamping our services

Prevention and Promotion

- We recommend that we institutionalise structures that will:
  - ensure that prevention activities and services receive an adequate slice of the NHI funding pool
  - that intersectoral action to promote health is facilitated, not hindered, by how funding flows through the NHI.
  - earmark the various “sin” taxes for Health Promotion (not treatment).
  - Describe a clear prevention function that is integrated at all levels of the health system.

Chapter 8: DHMO CUPS and PHC

- We support the establishment of the Office of Health Products Procurement

Medical Schemes

- Clause 33 says “Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund”
- There is lack of clarity on what ‘fully implemented’ means, and there is lack of clarity around how the Minister will make this determination (e.g. whether it will be a progressive determination or once-off
- Assimilation of the > 8million persons on MAS and those paying out of pocket should be in phased manner.
- **We suggest:**
  - **to follow the detailed recommendations made by the panel of the Competition Commission’s Health Market Inquiry**.
  - **gradual phasing out of the Medical Scheme tax rebate (not a sudden removal)**

Chapter 8: DHMO CUPS and PHC

- We support a 'panel' approach to community-oriented primary care with an enrolled population of 2000-10000 per panel and
- Multidisciplinary team including Ward-Base Outreach Teams with strong team- based links to facility-based health professionals.

- We suggest that a Primary Health Care Service Package be defined by:
  - The PHC elements of 285 guidelines in SA
  - Medicines List (Starting with Extended PHC Formulary)
  - Lab List (Starting with Extended NHLS PHC List)
  - Office Procedure List (136 from NHRPL to limit hospital referrals)
  - Home- and workplace-based screening and health promotion
  - Rehabilitation Services
  - Performance Outcomes (starting with Ideal Clinic requirements)

- Services that need attention:
  - Palliative Care
  - Service for those living with disabilities including intellectual disabilities

Chapter 8: DHMO CUPS and PHC

- The PHC service package would be revisited on an annual basis and could form the basis of a Comprehensive PHC benefit package

- For Community Health Workers, we emphasize the importance of training, supportive supervision and acceptable conditions of service, including from a payment perspective.

