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Stellenbosch University, Faculty of Medicine and Health Sciences (FMHS)
Presentation to the Parliamentary Portfolio Committee regarding its NHI Submission

2 June 2021

Prof René English, on behalf of the FMHS

OUR VISION

To be the leading research-intensive health sciences faculty in and for Africa.

OUR MISSION

We lead by facilitating transformative, life-long learning; creating, sharing and translating knowledge that enhances health and health equity; and co-creating value with and for the communities we serve.

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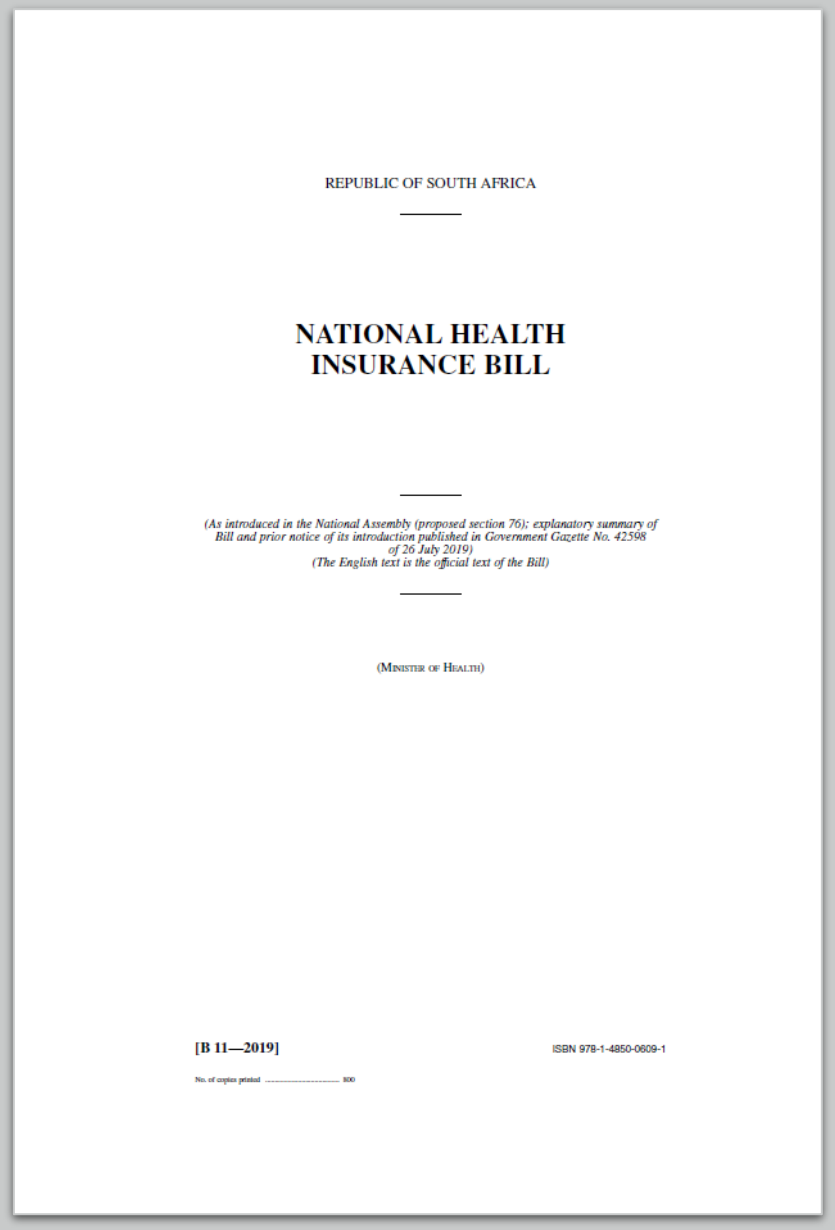
Inputs into the NHI Bill (2019) – Overarching comments regarding the FMHS position

- Committed to principles of **social solidarity** and **universal health coverage** (UHC).
- UHC not equivalent to a funding model
- Concerns:
  - Proposed model for funding model for medical care as opposed to consideration for broader **principles of philosophy of PHC** which includes social determinants of health.
  - Introduction of **fragmentation** as opposed to a unified health system.
  - **Strengthening of current health system** to be prioritized and funded in preparation for NHI
- Our position aligns with international, national conceptions of PHC, UHC, health systems thinking and related research evidence. It acknowledges that **health systems are complex and adaptive** and recognizes the importance of governance and leadership, and the 'software' of the health system.



REPUBLIC OF SOUTH AFRICA

NATIONAL HEALTH INSURANCE BILL

(As introduced in the National Assembly (proposed section 76); explanatory summary of Bill and prior notice of its introduction published in Government Gazette No. 42598 of 26 July 2019)
(The English text is the official text of the Bill)

(MINISTER OF HEALTH)

[B 11—2019]

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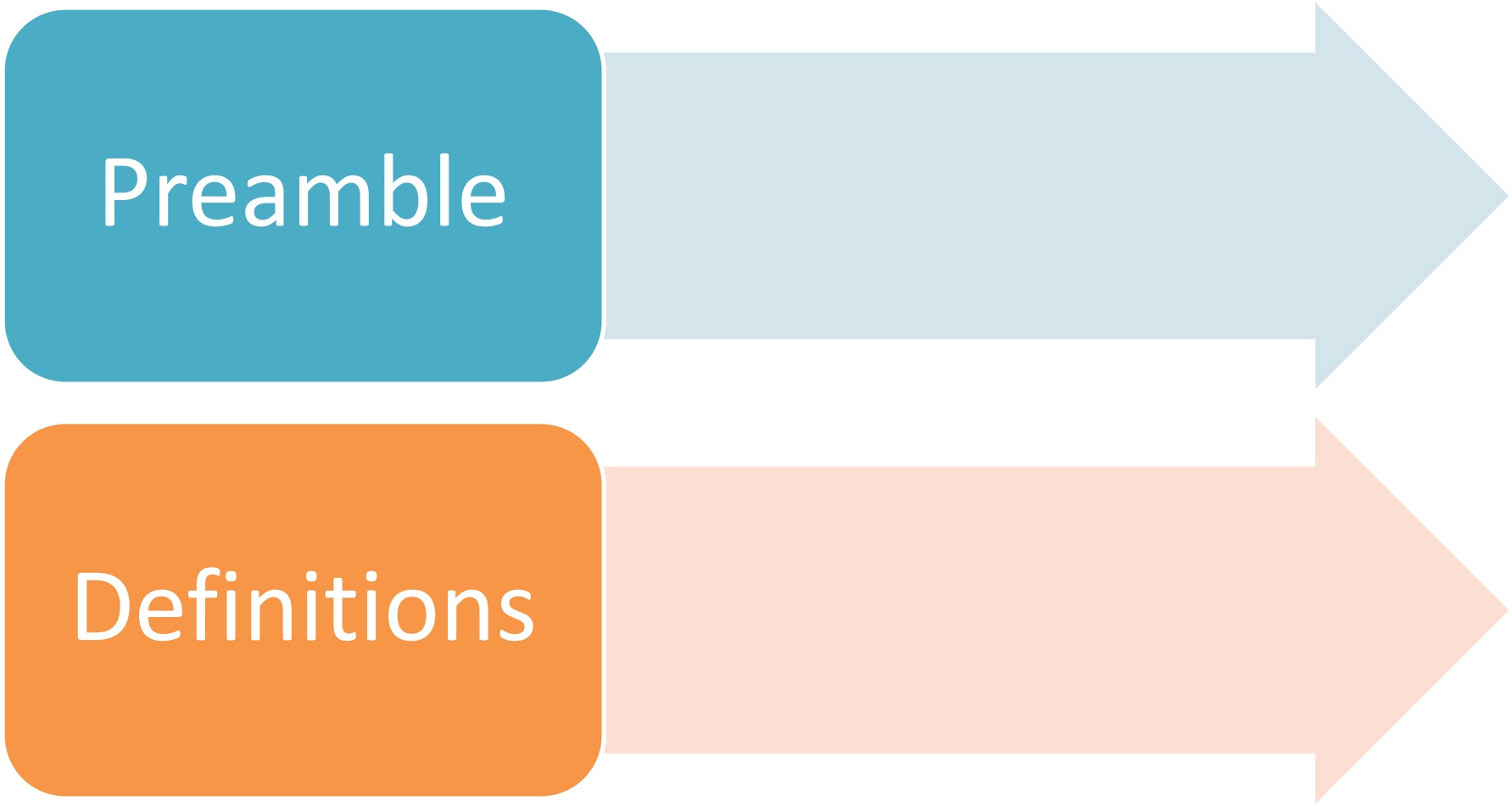
Opening Sections



