Submission to the National Department of Health on

NHI Implementation Structures

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TAC
TREATMENT ACTION CAMPAIGN

+SECTION27
catalysts for social justice

Health for All Now!
People's Health Movement
South Africa

Rural Health
Advocacy Project

STOP STOCKOUTS

Endorsed by:


LAWYERS FOR
HUMAN RIGHTS


MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS


RIGHT2KNOW


EQUAL
EDUCATION


RuReSA
Rural Rehab South Africa


RUDASA


BLACKSASH
MAKING HUMAN RIGHTS REAL

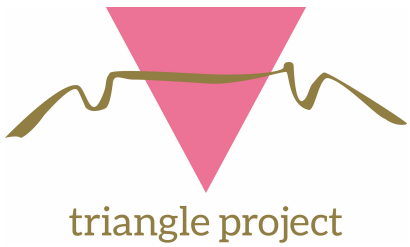

CANSA
Cancer Association of South Africa
Research • Educate • Support


groundWork


HEALA
Healthy Living Alliance


TEKANO
A healthier more equal nation
Atlantic Fellows
FOR HEALTH EQUITY
IN SOUTH AFRICA


OTASA
Occupational Therapy Association of South Africa


triangle project

A. INTRODUCTION

1. This submission has been prepared by the Treatment Action Campaign (TAC), People's Health Movement (PHM), SECTION27, Rural Health Advocacy Project (RHAP) and Stop Stockouts (SSP) following engagements with the Minister of Health, The Honourable Dr. Aaron Motsoaledi and Director-General, Ms MP Matsoso, during a meeting on 7 September 2017. This meeting was attended by civil society organizations (TAC, SECTION27, PHM, SSP and RHAP) and convened to discuss challenges regarding the implementation of National Health Insurance[1] (NHI) in South Africa.

2. This submission responds to the most recent version of the document: *NHI Implementation: Institutions, bodies and commissions that must be established*, dated 8 September 2017. It is put forward in reply to an extension granted to the public call for comments during the 7 September 2017 meeting.

3. In line with the invitation to provide comments, we address issues we believe to be important and deserving of the National Department of Health's (DoH) consideration in regards to the Terms of Reference (ToRs) for each implementation commission. We also provide conclusions and recommendations for the Department's attention.

4. All civil society organisations who have signed this document support and fully agree with establishing a National Health Insurance (NHI), specifically in order to reach a functional universal health care (UHC) system.

5. Therefore, we as civil society, would like to work with the DoH in realising the establishment of a functioning NHI based on equity, quality, comprehensiveness and financial protection.

B. OVERALL CONCERN WITH THE ToR: AN ABSENCE OF ATTENTION TO IMPROVING THE PUBLIC SECTOR

6. If an NHI is to realise its goals, we believe it has to be premised on the notion of a fundamental reorganisation of the current health care system, both public and private, rather than attempting to gradually broaden access to health care on the back of an extremely unequal and inequitable private health care system.

7. The NDP mandate lays emphasis on improving the quality of care at public facilities and reducing the relative cost of private medical care. We see little of this reflected in the Implementation Structures. As stated, the four key interventions simultaneously needed are:

[1] See Annexure 1

a. a complete transformation of healthcare service provision and delivery;
b. the total overhaul of the entire healthcare system;
c. the radical change of administration and management; and
d. provision of a comprehensive package of care underpinned by a re-engineered primary healthcare system.

8. The Implementation structures are overwhelmingly concerned with the institutional arrangements for medical schemes, the benefit packages, and pricing arrangements that will underlie purchasing from private providers. There is a serious lack of attention to the public health service – nothing is stated about how quality of public sector services and management will be strengthened nor how transformation to address the organizational impediments in the public health system will be effected.

Recommendation: An Implementation Structure for Strengthening Public Sector Services should be created. It should explicitly draw on the lessons from the NHI pilot sites to action improved public sector services.

C. GENERAL STRATEGIC AND OPERATIONAL ISSUES WITH THE COMMISSIONS

9. Consultation with a range of key stakeholders is written into the Terms of Reference for almost all the structures. However, none of the committees / structures include any form of **public consultations** or **engagement with communities** within their mandates. The majority of stakeholders who will be consulted with are the same stakeholders present on the various structures. We believe that public consultation on matters as important as this should be an important feature of implementation in general. Whether this is built into the mandate of each structure or is undertaken in a consolidated manner can be determined by the most effective way to achieve consultation, but it should be reflected in the implementation.

