BUSINESS UNITY SOUTH AFRICA

PRESENTATION TO THE PORTFOLIO COMMITTEE ON HEALTH
NHI Bill

29 JUNE 2021

NATIONAL OFFICE

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INTRODUCTION TO BUSA

1. BUSA is a confederation of business organisations, including chambers of commerce and industry, professional associations, corporate associations, and unisectoral organisations. It represents a cross-section of business, large and small, including health care providers, health care funders, medical manufacturers and employer groupings.
2. BUSA represents in excess of 350 000 employers.
3. In its deliberations on NHI, BUSA has sought the views of both its health sector members and its wider constituency, comprising industry bodies and employers with responsibility for workers across the whole economy.
4. BUSA would like to thank the Portfolio Committee on Health for the opportunity to make oral representation following its written submission dated 29 November 2019.

CONTENTS

Introductory remarks

- BUSA supports Government's policy objectives of
  - Progressive universalism to address inequality
  - Mandatory membership and prepayment for sustainability
  - Financial risk protection to ensure access to needed care
- BUSA supports the implementation of the NHI Fund and our inputs aim to highlight risks of execution, that may ultimately undermine these policy objectives
- Policy needs to be implemented in a way that is inclusive, affordable and sustainable
- BUSA believes that this should include:
  - A multi-funder dispensation
  - Access to a minimum package of healthcare services for all South Africans
  - Sharing the operational load of providing the care between the public and private health sector
  - Phased implementation to avoid concentration of operational risk and unintended consequences

Introductory remarks

- As Business we recognize that the principles underpinning the proposed NHI give expression to the policy objective of equitable access to health care as a socioeconomic right under our Constitution.
- We are mindful of the contribution of universal access to health care to fairness, human dignity and economic productivity.
- This objective can be advanced in various ways, and involves health service delivery and standards of care, investment in infrastructure, human resource mobilization and financing arrangements, amongst others.
- A founding assumption of our commitment to NHI is that society agrees to share the costs of providing universal access to necessary and appropriate health services, essential to the wellbeing and dignity of all. This forms part of our broader commitment to advancing comprehensive social protection.

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Introductory remarks

- South Africa has excellent medical and health science faculties in our universities, well-established hospitals and specialist practice in both the public and private sectors, pharmaceutical and other medical suppliers and distributors, and an extensive network of public clinics, GP practices and pharmacies for primary care delivery.
- The objectives and progression of NHI will be best achieved if we adopt an inclusive approach to narrow the gaps between rural and urban areas and between public and private providers through the evolving roles of public health services, medical schemes, health administrators and private sector health service providers.
- This requires an inclusive and collaborative approach, drawing on our country's collective skills and resources.

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Introductory remarks

- The lack of an accompanying paper from National Treasury on the fiscal implications as well as the associated Money Bill is a cause of serious concern.
- In adopting NHI as the organizing framework for financing health care, we believe that South Africa has the opportunity to incorporate its entire health infrastructure and build on the strengths, assets and capabilities of both the public and private sectors.
- Government has also not yet responded to the recommendations of the Health Market Inquiry (HMI), regarding the proposed operational reforms which were developed through an extensive and robust process and have the potential to enhance efficiencies with immediate benefits in healthcare funding and delivery.
- We support the NHI Bill in principle, however we have identified certain serious concerns and risks that may potentially impede successful implementation and achievement of Government's health policy objectives. We submit several constructive drafting considerations in this regard, for the Committee's review

Stavros Nicolaou

The context of the South African health system

Unique disease burden

Comparative health expenditure

Shortage of healthcare resources

- Requires a collaborative approach to address unacceptable levels of inequality and promote investment in health system strengthening
- Recognise the important role of the health system in the economy and in attracting investment