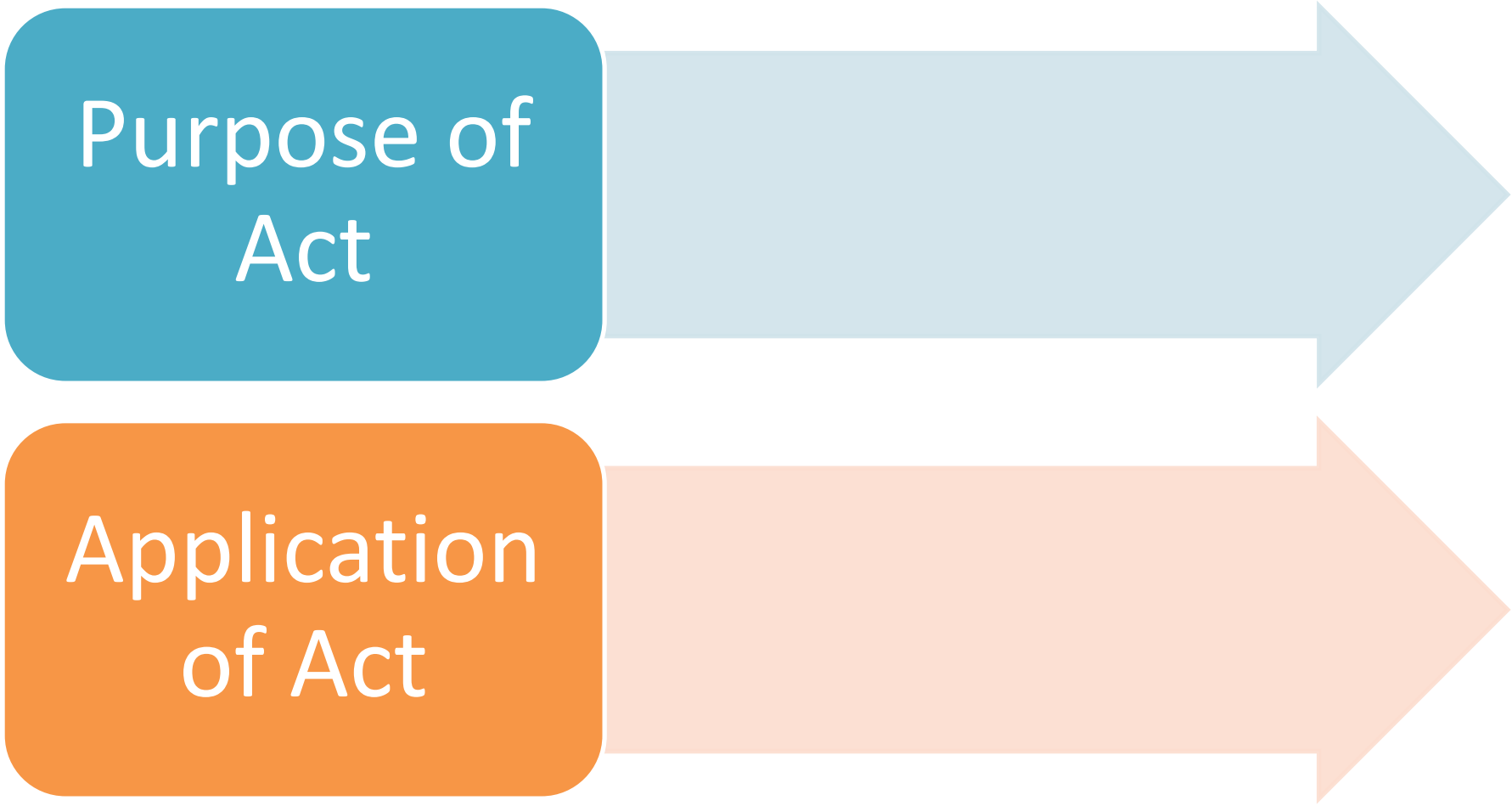
Preamble

Comment and suggested alternative	Motivation and/or suggested solution
Line: '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'**	Although a **strengthened health system** is implied in the statement 'quality personal health care services' it **should be emphasised as a separate point.**
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'**	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.

Definitions

Comment and suggested alternative	Motivation and/or suggested solution
Whilst **'health care service provider' is defined fairly generically**, the way the Bill refers to such providers appears to indicate health professionals, and **important cadres such as community health workers, mid-level workers, and traditional healers do not appear to be included.**	Clarity is required regarding health service providers such as community health workers, mid-level workers, and traditional healers.