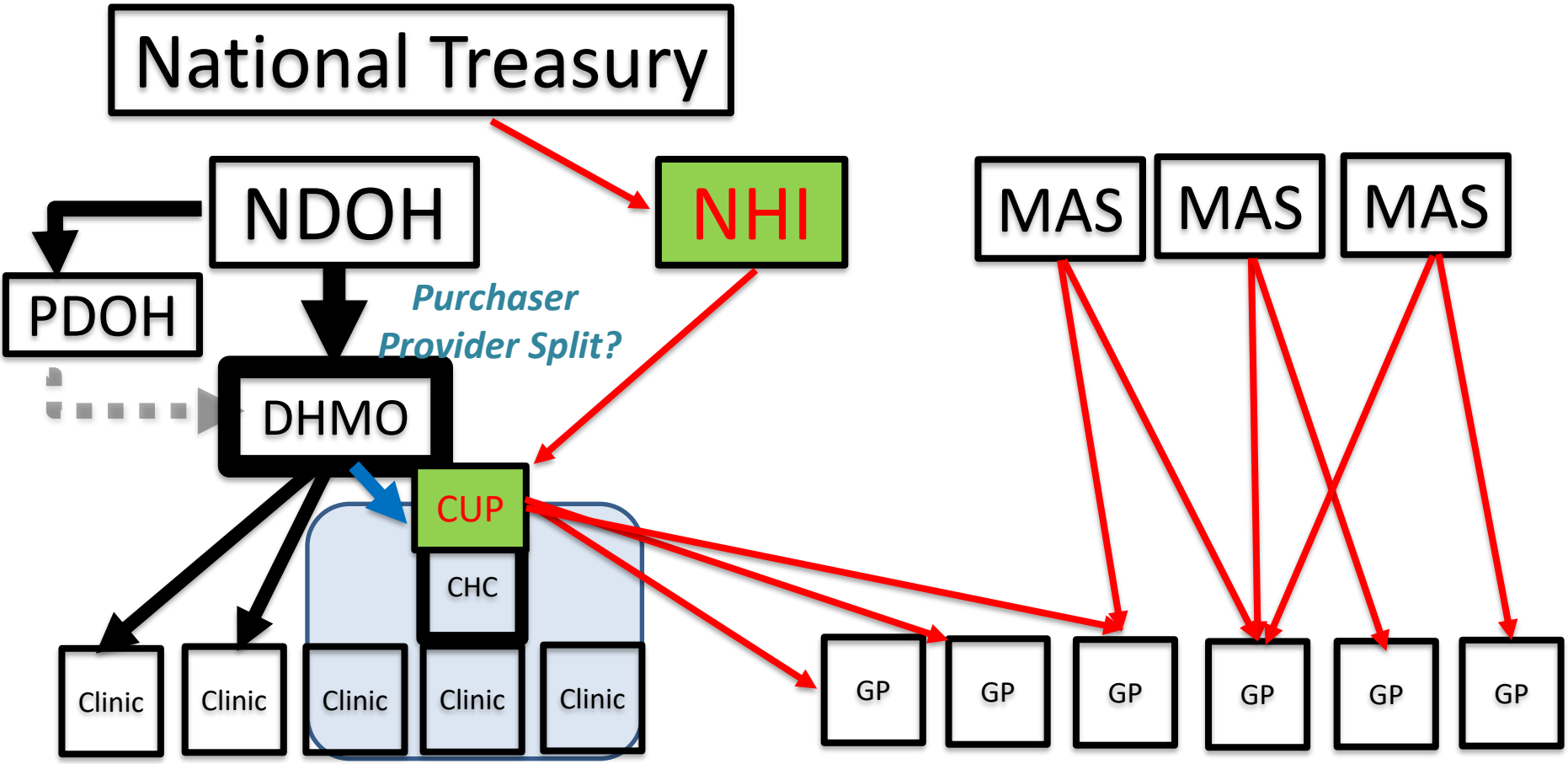
Purchasing of Health Services

- We are concerned about the maturity and the capacity of the health system to contract through CUPS and to use of DRG's for budgeting purposes
- We propose to establish provincial level CUPs initially given that we believe that there is currently insufficient managerial capacity at the sub-district level to handle contracting and/or purchasing
- As capacity is developed and lessons are learned, we propose that these might become district CUPs as a next step in a phased plan and if that is successful, further decentralization to sub-district CUPs could be beneficial. However, without necessary capacity, decentralization of such complex functions would not be recommended.