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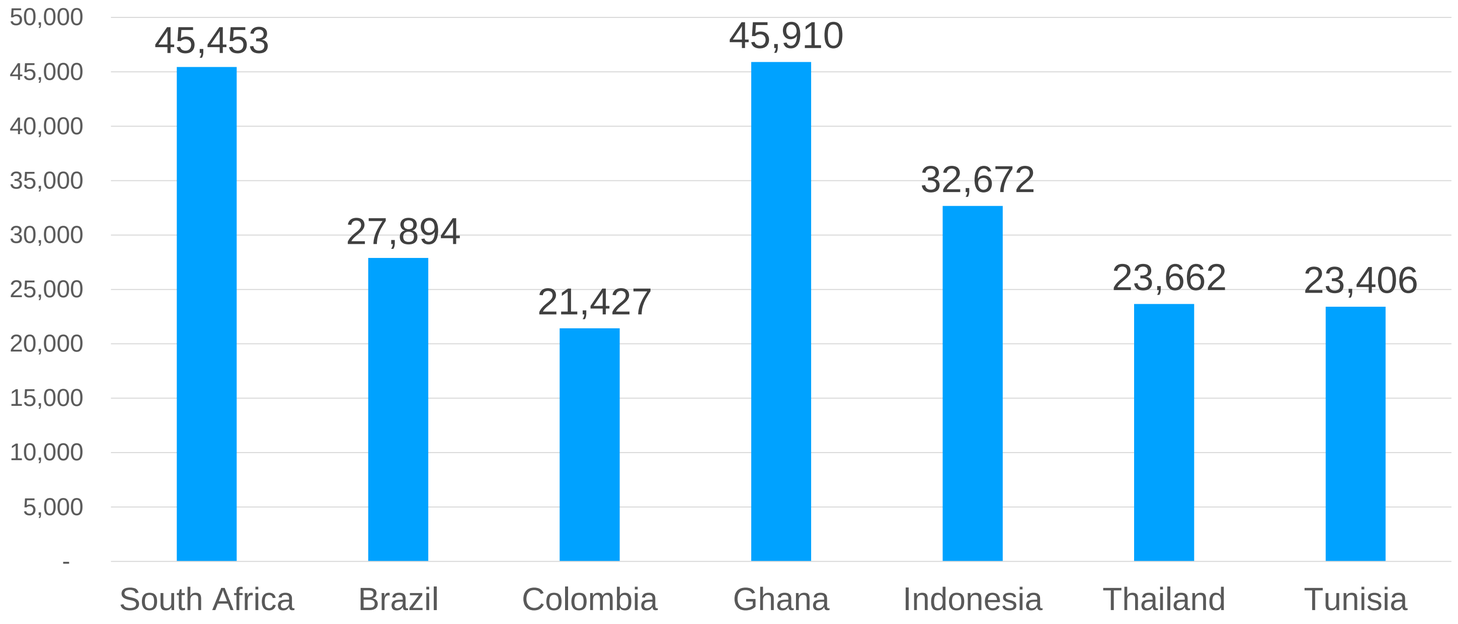
The South African context: SA health system is infinitely more complex due to high burden of disease – and this is escalating

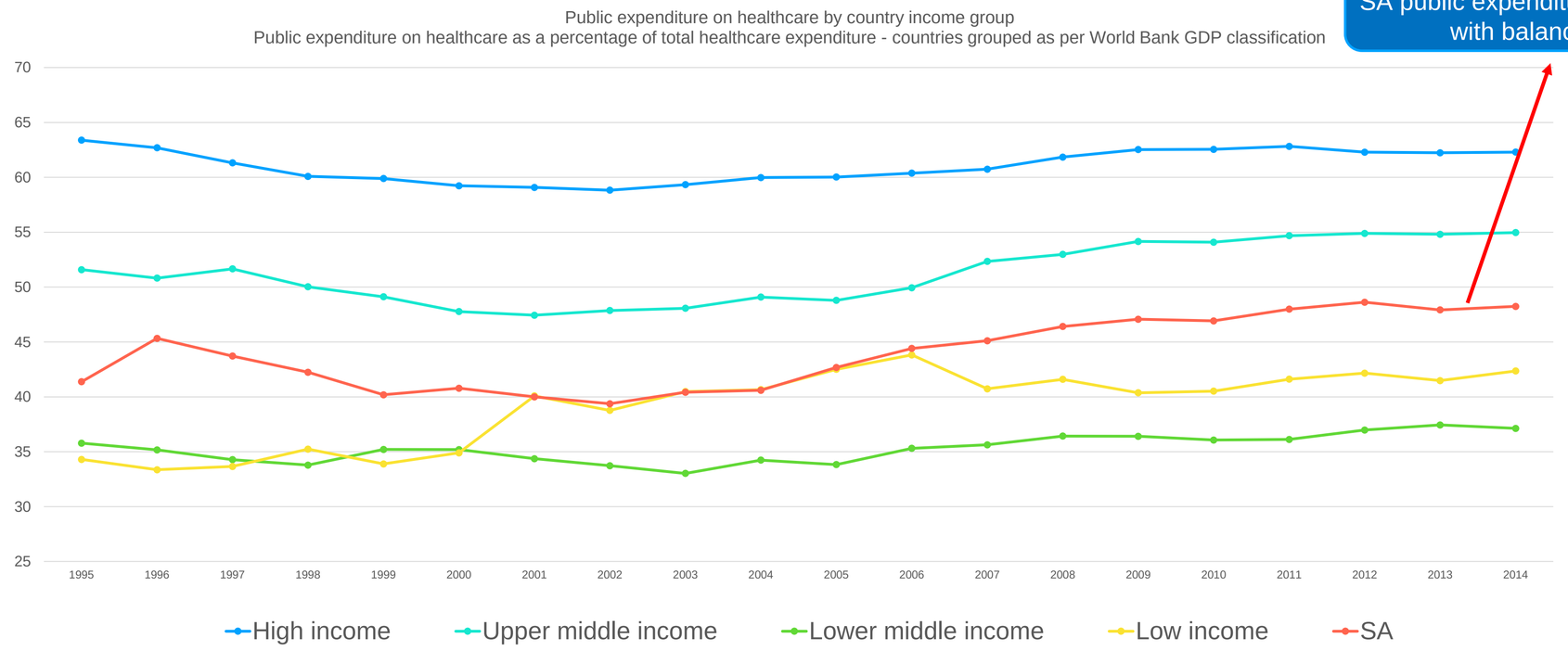
Absolute burden of disease compared with developing countries – 2017
Disability Adjusted Life Years (DALYs) per 100 000 lives
Source: OurWorldinData.org