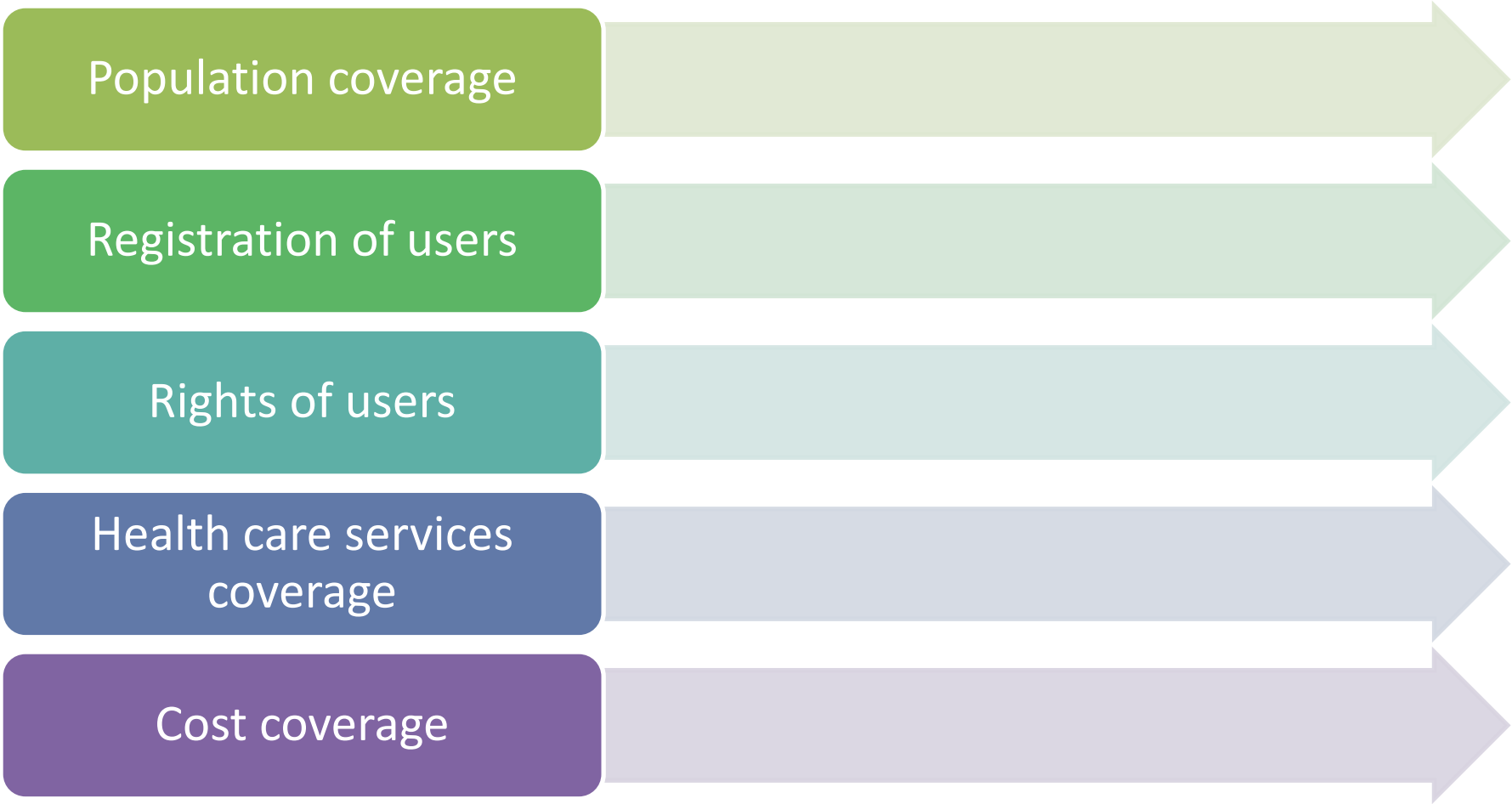
Chapter 1: Purpose and application of Act



Chapter 1 – Section 2: Purpose and application of Act

Comment and suggested alternative	Motivation and/or suggested solution
2(a) states 'serving as a single purchaser and single payer of health care services' 2(a) after 'use of' add 'quality'	Con the single strategic purchaser and payer roles is provided. Furthermore, strategic purchasing by one structure without consideration for **the role of the province and 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 are required. It is therefore proposed that these be developed concurrently with the Bill.

Chapter 2: Access to health care services



Chapter 2 – Section 4: Population Coverage

Comment and suggested alternative	Motivation and/or suggested solution
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'**	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).

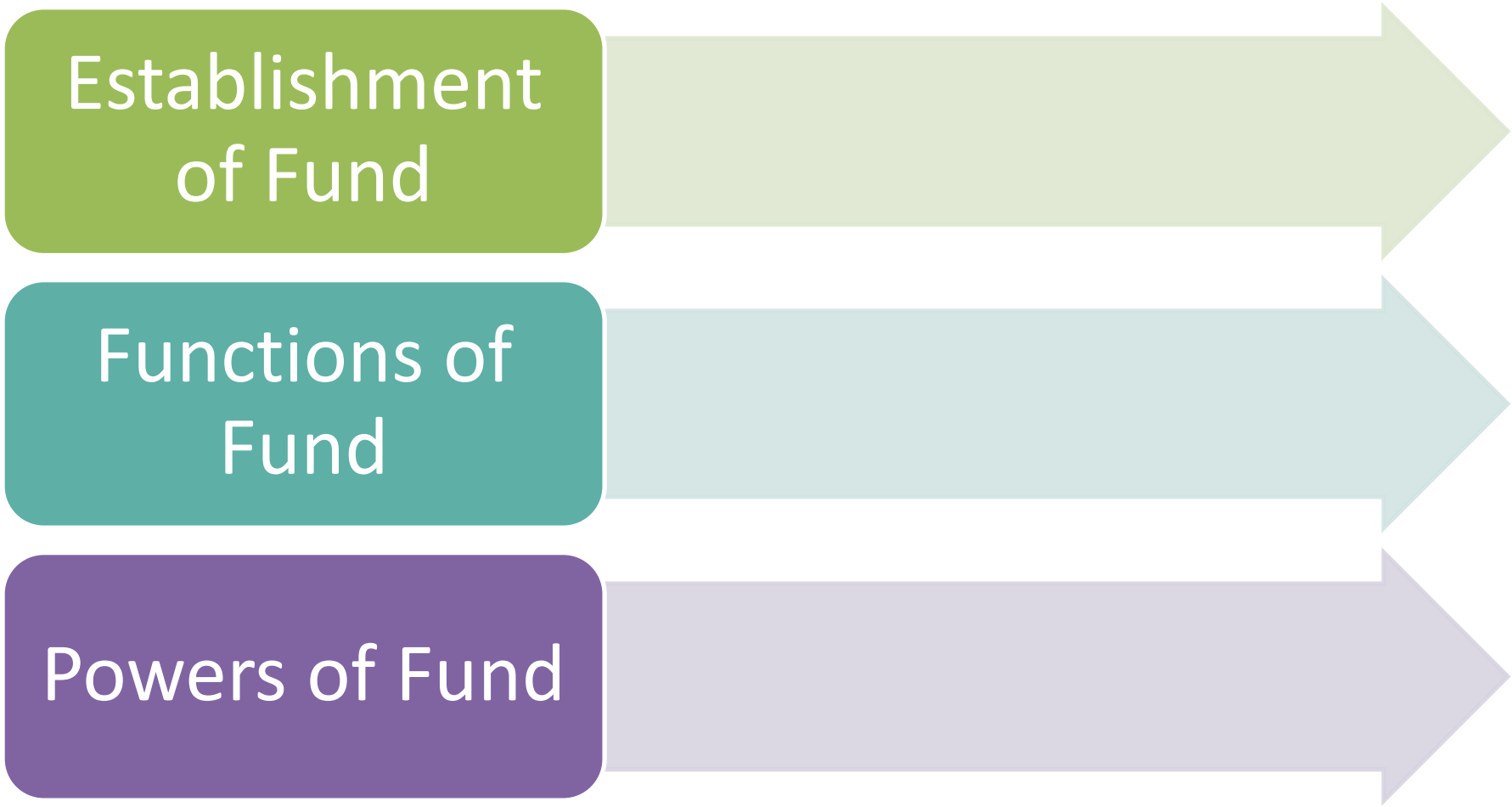
Chapter 2 – Section 5: Registration as users