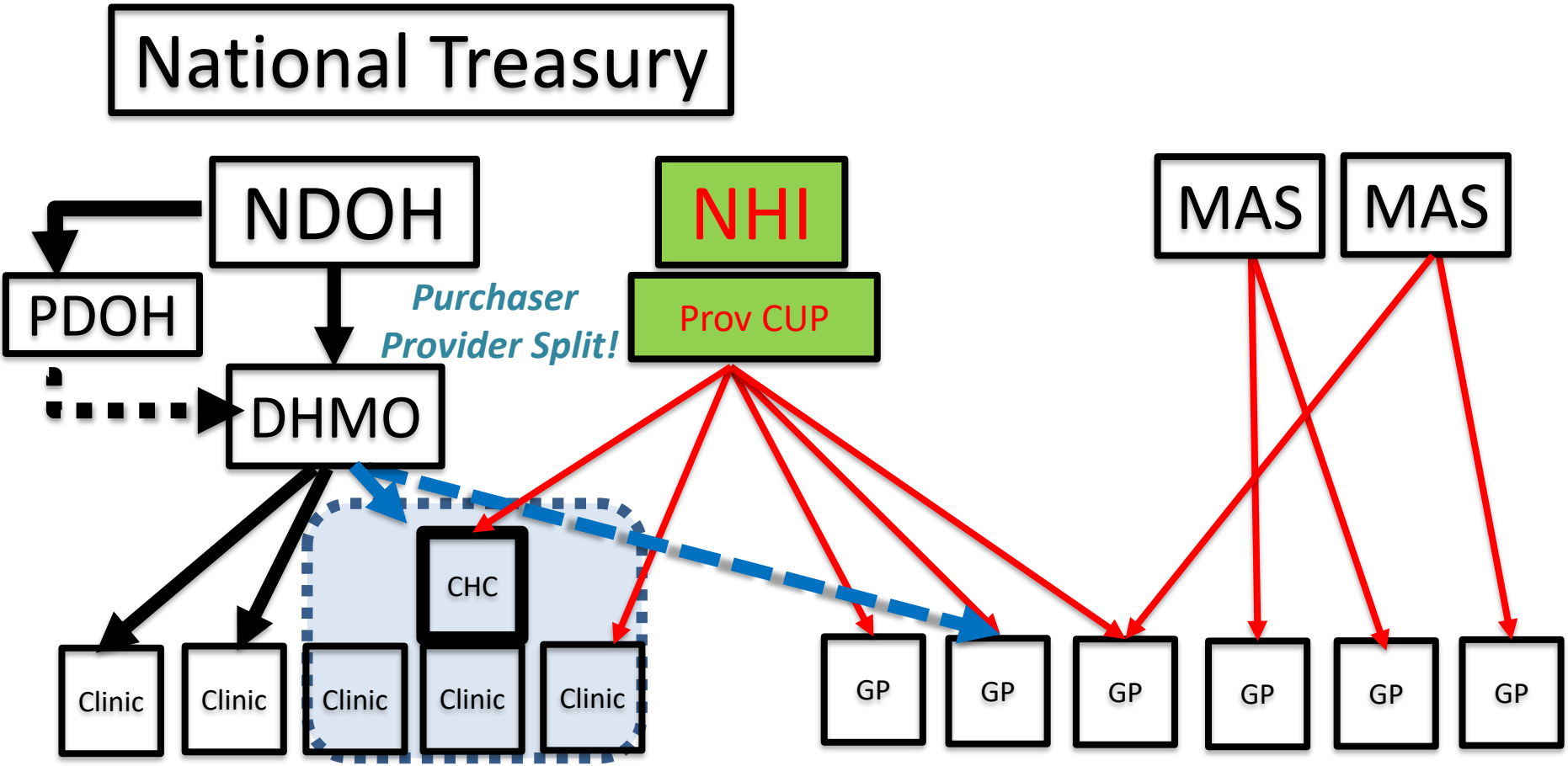
Purchasing of Health Services

- we propose that over time, provincial bodies should be required to purchase medicines and equipment from the Formulary while seeking to align their care with clinical guidelines.
- Currently a number of provinces are struggling with capacity issues, and we argue that these issues will only be more difficult if some of the roles currently played by provinces are decentralized to local government
- We argue that the role of the province must be maintained, and NDoH must play a role of capacity development to those provinces that are struggling.
- **Our current proposal is therefore that the current funding flows to provinces are maintained via conditional grants and equitable shares.**

Current plan



UCT Suggestion



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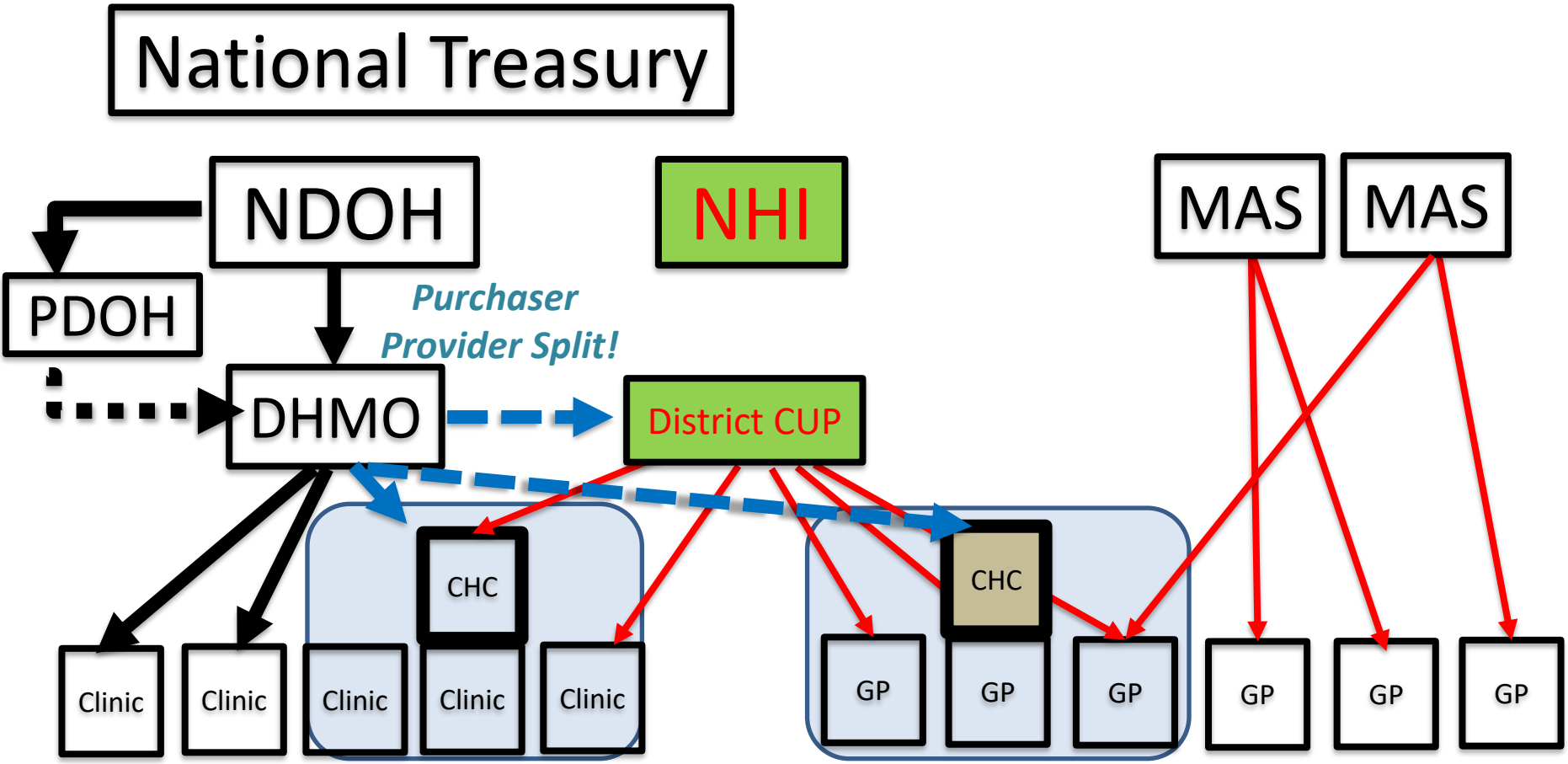

