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Portfolio Committee on Health
Parliament of the Republic of South Africa
29 November 2019

Dear Honourable Chair

Re: Invitation to provide comments on the 2019 National Health Insurance (NHI) Bill

The Faculty of Health Sciences at the University of Cape Town is honoured to submit comments on the National Health Insurance Bill 2019. While the Faculty strongly supports the movement towards Universal Health Coverage (UHC), the NHI proposal within the 2019 Bill elicits a number of concerns. The focus of our input is therefore to suggest some key changes to the Bill that the Faculty collectively believes will move the country closer towards UHC.

In order to include a wide range of voices within this document, the Faculty convened a public forum to debate the NHI Bill on 30 September 2019. The forum included 4 presenters (Ms Sasha Stevenson - SECTION 27, A/Prof Susan Cleary - Health Economics Unit UCT, Dr Geetesh Solanki - Health Economics Unit UCT and Health Systems Research Unit SAMRC, and A/Prof Shabir Moosa - University of Witwatersrand), 2 discussants (Dr Lydia Cairncross - Department of Surgery UCT and Prof Andrew Boulle -Western Cape Department of Health and Public Health Medicine Division, UCT) and strong audience participation through the facilitation of Prof Steve Reid (Primary Health Care Directorate, UCT).

A draft document based on the forum was thereafter circulated via Heads of Department and Faculty mailing lists for additional inputs. The result of these processes is contained herein.

We look forward to further engagement on the NHI Bill as we seek to strengthen our health system to the benefit of all South Africans.

Yours sincerely

C. Williamson

PROFESSOR CAROLYN WILLIAMSON
INTERIM DEAN

"Our Mission is to be an outstanding teaching and research university, educating for life and addressing the challenges facing our society."

FACULTY OF HEALTH SCIENCES
UNIVERSITY OF CAPE TOWN

Towards Universal Health Coverage

RESPONSES TO THE 2019 NATIONAL HEALTH INSURANCE BILL

TO THE PORTFOLIO COMMITTEE ON HEALTH, PARLIAMENT OF SOUTH AFRICA

SUBMITTED BY
FACULTY OF HEALTH SCIENCES, UNIVERSITY OF CAPE TOWN

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1. Approach to Reform

Many Faculty staff are actively involved in direct public sector service delivery and emphasized the importance of protecting the gains that have been made to date within the existing public health system. In the document that follows, we emphasise the importance of reforming the system in a way that protects existing service delivery, while seeking to test new initiatives or interventions within iterative cycles of action and learning.

2. Legislative Process

Following on the above argument, we argue that it would be useful to rationalize the legislation with a view to including the essential elements and leaving out a number of items that need piloting and refinement as we learn from experience during implementation. We also note that the Bill aims to action many changes within the current phase (i.e. before 2022); we believe that this is too ambitious, and we suggest that some of the changes should be moved to the next phase (2022-2026) and beyond.

The legislation should include:

- Details of the population to be covered under the National Health Insurance Fund (NHIF or 'the Fund')
- A clear statement of a requirement to spend within budget
- Clarity regarding *how* decisions will be made including appointments of members to the Board of the Fund and the structures surrounding the Fund (e.g. Benefits Advisory Committee), decisions regarding purchasing and price determinations, and decisions regarding the structures and mechanisms that will be tested within the NHI (e.g. provider payment mechanisms, Contracting Units for Primary Care (CUPs) etc.)
- Details regarding the changes to the current health system (e.g. role of provinces – see more below)
- Details regarding how inclusivity and participation will be handled
- Details regarding how transparency will be assured across the NHI

The legislation should exclude the new structures and mechanisms that need to be tested, and that will evolve based on learning. These include CUPs and payment mechanisms (e.g. DRGs, capitation). In addition, we find the level of political decision-making to be deeply problematic. Currently the Minister is mentioned 140 times within the Bill, which concentrates too much power centrally and will make the job of the Minister extremely difficult in years to come. We suggest that the majority of this is removed. Specifically, we recommend that:

- Any ad hoc committee that is established to make appointments (e.g. CEO of the Fund) must be legislated to include user groups, civil society, provider representatives and academia and should include a public process for interviewing members, and clarity around how transparency is to be achieved

- The National Health Insurance Fund (NHIF) Board should appoint its own chairperson and should appoint the CEO of the NHIF
- NHIF Board should be accountable to Parliament, not to the Minister
- The Benefits Advisory Committee, Stakeholder Advisory Committee and Health Care Benefits Pricing Committee should appoint their own chairpersons
- Additional clarity should be written into the act regarding the membership of the Board and Committees; specifically this needs to include civil society and user groups
- Membership of committees, especially those responsible for further shepherding the reforms, could have a stronger constituency basis through which members represent relevant stakeholder groups, with associated responsibilities to represent the views of these constituencies.