Comment and suggested alternative	Motivation and/or suggested solution
Add to 5 'passport, drivers licence' as another option for registration and 'asylum seekers'. If it is 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 is to be made explicit. The **implications of not having any documents** as stipulated in this section on registration of the user should be discussed in the Bill. Details of the management and maintenance of the register, as well as registration of users at unaccredited facilities are required. what will happen if the user does not have proof of registration?	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 should be carefully considered**. Furthermore, significant investment and time will be required to establish a streamlined, effective and efficient system. This will therefore 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.

Chapter 2 – Section 7: Health care services coverage

Comment and suggested alternative	Motivation and/or suggested solution
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 meant to access not be/no longer be accredited**. 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?** Thus add additional clause thataddresses management of the user should they present with a medical emergency.	The implications for rural areas is that there may be i**nsufficient 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). Add a clause on how this will be managed.

Chapter 3: Access to health care services



Chapter 3 – Section s 10,11: Structure of Fund; Powers of Fund

Comment and suggested alternative	Motivation and/or suggested solution
The functions and powers of the Fund are broad and cover a wide range of activities and actions. The Fund will require 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 4000 public health facilities in South Africa (excluding the private sector facilities).	For the Fund to **execute its functions and powers, strong, efficient and quality operations must be in place, and service provision must be high- quality, acceptable, appropriate and timely.** 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 abovementioned.** How the Fund will engage with provinces and district- based structures should be made explicit.
11(1)(h) We propose that an **independent entity investigate complaints against the Fund**.	This would aid improved governance, stewardship and accountability.

Chapter 4: Board of Fund

- Establishment of Board
- Constitution and composition of Board
- Chairperson and Deputy Chairperson
- Functions and powers of Board
- Conduct and disclosure of interests
- Procedures
- Remuneration and reimbursement

Chapter 4 – Section 12: Establishment of Board

Comment and suggested alternative	Motivation and/or suggested solution
The Board is accountable to the Minister in the Bill. This chapter establishes the **NHI Fund as a Schedule 3A autonomous public entity**. The **Minister has extensive powers in the current Bill** (such as section 13.(8) and 13.(9) of this section). This may undermine the purpose and effective implementation and independent functioning of the Fund.	We propose that the Fund reports to Parliament and that the Minister's powers are reduced

Chapter 4 – Section 13: Constitution and composition of Board

Comment and suggested alternative	Motivation and/or suggested solution
13(1)(3) details on who the ad hoc advisory panel will be must be made explicit. 13(5)(a) details on what be 'a fit and proper person' constitutes should be provided. 13(5)(b) add 'public service administration, business management' Section 15(c) states that the Board must advise on comprehensive health care services to be funded by the Fund through the Benefits Advisory Committee'. 13(5)(e)	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.** Given the importance of **community participation**, someone who represent civil society should also be on the Board. **Sufficient expertise** should be on the Board to ensure that this is possible. More **details should be included such as shares or stakes in insurance industries, pharmaceutical companies, involvement in tobacco or sugar industries etc.**

Chapter 4 – Section 15: Functions and powers of Board

Comment and suggested alternative	Motivation and/or suggested solution
Section 15(b-d) 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'.	The Board members **should be selected so that they are able to fulfil these functions**. Furthermore, it is **not clear whether the Board can co- opt or contract advisors** to assist with this activity. This should be added to the section