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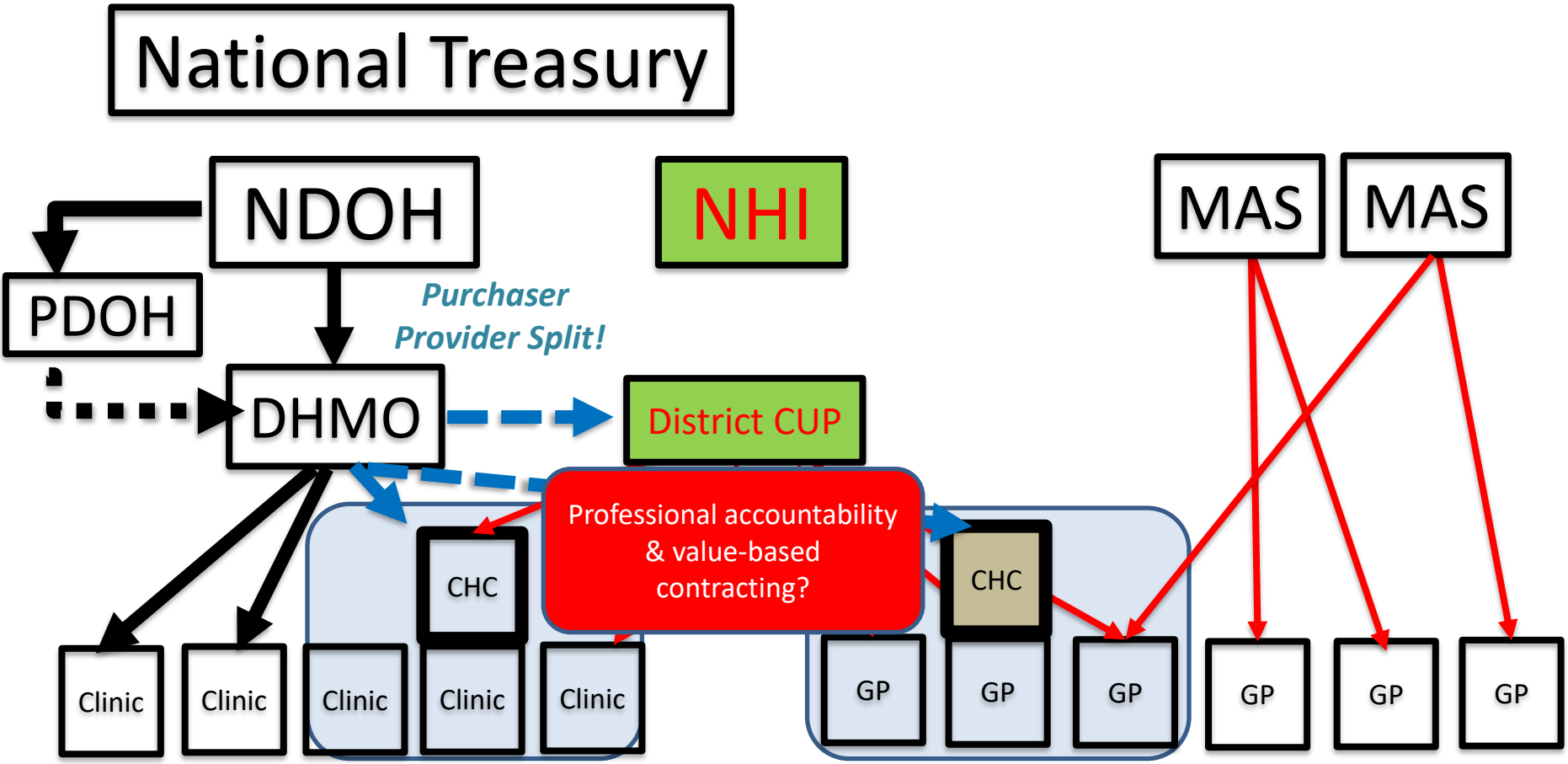