- SA already has high communicable disease burden (especially HIV/TB)
- Growth in Non-Communicable Diseases (NCD) prevalence is concerning and means significant risk of under-estimated pent up demand
- Requires **collaborative** approach to address

Global public expenditure as % of total spend

Impact of proposals is to increase SA public expenditure to over 85% with balance OOP



- Countries grouped by GDP per capita
- SA public expenditure contributions compare well – not unusual for middle income countries to have 50% of healthcare spending in private sector
- No low or middle income countries (LMIC) have adopted single funding approach
- All of the countries reviewed in the Insight study allow private insurers to operate in conjunction with the publicly funded cover - no country has attempted to outlaw private cover
- In the absence of insurance, balance from private funding sources or out of pocket (OOP) – highly regressive

FTI Note 1: Section 33 shifts cost of medical scheme lives to public sector funds:

PHC + maternity for medical scheme lives costs more than R33bn

Costs to cover medical scheme population	Lower bound estimates	Upper bound estimates
Primary Healthcare (PHC)	R12.32bn	R22.33bn
Maternity care + medication	R27.35bn	R49.54bn
Prescribed Minimum Benefits	R48.07bn	R87.41bn
Emergency care	R0.57bn	R3.7bn

R40bn-R70bn

The Explanatory Memorandum makes reference to R33bn additional funding
PHC and maternity – R40bn to R70bn
Cost of providing care to currently covered lives would consume the R33bn additional funding
i.e. no increased cover for the most vulnerable

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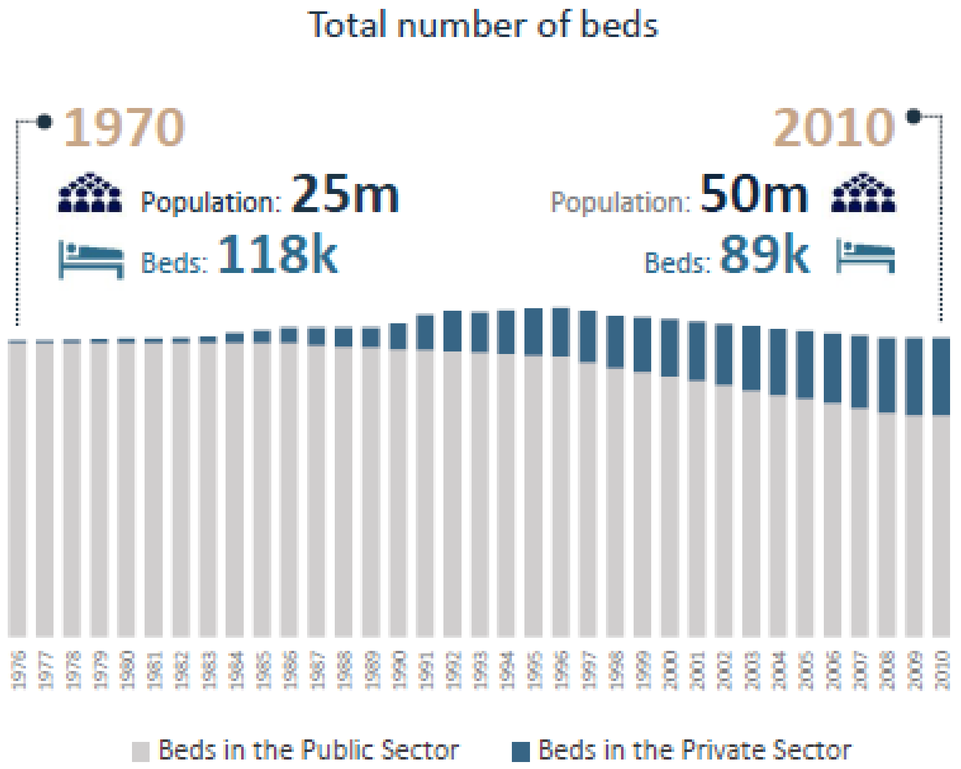
FTI Note 2: There is limited excess capacity in the private sector