Chapter 5: Chief Executive Officer

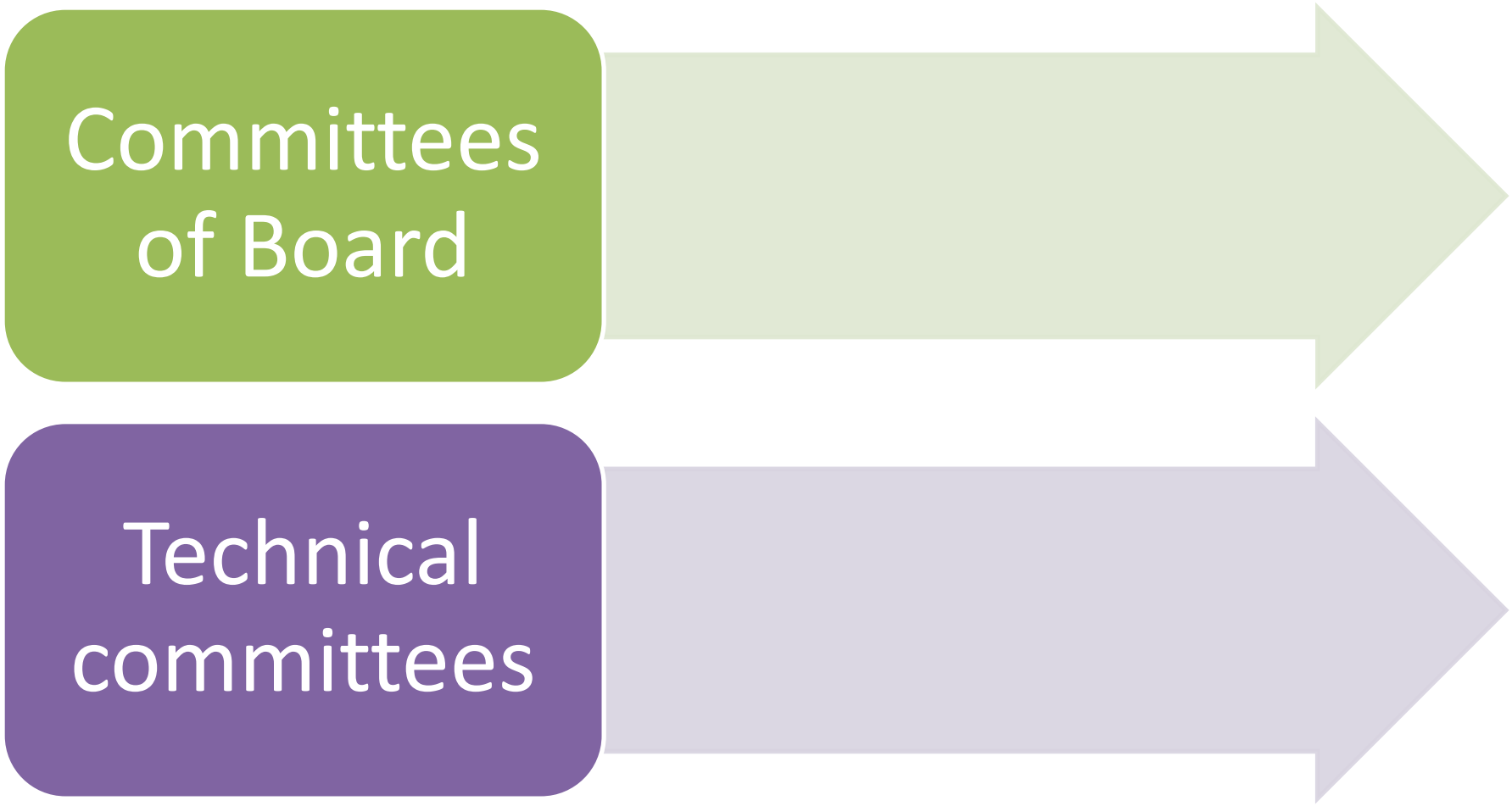
Chapter 5 – Section 19: Appointment

Comment and suggested alternative	Motivation and/or suggested solution
Section 19(1) states that the CEO 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.	Clarity regarding the appointment is required.

Chapter 5 – Section 20: Responsibilities

Comment and suggested alternative	Motivation and/or suggested solution
Section 20 (2) (e) (ii) **add 'Provinces' before 'District Health Management Office'.**	Again the role of the province with regards to the Investigating Unit requires clarity

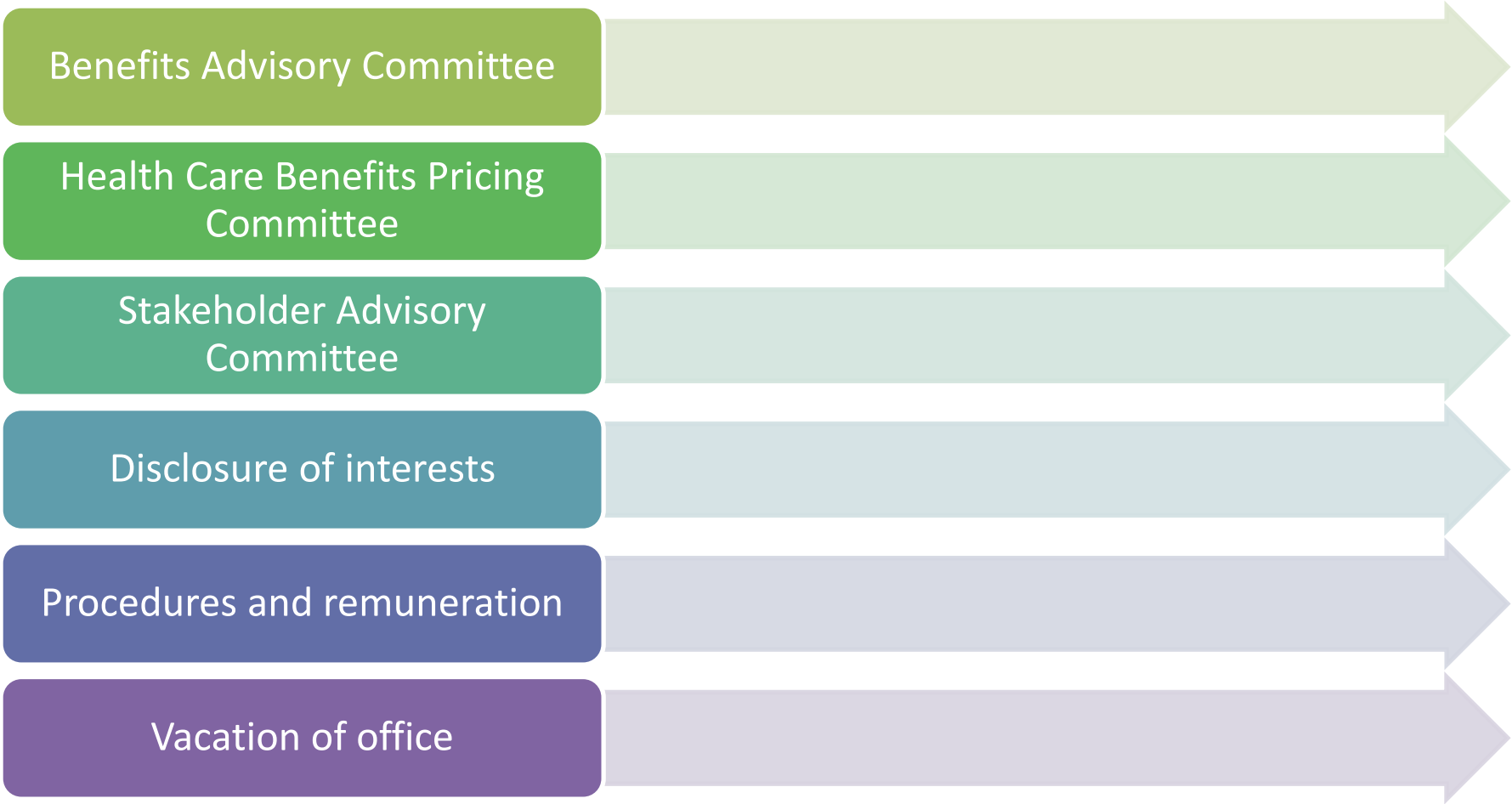
Chapter 6: Committees established by Board



Chapter 6 – Section 24: Technical committees

Comment and suggested alternative	Motivation and/or suggested solution
It is not clear if the Technical Committee is comprised of members of the Board. It is assumed that it is not given that the following is included in Section 24(3) (a) the person much be 'fit and proper'.	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. It should be stated whether additional expertise can be bought in, or an expert can be co-opted into the Committee. **Civil society** should be represented on Committees as far as is reasonable.

Chapter 7: Advisory committees established by Minister



Chapter 7 – Advisory committees to be established by the Minister

Comment and suggested alternative	Motivation and/or suggested solution
FMHS welcomes this change from the 2018 Bill, that health service benefit determinations and pricing are separated from the Fund, and incorporated into the roles and functions of Advisory Committees, as well as the establishment of a Stakeholder Advisory Committee. However, **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 are required. The role, including powers, roles and capacity of the person appointed by the Minister on each Committee should be stipulated. Civil society should be represented on the Committees, and the Stakeholder Committee should have adequate representation from civil society.