Recommendation: Public Consultations should be built into the work of the Implementation Structures

10. The Advisory Committee on Consolidation of Financing Arrangements is described in the NHI Policy White Paper as having the responsibility to "advise the Minister on the strategies to be followed in consolidating current fragmented funding pools in the medical schemes environment", amongst other tasks. However, from the Terms of Reference for this Committee in the most recent gazette, it appears that these strategies to consolidate funding pools have already been decided. The approach evident is to:

    a. Firstly, consolidate separate arrangements for civil servants, the formally employed in SMEs, the formally employed in big businesses, the

informal sector and the unemployed; and, secondly, make medical scheme membership mandatory for formal sector workers.

b. **Neither of these strategies have been publicly consulted**. The fact that they are written into the Terms of Reference means that the Advisory Committee will not be in a position to advise the Minister on the best strategies to be followed in consolidating current fragmented funding pools – rather, it's job will simply be to advise the minister how to implement an already-decided strategy. However, we believe the elements to this strategy are seriously problematic and should be removed from the Terms of Reference. We explain why they are problematic in section 2 below

Recommendation: The Terms of Reference of this Committee must be revised without pre-empting which strategies are best for achieving universal coverage. Strategies should be widely consulted. The Committee should provide advice based on best evidence, free of conflict of interest, as to the best strategies to achieve the NHI.

D. SPECIFIC OPERATIONAL AND STRATEGIC ISSUES WITH EACH COMMITTEE

11. National Governing Body on Human Resources for Health

a. This committee focuses almost entirely on clinical teaching in the health sciences, with a heavy emphasis on doctors and specialists (e.g. the Composition refers to Health Professional societies as including specific knowledge of matters relating to Junior Doctors, Rural Doctors, Registrars and Specialists.) This understates the importance of nurse education and completely overlooks the contributions of Community Health Workers to the Health System. It also ignores the contribution of public health skills and population-oriented competencies needed in the health system. We believe this is a serious flaw. For the NHI to work, it has to adopt the perspective of the health system, not that of a national insurance scheme. If it were only about curative care in a national insurance scheme, it is understandable that the focus would be on doctors and specialists, since they have a direct interest, whereas nurses are support personnel and CHWs have no role in curative care. But for the NHI, the Re-engineering of PHC and the WBOTs to deliver their promise, human resources have to be viewed more broadly than the current ToR provide

Recommendation: The ToR of this structure should be broadened to have a whole system perspective, not just the perspective of actors who will sell services or provide curative care for which purchasing will be needed – CHWs, nurses and public health competencies must feature centrally in the concerns of this structure.

b. A second concern about the Human Resources vision is that the elements of management and leadership appear to be absent from the Terms of Reference for this committee. Yet the National Development Plan makes it clear that leadership and management capacity at national and provincial levels should be strengthened "to provide overall guidance on activities that improve levels of health." Strengthened management and leadership skills in the public sector is essential to lay the basis for the NHI, particularly through decentralised management authority. The Terms of Reference for this committee (which are an extensive and long list of asks) mentions management and leadership only once, as being a responsibility to "Develop guidelines for the optimal leadership, governance and management of the health." However, the need to build sustainable capacity in the health system for optimal leadership, governance and management must be as important as any of the clinical skills occupying the attention of the Committee. Patients discharged from Life Esidimeni died as much from administrative misjudgement and poor leadership as they did from the lack of adequate clinical care.

Recommendation: The committee should be charged with responsibility for identifying effective and sustainable strategies for enhancing leadership and management capacity in the health system.

12. National Health Pricing Advisory Committee

    a. The Private Sector representation for this committee is huge, which raises alarm as this committee is crucial to the financial accessibility and feasibility of the NHI

    b. The National Health Pricing Advisory Committee creates two components to address case mix payments to hospitals– one for hospital costs and one for medical specialists. This may be applicable to how the private health sector currently operates but the focus of the pricing committee should be to come up with appropriate provider payment mechanisms under a single purchaser model. It is not the responsibility of the NHI to sort out price problems in the private health sector

Recommendation: The terms of reference for the National Health Pricing Advisory Committee should be revised to move away from a medical scheme focus to an overall health system focus – solving system wide issues that will strengthen the Single Purchaser system.

13. Ministerial Advisory Committee on Health Care Benefits for National Health Insurance

    a. The Ministerial Advisory Committee will be established as a precursor to the NHI Benefits Advisory Committee

b. In the background section of the Ministerial Advisory Committee it states that 6 work streams were created for phased implementation. Only stream 2's recommendations on respective mandates have been published.

Recommendation: There needs to be a detailed timeline and explanation of how the Ministerial Advisory Committee will be phased into the NHI benefits Advisory Committee

14. National Advisory Committee on Consolidation of Financing Arrangements

a. By consolidating medical schemes and possibly other financing arrangements which are not referred to in the ToRs into five different silos, the Department will make future integration more difficult.

b. Evidence from other countries show that – that creating a sector who have preferential benefits, especially as government employees, will lead to unwillingness on the part of this sector to relinquish funding to an integrated model. Experience from Tanzania and Thailand confirms this.

c. We therefore believe that the Committee for the Consolidation of Financing Arrangements should return to the Policy White Paper mandate – which is to advise on the best strategies, rather than to implement what we (and Dr Joe Kutzin from the WHO[2]) believe are flawed strategies.