The SA population has doubled, whilst public sector beds have declined by 25%



- Monopsony purchasing assumes that there is a private sector market to purchase from.
- Once service providers contract with NHI Fund there is no alternative market – no competitive pressures and limited incentive for innovation to the benefit of patients.
- There is a need for **collaborative investment** in health resources to build and strengthen the SA health system

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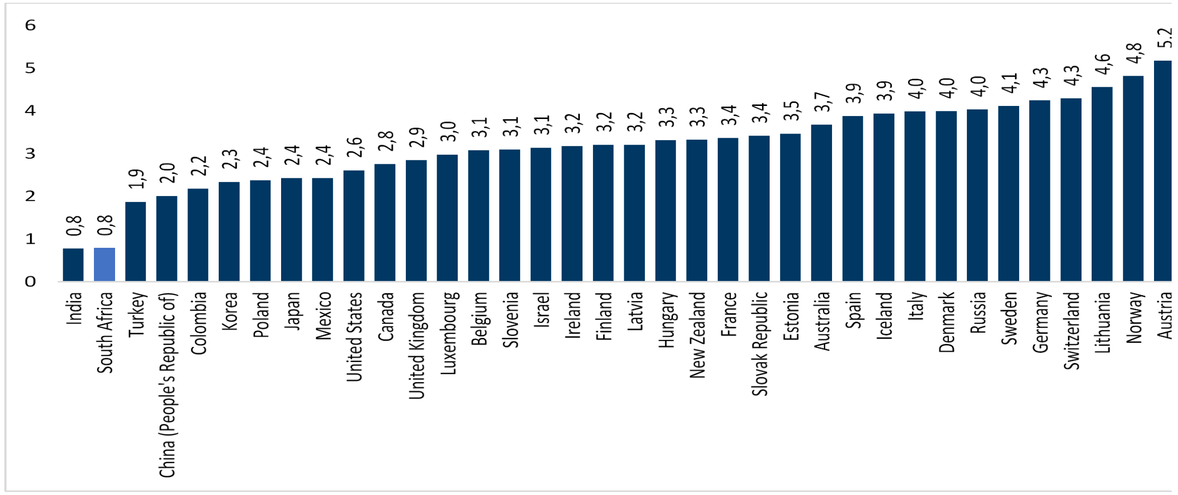
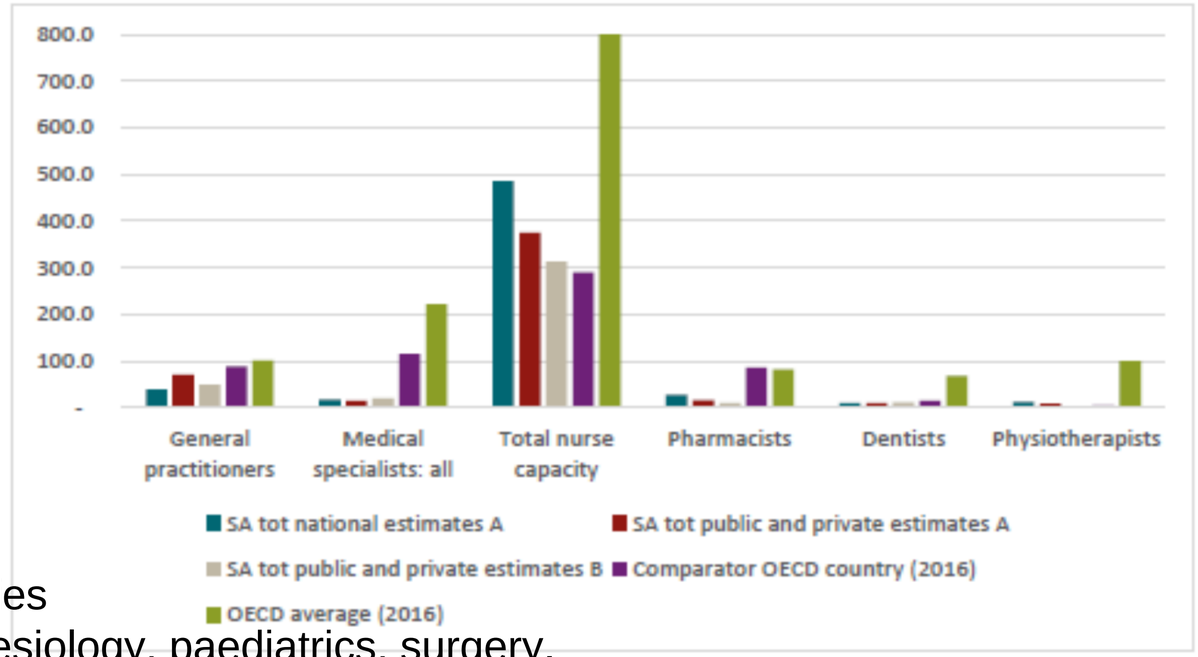
South Africa has a shortage of health professionals overall (FTI Note 2 and Percept Report)