Chapter 8: General provisions applicable to operation of fund

- Role of Minister
- Role of Department
- Role of medical schemes
- National Health Information Systems
- Purchasing of health care services
- Role of District Health Management Office
- Contracting Unit for Primary Health Care
- Office of Health Products Procurement
- Accreditation of service providers
- Information platform of Fund
- Payment of health care service providers

Chapter 8 - Section 32: Role of Department

Comment and suggested alternative	Motivation and/or suggested solution
Section 32(1)(c) **add 'non-personal' between 'additional' and 'health services'**	Provinces should be playing a stewardship role. Clarity regarding the role of the provinces is required.
Section 32(2)(a): The role of **the provinces is presented as management agents**.	The role of the province is once again not clear. This should be the role of the Provinces in terms of establishment and oversight.
Section 32(2)(d) states that Minister will 'establish **District Health Management Offices** as government components'.	DHM structures already exist – is this different?

Chapter 8 - Section 33: Role of Medical Schemes

Comment and suggested alternative	Motivation and/or suggested solution
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'.	

Chapter 8 - Section 35: Purchasing of health care services

Comment and suggested alternative	Motivation and/or suggested solution
In terms of section 35 (2), the Fund can only purchase services from accredited and contracted hospitals.	If facilities did not receive accreditation due to factors related to funding or support (e.g. inadequate infrastructure etc.), **what will the funding/financing arrangement be to ensure that these facilities can be improved to meet accreditation standards?**
Whilst the strategic purchasing of health care services by the Fund is intended to reduce costs and improve value of health services and impact on health outcomes, **any single buyer system like the NHI Fund, on its own that is without complementary supply-side regulation cannot succeed**. In a mature and long-standing single purchasing system like NHS in the United Kingdom, all public and private providers that provide care paid for by the NHS are regulated by Monitor, the independent supply side regulator (now part of NHS Development) as well as by the Competition and Markets Authority, the competition enforcement agency.	The Health Market Inquiry found a private healthcare market that is characterized by high and rising costs of healthcare and medical scheme cover, and significant overutilization without stakeholders having been able to demonstrate associated improvements in health outcomes. The HMI also found a poorly regulated and coordinated supply side**. To remedy this, the HMI proposed and independent supply side regulator, who's job will be to:** assist provinces in issuing licenses for hospitals assist with a process and a platform for price setting for doctors – (Multi-Lateral Negotiating Forum); conduct or contract out research looking at cost-effective healthcare interventions, including technology assist and facilitate reliable information on quality of health and health outcomes measurement

Chapter 8 - Section 36: Role of District Health Management Office

Comment and suggested alternative	Motivation and/or suggested solution
In terms of section 36, the District Health Management Office must be established as a 'national government component' for the provision of primary health care services at district level The Bill refers to the establishment of the DHMO in terms of section 31A of the National Health Act, whereas section 31 (1) (a) of the NHA speaks to district health councils with a different role and function to that envisaged for the DHMO.	Evidence shows that **current district level services are not sufficient in terms of resources of technical capacity** to managed additional financial, technical and operational functions. Clarity is required on how this level will be strengthened. Furthermore, **to whom district level structures are accountable is not clear.** The provinces are completely excluded from this section and chapter, which would be in contravention of sections of the Constitution as well as National Health Act.

Chapter 8 - Section 37: Contracting Unit for Primary Health Care

Comment and suggested alternative	Motivation and/or suggested solution
The relationship between **the CUPs and the district, the Fund and province is not clear,** given that Section 37(1)(b) states that is 'is the preferred organisational unit with which the Fund contracts for the provision of primary health care services within a specified geographical area.' The Bill speaks of CUPs operating at sub-district level.	**Clarity must be provided in the Bill as to the governance and relationships between entities.** Principles should be developed to ensure cost-effective contracting, such as, for example avoiding open-ended commitments in provider payment arrangements. The **expertise needed in such a unit needs to be specified, as with the advisory committees**. Who will constitute this office? (i.e. what competencies are required to deliver on the mandate of this office?) This unit is also prone to capture, fraud and corruption as it is linked to product service provider appointments etc. How will these be mitigated against?

Chapter 8 - Section 39: Accreditation of service providers

Comment and suggested alternative	Motivation and/or suggested solution
Reliance of accreditation and certification in section 39 **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 the public sector.	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, processed 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 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.

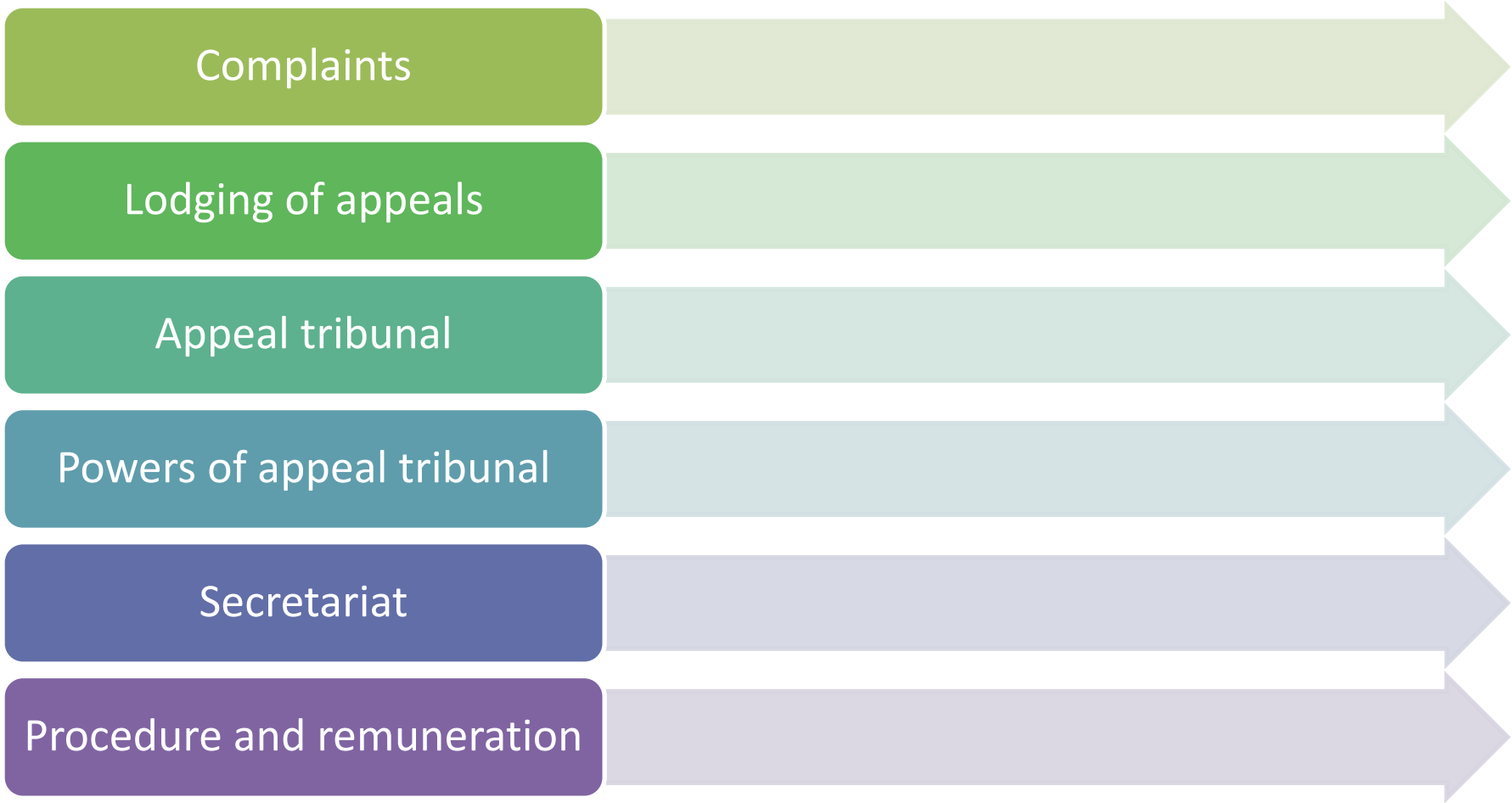
Chapter 8 - Section 40: Information platform of Fund