- We strongly support the early exploration, under the existing district health system mandate, of community-oriented practices in which all primary care services for defined smaller communities are based on capitation funding principles, and may be provided by a single practice which has the flexibility to innovate, drawing providers from the current public or private sector.

Accreditation of Health Facilities

- We support the work of the Office of Health Standards Compliance in accrediting health facilities so that they can provide quality services within the NHI framework
- However, over the past few years, scores from National Core Standards assessments have not improved and few public facilities are able to achieve compliant scores.
- This is because the resources are not available.
- If no resources are available to improve scores, then the process is entirely punitive.
- In addition, we are concerned that private providers and tertiary and regional hospital will find it easier to gain accreditation, leading to monopoly power and cost escalation through supplier induced demand, particularly in urban centers.
- **We recommend: public and rural facilities must be assisted to gain accreditation earlier in the process in order to counter the potential for monopoly power in private providers and in hospital care undermining PHC**

Training Platform for Health Sciences

- We are concerned about the potential impact on the training platform for health sciences from the implementation of NHI.

- It is not clear where training will take place, how trainers will be contracted, etc. For example, several scenarios might suggest that:
  - There will be very few trainers remaining, particularly if the public health sector cannot compete with private.
  - There will be limited scope for training in public health facilities at specialist level – with the possibility that much of specialist care gets moved to private.

- We welcome the establishment of:
  - The National Tertiary Health Services Committee responsible for developing the framework governing the tertiary services platform
- The National Governing Body on Training and Development 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

Training Platform for Health Sciences

- We propose that the role of private medical schools or private training platforms and payment for training as part of service delivery needs to be clarified

Pathology services

- Unlike the general clinical training platform where there are multiple provincial bodies responsible for the interface of service and training, the NHLS is the sole custodian of pathology in South Africa (in partnership with universities).

- Thus, there is no redundancy in the system, and special care should be given to this critical national platform

- We are supportive of the pathology sector's move towards greater quality of service, and laboratory accreditation.

- Neither the NHI Bill nor the White Paper gives any guidance as to what form, level and timing of laboratory accreditation will be required.

Pathology services

- Both the NHLS and private laboratories will need to give assurance of accreditation and quality standards at time of contracting.

- No guidance is given as to whether provinces (or districts) would contract private pathology service providers, or whether the entire mandate would be allocated to the NHLS, which in turn would then contract the private sector for segments of the population. This needs clarification

- We propose that the NHLS be the primary custodian of pathology services everywhere, and that private laboratories bid through open tenders for specific parts of the country. It may be possible to pre-specify the proportion of the national pathology work that is available to private providers (at pre-specified costs per test) using this mechanism.

Pathology Services

- The NHLS also has a research mandate
- The current grant given to the NHLS (separate to fees-for-service charged by the NHLS) to support pathology teaching, training and research is woefully inadequate, and is subsidized by the general budget of the NHLS.
- The new system needs to acknowledge that reality, and ensure that there is adequate funding for the teaching, training and research mandates of the NHLS.
- The importance of the NHLS to the universities should not be understated. However, the Bill gives no clarity on the ongoing relationship, and how teaching of pathology will be structured and funded.
- Every university with a health science faculty is reliant on a functioning NHLS and a healthy teaching/research relationship that supports the discipline adequately.
- Other matters relating to costing of pathology, logistics, infrastructure, etc are critically important, but the University of Cape Town supports the NHLS submission in this regard

Communication

- We note confusion as to what NHI is about in the media as well as the contradictory messages that come from key officials
- We suggest that it is important for a clear communication strategy to be developed.

I thank you