Figure 1: Doctors per 1,000 inhabitants, 2018 (or latest available)



Source: OECD; Note: South Africa data is from 2015[1]

Figure 5-1: Comparison of ratios for the South Africa, OECD average and OECD comparator country



- Overall shortages compared to targets and comparator countries
- The largest shortages affect the following disciplines: anaesthesiology, paediatrics, surgery. These are the disciplines most needed for maternal and child-care.
- Cost of filling posts estimated at R10bn per annum
- Need is for training and retaining of HRH
- Limited available data – needed to combine data sources
- The NHI Bill expects the monopsony power of the NHI Fund to persuade doctors to increase their workloads (caring for more patients) for equivalent or lower remuneration.

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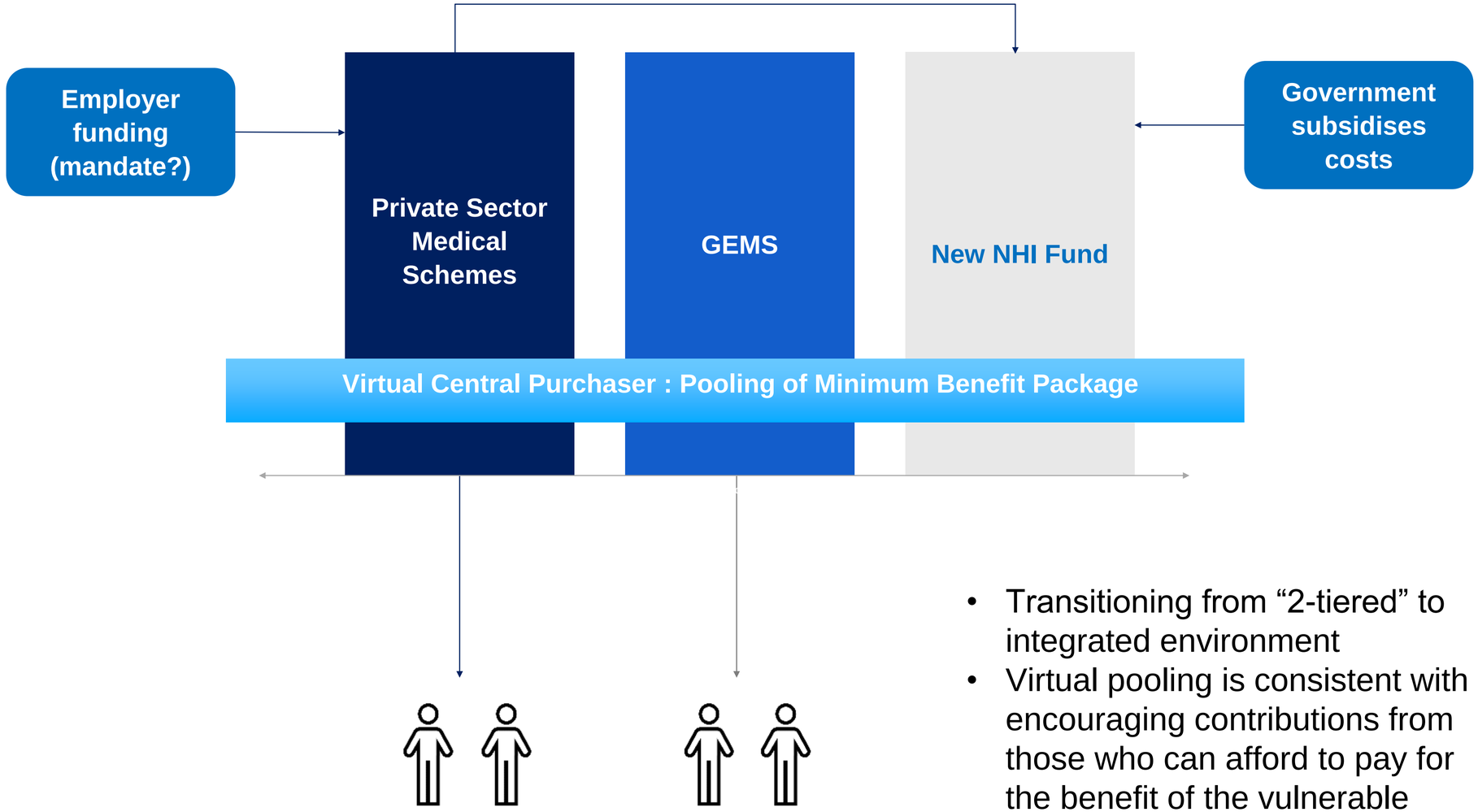
Our independent research findings:

- **Single payer approach**
- Both high income (Germany, Netherlands, Switzerland) and middle income (Chile, Mexico) countries, have multi-fund partnerships between the public and private sectors.
- South Africa is well-suited to a multi-fund NHI, given its existing systems and capacity.
- No countries with large “single fund” approaches have legislative restrictions on private cover
- **Key risk**
- Drawing on international evidence, there is a clear risk that the NHI as proposed will be underfunded, leading to unintended rationing and discrimination against the vulnerable
- **Proposed solution**
- A multi-fund partnership approach is still consistent with policy objectives
- If the infrastructure investment needs of the public sector (>R190 billion) are to be addressed, both public and private funding sources should be mobilized
- Expanded training and provision of health professionals is needed, supported by both public and private funding streams.