Comment and suggested alternative	Motivation and/or suggested solution
The envisaged Information platform of the Fund in section 40 is vital to the measurement and assessment of success in achieving the desired equity, quality and performance outcomes.	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** (e.g. Treasury). **Statutory bodies' data bases 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 8 - Section 41: Payment of health care service providers

Comment and suggested alternative	Motivation and/or suggested solution
Section 41 indicates that payment should be 'all-inclusive' and 'based on performance', and that the Fund must determine the payment mechanisms'. **FMHS welcomes this move towards delivering a more efficient and cost-effective health service.** This is further confirmed in Section 10 (1) (k), where 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'	**It is well documented that fee for service reimbursement promotes perverse incentives.** **The Bill names specific forms of alternative reimbursement mechanisms (ARM), diagnostic related groups, capitation, and a capped case-based fee ('diagnostic related groups' has been replaced with 'all-inclusive' payments between the 2018 and 2019 bill).** However, we are of the view that **naming the forms of ARM will limit innovation and create rigidity in the system.** **<u>We recommend the following wording be included: 'The Fund's contracting arrangements should include: risk sharing between health care service providers, health establishments or suppliers of health goods, and the fund; encompasses a value component [price and quality (outcomes)], and should comply with the Competition Act'.</u>**

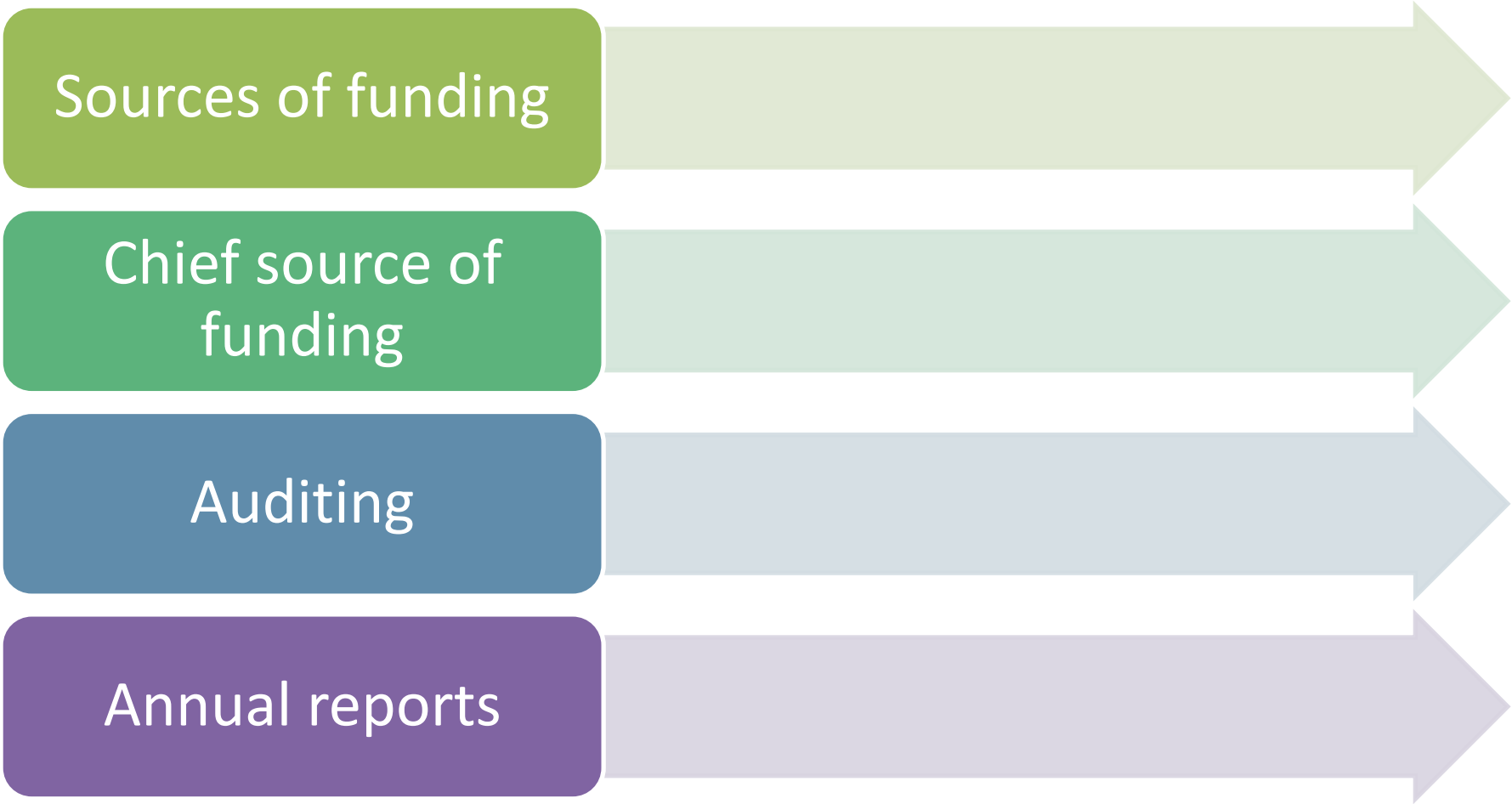
Chapter 9: Complaints and appeals



Chapter 9 - Section 42: Complaints and appeals

Comment and suggested alternative	Motivation and/or suggested solution
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. FMHS proposes that the findings of the Investigating Unit must also be submitted to the Board.