3. Governance

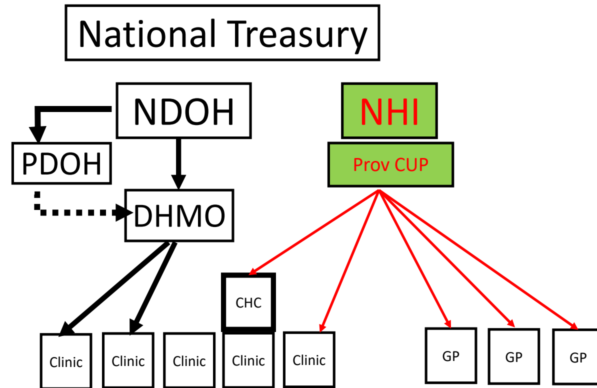
We support the idea that the Benefits Advisory Committee, Stakeholder Advisory Committee, Health Care Benefits Pricing Committee and Office of Health Products Procurement should be national bodies. However, the outputs of these bodies are highly technical and also politically contentious and so we suggest that it will be necessary to take an incremental approach to implementation, with clear cycles of feedback and learning. In addition, we are 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.

While it may not be necessary for the Bill/Act to determine the role of the DHMOs or the CUPs, given that it is preferable that these structures evolve based on learning, we have suggestions as to how we think these arrangements could be structured, as shown in Figure 1. Our proposal is to establish provincial level CUPs initially (Figure 1a), 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 (Figure 1b), 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.

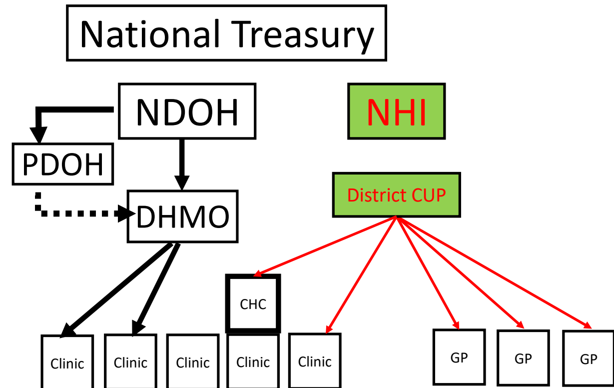
Instead, we propose that over time, provincial bodies should be required to purchase medicines and equipment from the Formulary while seeking to align their care with clinical guidelines. Currently a number of provinces are struggling with capacity issues, and we argue that these issues will only be more difficult if some of the roles currently played by provinces are decentralized to local government. In the past, South Africa has experimented with decentralization to local government level and it was not successful. We therefore 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.

Figure 1: Proposed governance arrangements

1a: Short-term arrangements



1b: Long-term arrangements



Key:
Red arrows: funding flows
Black arrows: oversight

With regard to the National Health Laboratory Service (NHLS), we propose that the financing mechanism moves away from the current system where provinces pay for the pathology services. Given the defined space of testing patient samples, we do not support a capitation system for funding research. We support a national payment for pathology services on a fee-for-service basis – through a national payment and accountability system.

We support the involvement of private pathology services into the future. However, given the complexity of allocating work to such private service providers across a system that will be a single provider system, 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.

4. Provider and Facility Accreditation

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 will find it easier to gain accreditation, leading to monopoly power and cost escalation through supplier induced demand, particularly in urban centers.

We therefore recommend that public facilities must be assisted to gain accreditation earlier in the process in order to counter the potential for monopoly power in private providers. Affirming the orientation of the future health system as a "public good" built around a strong public sector, with explicit provisions for strengthening the public sector, may be required.

In the same way, we are supportive of the pathology sector's move towards greater quality of service, and laboratory accreditation. However, neither the NHI Bill nor the White Paper gives any guidance as to what form, level and timing of laboratory accreditation will be required. This is important, as it is foreseen that both the NHLS and private laboratories will need to give assurance of accreditation and quality standards at time of contracting.