A multi-fund approach – BUSA Nedlac presentation
23 February 2018



- Transitioning from “2-tiered” to integrated environment
- Virtual pooling is consistent with encouraging contributions from those who can afford to pay for the benefit of the vulnerable
- Appropriate approach for LMIC to achieve optimal coverage

Main points of principle

1. **Governance – Chapters 4 to 7**
    - Robust governance and transparency are essential to public confidence across the public and private systems – needs review
    - Professional, independent adjudication of appointments needs to be incorporated across the Fund's governance arrangements
2. **The role of medical schemes – Sections 6, 8 and 33**
    - NHI coverage must accommodate all members and beneficiaries equally and should aim to expand the reach of coverage over time, while recognizing the right of individuals to supplementary voluntary insurance.
    - Notwithstanding mandatory participation in the NHI Fund, patient choice should be respected, both in the selection of service providers and between administrators and insurers

Main points of principle

- **The role of medical schemes (cont.)**
  - Business is therefore concerned about the limitation of rights to insure privately, notwithstanding all solidarity objectives having been met through mandatory participation in the NHI Fund (sections 6, 8 and 33 of the Bill when read together)
  - This limitation will drive out of pocket funding for exclusions envisaged under section 8(2) which will be regressive in nature for most South Africans
  - Insurance, whether statutory or private should not undermine the rights of individuals to physiological and psychological integrity and autonomy under Section 12(2) of the Constitution

Main points of principle

3. **Phased implementation – Section 57**
    - Phases should be defined by milestones achieved rather than dates
    - A progressive realisation of cover should target the most vulnerable with an incremental approach to tax-based funding within the construct of our national social protection floor.
    - This includes the development of referral pathways to optimize the utilisation of resources
4. **Legislative changes – Section 58**
    - Legislative changes are premature and inconsistent with progressive phased approach
    - Risk of legislative uncertainty which will limit investment in the sector
5. **The single payer approach – Section 2**
    - A single payer, single purchaser system does not ensure optimal outcomes for price or supply and is not conducive to strategic purchasing
    - Optimal scale and diversified supply ensures best outcomes, limits systemic risk and unintended narrowing of the supply side

Specific recommendations

- The NHI Bill requires review to ensure that there is a clear framework for implementing the NHI Fund and that the scope for uncertainty is limited. This includes:
  - Clear definitions and consistent use of terminology throughout the Bill
  - Amendments to section 6 and 8 of the Bill to ensure that the supplementary role of medical schemes is clear
  - The role of medical schemes, as set out in section 33 of the NHI Bill should be amended to allow for the coexistence of the NHI and medical schemes.
  - Revision of the governance framework including the process for appointments being based on required qualifications, skills and experience
  - Revision of the definition of the implementation phases to incorporate clear and objectively measured metrics
  - Amendments to legislation should be proposed as required to accommodate phased implementation and reduce unintended consequences
- Specific drafting recommendations respectfully submitted

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Ayanda Ntsaluba

Covid 19 – An integrated approach

- Working together to overwhelm the problem

  Our achievements and challenges in providing care to Covid-19 patients, ramping up testing and advisory capacity, providing PPE equipment and this year in ramping up vaccine implementation capabilities have relied on public-private collaboration

- Public / private coordination structures

  Progress has required hard work and continuous engagement – we have learnt that public / private coordination structures need dedicated capacity and constructive, in-depth engagement

- Supplies and services

  While centralised procurement and “framework”/transversal agreements have a useful role, decentralised supply and servicing contracts are essential if needs are to be met efficiently and appropriately

- Vaccine acquisition, logistics and administration, resource mobilization

  Careful planning and coordination is needed to optimize the respective roles of the national and provincial departments, private industry capacity and the contribution of medical schemes and administrators

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Martin Kingston

Concluding remarks

- Health policy needs to be considered within the context of priorities for the country as a whole
- This includes social inclusion, affordability, sustainability and investment in services and manufacturing
- Health is a fundamental necessity for business productivity and growth in the same way that it is a very personal priority for individuals
- Optimal investment and innovation in the health sector is the product of vision, skill, competition, policy and regulatory certainty and a diversity of views. NHI as a single fund will not promote such an outcome.
- We therefore support National Health Insurance as a necessary component of the broader social security system on an incremental, integrated multi-fund basis
- We support the funding of NHI within the parameters of affordability to the fiscus

cont.