[2] Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. Bull World Health Organ 2013; 91: 602–611:
Where SHI schemes begin by covering the formal sector, they tend to concentrate resources on a relatively small and economically advantaged part of the population. Such schemes do not naturally "evolve" to include the rest of the population. Instead, the initially covered groups, who tend to be well organized and influential, use their power to increase their benefits and subsidies, rather than to extend the same benefits to the rest of the population." Neither Mexico nor Thailand, who have gone this route, "has been able to integrate the population outside the formal workforce into the pre-existing schemes." Successful examples (Moldova, Kyrgistan) pursued "reform from an early stage by putting payroll tax contributions and general revenue transfers into the same pool on behalf of both the formal and informal sector populations, and then using the new SHI funds to drive system-wide efficiency and equity gains through the combination of centralized pooling and output-based provider payment mechanisms."

d. Consistent with Kutzin's views, we believe that Consolidation of Financing Arrangements must be viewed in the context of the whole system with Universal Access in mind, rather than from the viewpoint of the separate schemes. As stated by Kutzin: "The unit of analysis for goals and objectives must be the population and health system as a whole. What matters is not how a particular financing scheme affects its individual members, but rather, how it influences progress towards UHC at the population level. Concern only with specific schemes is incompatible with a universal coverage approach and may even undermine UHC, particularly in terms of equity. Conversely, if a scheme is fully oriented towards system-level goals and objectives, it can further progress towards UHC. Policy and policy analysis need to shift from the scheme to the system level."

Recommendation: The strategies of consolidation within 5 pools needs reconsideration

15. Ministerial Advisory Committee on Health Technology Assessment For National Health Insurance

    a. The Ministerial Advisory Committee on HTA will be established as a precursor to the HTA agency[3] but no explanation is provided of how the former will be phased into the latter.

Recommendation: There needs to be a detailed timeline and explanation of how the Ministerial Advisory Committee will be phased into the HTA agency

E. MEMBERSHIP

16. Civil Society was initially listed as only being part of the National Health Commission and was not mentioned in relation to any of the other 6 structures. It has now been added to all the other committees/structures and so is 'represented' in all 7 Implementation Structures.[4]

17. This is a welcome development given the multiple places afforded to private sector actors on all the committees, which remains unchanged in the 8 September version. To our count, of the 104 'places' named in the 7 structures, 52% are for government officials; of the remaining 50 'places', stakeholders who are dependent on private sector health care comprise the largest group at

[3] Ibid pg. pg. 61

[4] The National Tertiary Health Services Committee, The National Governing Body On Human Resources For Health, National Health Pricing Advisory Committee, The Advisory Committee On Health Care Benefits, Advisory Committee On Consolidation Of Financing Arrangements, And Health Technology Assessment

34% of 'places'. Even if one counted the CMS as a statutory body, private sector interests (meaning private hospitals, medical schemes or medical scheme administrators, actuarial society experts) comprise the largest single group amongst stakeholders who are not government (28%). Private sector interests continue to outweigh public interests (civil society and labour) who comprise only 18% of stakeholder 'places'. For example, it is unclear why four of the structures require participation and skills from the Actuarial Society of South Africa. Actuaries' contribution in health care are restricted to servicing medical schemes.

18. The NHI is not simply a giant insurance scheme but is a fundamental reorganisation of the health system. We do not agree that people whose sole involvement in health care is to support private medical schemes should have such influence over our future health system.

Recommendation: We would like to see the number of participants who have a vested interest in maintaining the operations of private health care reduced substantially on these structures. We support the position articulated in the 2011 Green Paper that the NHI development should draw on expertise from administration and management of health insurance *"where necessary and relevant" so as "… to ensure adequate in-house capacity is developed."* Drawing on expertise is not the same as allowing health insurance and private actors to shape the implementation of the NHI.

19. Consistent with the need to focus on what people bring to the work of the committee, rather than being representative, the participation of 'civil society' should be framed as 'experience of civil society in health and ability to bring civil society perspectives to the work of the committee.' The special knowledge required of other categories is not always clear. For example, what experience and knowledge that a member of the Human Resources for Health Committee would bring on the basis of "Operational experience of Private Hospital management and service delivery" is unclear.

Recommendation: All the Committees' composition should be carefully reviewed to identify where membership is clearly representative of a sector and where not, the particular skills, insights, understanding or perspectives required should be defined

F. CONCLUSIONS

We believe that in the transition from the Green and White papers of 2011 and 2015 to the current Policy and its Implementation Structures there has been a massive shift in focus from developing an equitable health system capable of delivering UHC towards protecting the interests of medical schemes and the private sector scheme perspective. This was never the intention of the NHI initially and will seriously

undermine the stated policy intention of Universal Health Coverage. This is reflected in a focus of the structures on issues in the private health sector (in schemes and pricing of providers) but which neglects totally the strengthening of the public sector. The Single Payer model, which is what the Implementation Structures should be most preoccupied with developing, would be far more effective.

The arrangements being put in place through some of these structures purport to be transitional but are rather setting a course that will entrench a US-type health care system that is incompatible with the achievement of Universal Health Coverage. There is no doubt that we can learn from international experience but if we do so, it should be from the full range of international experiences – including Mexico and Moldova, Thailand and Tanzania – not just North America. We believe there is sufficient local expertise to provide guidance on these matters.