5. Role of Medical Aid Schemes

Currently, the Bill suggests that Medical Aid Schemes will only be allowed to provide complementary cover (defined as services that are not covered by the Fund) once the Fund is fully implemented, as determined by the Minister. 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). In addition to our concern that there is too much political decision-making, we suggest that limiting Medical Aid Schemes in this way will not be sustainable; most countries allow for private health insurance that is carefully regulated. Further, the assimilation of the more than eight million individuals in South Africa utilizing private medical schemes into the NHI will place substantial strain on the provision of services under the NHI, even if done in a phased manner. A similar point applies to those currently paying out of pocket for primary care services. We therefore suggest that the approach to take with the Medical Aid Schemes would be to follow the detailed recommendations made by the panel of the Competition Commission's Health Market Inquiry. In addition, we propose a gradual phasing out of the Medical Scheme tax rebate (not a sudden removal). Due to many health care workers themselves as well as politicians benefiting from private medical insurance, it is important that we do not end up in a situation where the coherence of the current public sector is fragmented as an early initiative towards NHI, but that the follow-through is stalled due to concerns around changes for these powerful groups.

6. Determination of Health Care Benefits

Within Chapter 2, the Bill suggests that users will have a number of entitlements, including the right to services that are part of the benefit package, if in need. To deliver on this entitlement, it is necessary to be explicit about health benefits, referral pathways and the Essential Medicines and Essential Laboratory Lists. This approach to explicit rationing is commendable, and will offer a welcome movement away from implicit rationing, which is largely achieved through horizontal inequity (e.g. medicine stock outs, differential service availability); poor quality of care; and long

waiting times, all of which puts unsustainable pressure on health workers and the health system. The levels of absenteeism and high staff turnover are symptoms of this malaise, and further reinforce a vicious cycle of work pressures and poor working conditions.

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. The resultant quality of care improvements may also alleviate the current threat posed by massive increases in medico-legal claims. What this means is that areas of disinvestment need to be explicitly identified and clinical guidelines need to be rationalized so that the strain on the health system is alleviated.

However, while this focus on equity and transparency is commendable, we are concerned that it will be extremely challenging to create a list of explicit benefits that is affordable to all in need (which is what would be required in order to achieve equity and to deliver on the legal entitlements of users). 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. This will require changes to the wording of the rights of users in Chapter 2.

Going forward, we support the idea of progressively incorporating economic evidence into decision-making and 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).

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. 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). In addition, there

are useful lessons that can be learned from other agencies such as the Scottish Medicines Consortium, New Zealand's Pharmaceutical Management Agency (Pharmac), and recent developments in central and South America: Mexico (CENETIC), Colombia (IETS) and Brazil (CONITEC).

7. Community-Oriented Primary Care

We support a 'panel' approach to community-oriented primary care with an enrolled population of 2000-10000 per panel. The approach would include understanding the population in their homes or places of work; understanding how the population uses services at the primary care facility; engaging community stakeholders to prioritize services; supporting community initiatives that promote health; and delivering targeted health promotion based on community health needs.

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)

The PHC service package would be revisited on an annual basis and could form the basis of a Comprehensive PHC benefit package. The model will need to include a multidisciplinary team responsible to a specific population, including Ward-Base Outreach Teams with strong team-based links to facility-based health professionals. For Community Health Workers, we emphasize the importance of training, supportive supervision and acceptable conditions of service, including from a payment perspective.

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.

8. Prevention and Health 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, the NHI needs to:

- Institutionalise structures that will ensure that prevention activities and services receive an adequate slice of the NHI funding pool and 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.

9. 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.

Given these issues, 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.

With regard to the NHLS and clause 57 we specifically highlight the following:

- The three mandates of the NHLS entrenched in the NHLS Act (service, teaching and research) all need to be supported into the future, and the only reference to the NHLS in the NHI Bill (Clause 57) gives no guidance on any of the issues that need clarity for pathology.
- The training platform realities of the general clinical platform and the pathology platform are different. Special consideration needs to be given to the funding streams and structure required for pathology.
- 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.
- 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. The current structure has NHLS staff (on joint conditions of service with the university) train every medical student, physiotherapy student, dentistry student, etc across the entire country. The NHLS also trains pathology registrars as they become specialists. Every university with a health science faculty is reliant on a functioning NHLS and a healthy teaching/research relationship that supports the discipline adequately.
- Clause 57 of the NHI Bill gives certainty to the NHLS's involvement in public sector pathology service, but gives no indication as to the role of the private sector, and how it might be contracted. 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.
- The NHLS also has a research mandate. The NHLS staff (pathologists, scientists, technologists) are a central part of research that contributes to policy and good practice in SA and beyond. As the NHI takes shape, this important shared mandate of the NHLS and the universities needs to continue to be funded and structured appropriately.
- 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.

10. Communications

Finally, we note the ongoing issues of 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.