Concluding remarks

- We highlight four major concerns noted above:
  - Governance
  - The right of persons to insure their health risks in addition to their mandatory membership of the Fund
  - Risk of policy and regulatory uncertainty during the transition period, if the meaning of “fully implemented” is not clarified in the Bill
  - The economic and financing impact of the NHI Fund as framed misconstrues the virtues of a public good with the necessary dynamic of investment in the sector
- Policy should promote expansion of the health sector as a whole to promote coverage and quality of care
- Policy should co-opt and support the private sector as a partner, to provide inclusionary coverage
- Policy should be aimed at attracting investment in South Africa and creating employment opportunities
- We support a strong partnership and effective NHI to the benefit of all South Africans

Drafting Consideration

Drafting considerations: Governance

- **Section 12:** The appointment of the Board should include assurances of independence, transparency and relevant technical expertise independently adjudicated. The sheer size and significance of this fund once fully implemented warrants dual accountability to both the Minister of Health and Minister of Finance. Both Ministers should have a representative on the Board.
- **Section 14:** The Chair of the Board should be appointed by its members
- **Section 25(6):** The chairperson of the Benefits Advisory Committee must be appointed by the members of the Committee and not by the Minister
- **Section 26 (1):** too much relies on the discretion of the Minister in the appointment of the Benefits Pricing Committee
- **Section 26(3):** The singular view of a committee in determining price outcomes for the sector is vulnerable to skewed or narrow development of the health sector. The cost of capital associated with an investment should be duly considered in a price determination. National Treasury should be represented on this committee.
- **Section 27:** there is no clear mechanism on how the deliberations of the Stakeholder Advisory Committee will be incorporated into the processes of the NHI. The intended purpose and function of the Committee is similarly omitted from the Bill as well as the influence, if any, of the representatives of the Committee on the decisions of the Board.

Drafting considerations: Governance continued

- **Section 31 (1 & 2):** See section 12 comment above. (2) is inappropriate as an ongoing empowerment of the Minister. The policy intention here would be better captured as a specific obligation in section 57(4)(h), i.e., a duty on the Minister to propose legislation regarding the re-allocation of functions/duties in order to get NHI set up. The Minister cannot have an indefinite empowerment to propose such re-allocations of powers that are constitutionally conferred.
- **Section 32(1)(d):** contemplates the enactment of section 36 (certificate of need) of the NHA. There are currently no regulations supporting section 36 of the NHA. Such regulations would have to be brought into effect through an appropriate public participation process and the constitutionality of section 36 would have to be determined: in so far as section 36 may cause healthcare providers to be unable to render services in a particular area where such a determination is made, pursuant to the provisions of section 36. This will, in turn, have implications pursuant to section 22 of the Constitution in respect of "the rights [of medical practitioners] to choose their trade, occupation or profession freely."

Drafting considerations: The role of medical schemes

- **Section 33** raises several constitutional concerns:

➢ When read with section 6 and section 8, it appears to reduce/abolish the existing right of citizens to acquire healthcare services from private providers, which may infringe sections 12(2)(b) and 27(2) and 28(1)(c) of the Constitution;
➢ When read with section 6 and section 8, it appears to reduce/abolish the existing right of citizens to insure themselves against the risk of non-coverage by the Fund, potentially infringing the same sections of the Constitution;
➢ It may, for reasons related to the two preceding concerns, unreasonably restrict healthcare providers' and healthcare funders' freedom of trade, occupation and profession in addition to the right to acquire healthcare services from private providers;
➢ "fully implemented" is neither defined nor clear which makes the Act vague. Further, the Minister should not have the power to "determine" when NHI is fully implemented, as there is no basis stipulated in the Bill against which to measure the legitimacy of the Minister's determination. The Minister should have the power to "notify" or "declare" the objective achievement of that state, subject to a definition in the Bill for what constitutes that state.

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Drafting considerations: Strategic purchasing

- **Sections 35-38:** The term “strategic purchasing” has not been defined. This needs to be linked to sustainability and quality outcomes and not just the “lowest possible price” per section 11(e). Clarity is sought with regards to the nature of legal entity the CUPCs will be at district level as they are yet to be established in terms of the NHA. These entities will need to have the appropriate expertise and accountability framework to receive and manage allocations of funds as well as to implement and monitor contracting requirements.
- **Section 39:** The proposed amendment in the NHI Bill to the Health Professions Act will prohibit registered practitioners from providing services covered by the NHI Fund if they are not accredited by and contracted to the Fund. This seems Constitutionally unjustifiable considering s12(2)(b) and 22 of the Constitution. Suggest: the limitation of rights imposed by s33 and s39 infringe on the freedoms of both patients and health professionals under the Constitution.
- **Section 39(8):** The Fund may withdraw or refuse to renew accreditation of a provider/establishment “if it is proven that” there have been one or more failings as listed. It suggests that the Fund would need to go through a legal process (otherwise, to whom must it be “proven”?), which may frustrate legitimate striking-off of failing providers. Suggest the words “if it is proven that” be replaced with “if the [provider] …has failed”.
- **Section 40(3):** provides that the Fund “may” use personal data for six listed functions. Proposed the wording change either to “may only” or “must” so that there is no suggestion that the Fund may use such data otherwise in its discretion. General privacy concerns need to be reviewed in section 40.