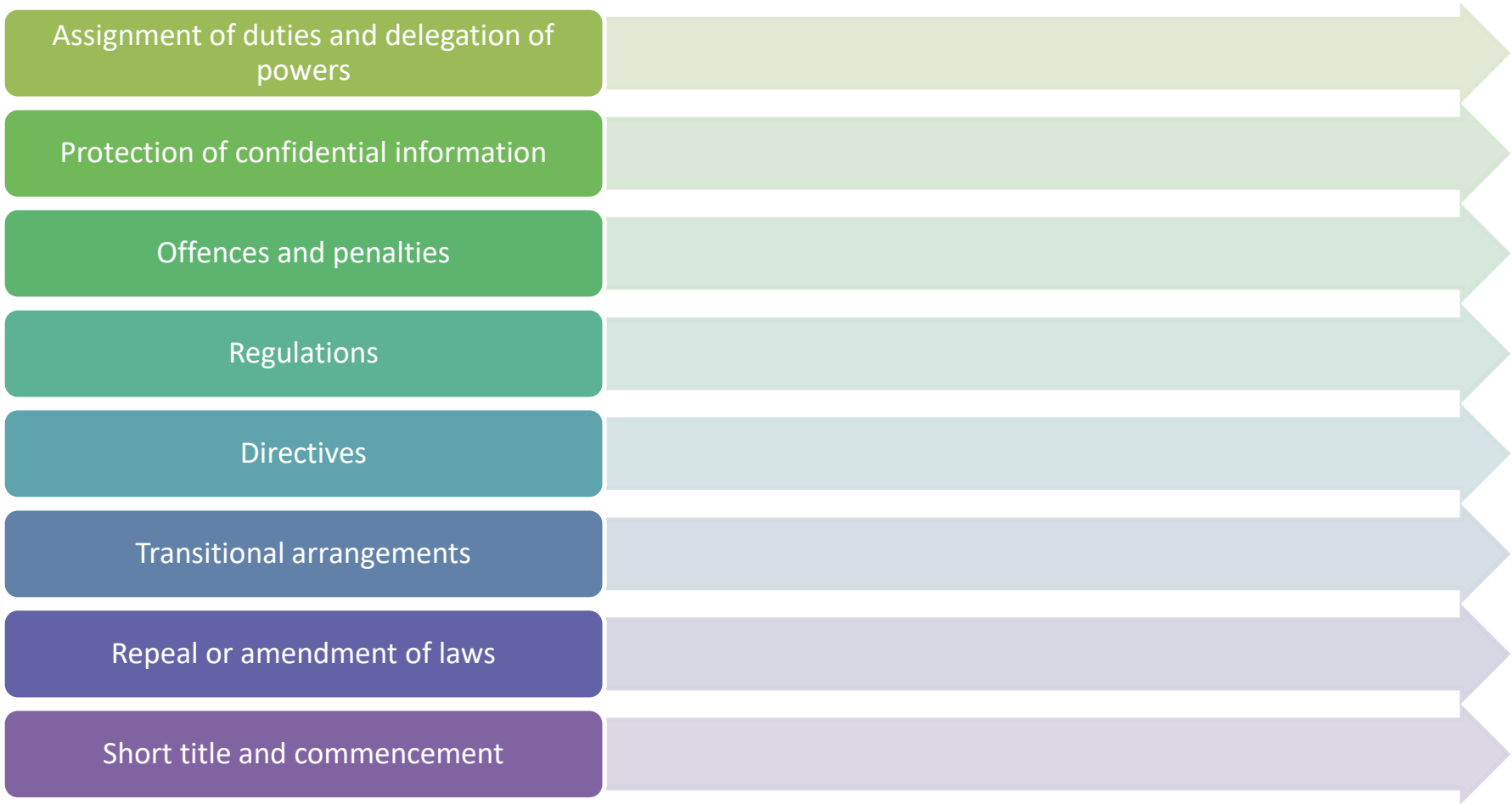
Chapter 10: Financial matters



Chapter 10 (Financial Matters) - Sections 48, 49: Sources of funding; Chief source of income

Comment and suggested alternative	Motivation and/or suggested solution
The **sustainability of sources of funding is a concern,** especially if the main source relies on a small taxpayer pool. How will this pool be affected by challenging economic times, high rates of unemployment and rising costs of fuel and food? There is already a concern about a decreasing pool of people able to maintain contribution to medical aid schemes, with those who continue contributing downsizing on benefit packages. There is also **an assumption that private individuals are happy to make contributions to private medical schemes.** Yet this is known to be a grudge expenditure due to uncertainties in quality that have come to represent public healthcare.	We can start with **maximising efficiency as the system stands through proper governance at all levels and in both public and private sectors. Eliminate wasteful expenditure and adopt lean management approaches throughout the system.** Then by the time we ask taxpayers to contribute, the system has proven to be reliable. Whatever taxes are proposed thereafter, bring taxpayers into your confidence and make them understand the justification for asking them to do what they are asked to do.

Chapter 11: Miscellaneous



Chapter 11 (Miscellaneous) - Sections 55: Regulations

Comment and suggested alternative	Motivation and/or suggested solution
Section 55 – no mention is made of the Provinces	

Chapter 11 (Miscellaneous) - Sections 57: Transitional Arrangements

Comment and suggested alternative	Motivation and/or suggested solution
In this section, a **'progressive and programmatic approach based on financial resource availability' is proposed with two Phases highlighted.**	A **monitoring and evaluation framework be established to guide implementation**. **Evidence-based approaches be used to guide and learn from implementation activities.** 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.

Some priority areas that require attention to enable NHI implementation and attainment of HS goals

Health information systems

- ICT infrastructure and related systems
- Hardware and software provision at lowest levels.
- Increase computer literacy and competencies to use health information
- Strengthen Monitoring and Evaluation systems (e.g. what and how to measure, analyse and report on quality or provider performance)

Capacity

- Support services –for contracting/accreditation, including HR, SCM and financial management
- Quality measurement, improvement and assurance
- General management
- Monitoring and evaluation
- Priority-setting;health technology assessment; health economics; financing; research
- More appropriate staffing
- Governance, leadership

More efficient health system

- Strengthen building blocks of health system
- Dealing with corruption, mismanagement
- Changing the values, culture, attitudes of system and those who work in system
- Detailed, costed planning
- Role of provinces – accountable intermediary?
- Role of other sectors
- Establishing a culture of ongoing learning

Educational systems

- Stronger engagements with HEIs
- Alignment of training and production with needs.
- Concurrent changes in PFMA and DPSA legislation – concurrent to enable implementation.
- Role in research to build a better body of evidence

A word on implementation…

- Progressive implementation and piloting
- Use of research and evidence to inform and guide best practices
- The role of local innovation and expertise – particularly of established public servants are not to be undermined.
- HEIs can play an important role throughout the planning for and implementation of the financing mechanism towards UHC attainment.

THANK YOU | DANKIE | ENKOSI

Prof René English
Head: Division of Health Systems and Public Health
Department of Global Health
(renglish@sun.ac.za)

UNIVERSITEIT iYUNIVESITHI STELLENBOSCH UNIVERSITY 100 1918 · 2018