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Drafting considerations: Complaints and Appeals

- **Section 42(1):** Only an “affected natural or juristic person” may furnish a complaint. There may be partnerships or unincorporated associations which should also have this right.
- **Section 45:** An appeal against a Fund decision must be appealed within 60 days, i.t.o. section 43, but the Appeal Tribunal has no power to condone late filing of an appeal. The power should be conferred, otherwise two interpretations arise: either there is no right of appeal at all after 60 days, or the appellant has to approach the High Court.
- **Section 46:** contains an incorrect second reference to “the Board”: it should read “the Appeal Tribunal”.
- **Section 47(2):** is appropriate in intent, but impractical. There are only five tribunallists, of whom only one is a lawyer, and the case load is likely to be insurmountable in any event. To then compel recusal and temporary substitution by the Minister “if it transpires that [a member] has…indirect personal interest” is inviting opportunistic frustration of process and burdening of the Minister. Strongly recommend that the whole process be amended to simply allow parties to approach the Magistrates or High Court in the ordinary course.

Drafting considerations: Funding and financing

- **Section 48(d):** Whether or not money was “paid erroneously” is a question of law, which could only be determined by the judiciary; whether or not such money is capable of being refunded is a matter that the Bill leaves to the opinion of the Minister. Since the Minister can only exercise that opinion in respect of a matter that requires a prior legal determination, it makes sense to leave the Minister’s discretion out of the section entirely. Paragraph (d) should be deleted; although the Fund may end up acquiring assets, especially money, it receives erroneously, this cannot be characterized as a “revenue source”.
- **Section 49(2):** these provisions are the subject of tax policy and belong in a money bill
- **Section 49(2)(a)(ii):** this statement is factually incorrect as no medical scheme tax credits are paid to medical schemes but rather impact the amount of personal income tax paid by individual medical scheme members
- **Section 55(1)(m)-(n):** delegates regulation of the relationships between private and state healthcare provision and state and private health funding / insurance to the Minister. Matters that are so central to the constitutionality of the Bill and the feasibility of the UHC project should be contained explicitly in the Bill itself.
- **Section 55(3)(b):** provides for a truncated pre-regulation public consultation process if the Minister deems it to be in the public interest. The Minister is obliged first to consult with the Board. Suggest that this consultation should be with the Stakeholder Advisory Committee as well as the Board.

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Drafting considerations: Phased implementation

- **Section 57:** Implementation phases should not be defined based on fixed dates but should be clarified through objective milestones, such as:
  - ➢ Expansion of priority services (towards the package of comprehensive health services)
  - ➢ Population coverage
  - ➢ Reduction in out-of-pocket expenditure
- Broadly these include the following possible steps:
  - Establishment of an institutional framework, including a governance framework
  - Defining initial benefits and an incremental approach (affected by affordability)
  - Information framework – records to facilitate delivery of care and monitoring
  - Accessible delivery – existence of resources accessible to the population, appropriate ratios
  - Effective delivery – people are able to access care when they need it
  - Outcome measures – quality and clinical effectiveness as well as preventative coverage
- We suggest that legislative reform should only be considered once the NHI fund is practically established
- We recommend further engagement on appropriate metrics for transparent monitoring and reporting as part of implementation
- Caution on liabilities being transferred to taxpayers during transition

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Drafting considerations: Legislative amendments

- **Repeal and amendment of related legislation included in the schedule**: The Bill should not serve as an omnibus bill to compress the legislative process. There are too many contingencies that yet have to be worked through. Related legislation should be amended at the relevant stage of NHI implementation.
- The immediate effects of the proposed changes include
    - Coverage for advice and medication for pregnancy and terminations is no longer the business of a medical scheme under the MSA;
    - “compensation” as defined in COIDA will exclude ”medical aid or payment of the cost of such medical aid”;
    - The cost of a medical examination under ODMWA “shall be purchased and be paid for by the NHI Fund” (not the mine owner or DG as currently stipulated);
    - The RAF’s tariff structure will be replaced by “the reimbursement strategy for health care services contemplated in the NHI Act”.

- An appropriate incremental approach should involve assessment of experience and determining legislative amendments as required.
- The legislative changes should be revised and limited only to those required for the establishment of the NHI Fund.

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