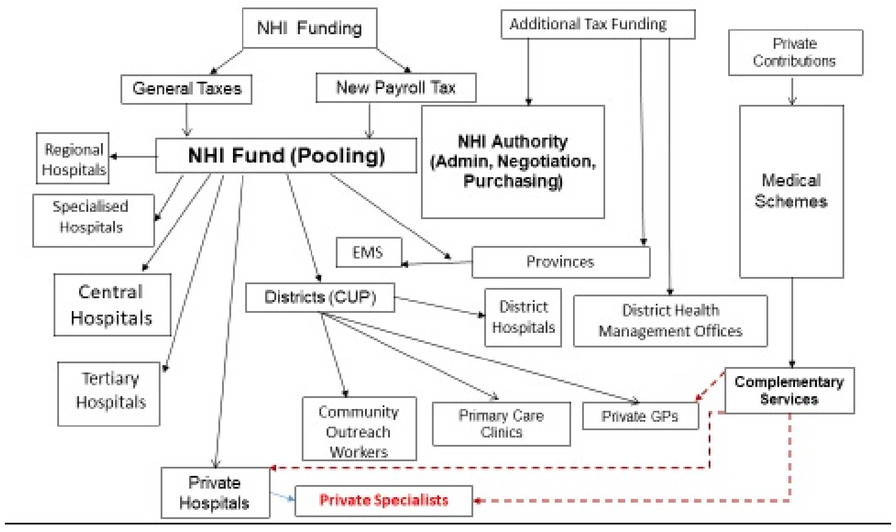
NHI Draft Bill Daily Analysis

The NHI Draft Bill was published in Government Gazette 41725 on 21 June 2018. The South African Private Practitioners' Forum will be sharing an analysis of the Draft NHI Bill with members, highlighting issues of importance and concern.

NHI Draft Bill – Day 9

Excerpt from the Draft Bill

NHI Funding and Functional Structure



Analysis

NHI Funding will be obtained from an increase in general taxes and a payroll tax, to cover service delivery in the NHI. These funds will be pooled in central NHI fund. This fund will contract directly with Regional-, Specialised-, Central- and Tertiary Government hospitals to render services. Payment will either be based on Diagnosis Related Groups (DRG) per event payment, or as a global budget.

The NHI Fund will also contract with Private Hospitals to render services on a DRG basis. This model implicitly assumes specialists are employed by hospitals.

There is no proposed funding structure in place to contract directly with Specialists, so there does not appear to be scope for Specialist to provide services outside the hospital admission environment.

A Hospital will not be allowed to contract with the NHI Fund if it is non-compliant with the OHSC norms and standards. The question arises of what happens to the staff at any Public Hospital that does not qualify to contract with the NHI Fund, in the absence of provincial funding of staff salaries.

The same problem can arise with Public hospitals that do qualify to contract, but does not get contracted with by the NHI fund because the quality is still below that of the private hospital competitors in the area.

Primary care services will fall under the ambit of the District Contracting Unit for Primary healthcare. The fund will contract with this unit, who will in turn contract with District Hospitals, Primary Care Clinics, Community Outreach workers, School Health Teams and Private GPs. Contracting with GPs will be on a capitation basis.

Additional Funding will be required to fund the administration of the NHI fund as well as the administration done in the National Department of Health, Provincial Departments of Health and District Health Management Offices. Hospitals that previously fell under the Provincial Department (Regional-, Specialised-, Central- and Tertiary Hospitals) will now contract directly with the NHI fund.

The NHI fund will also contract directly with other suppliers to achieve economies of scale. Provinces will therefore only be responsible for co-ordinating Emergency Medical Services; Maintenance of Buildings, Vehicles and Equipment; and Mortuary and Forensic services.

EMS services will also be paid directly by the NHI Fund, on a capped case -based fee with adjustments made for case severity.

This leads to the assumption that the Administrative, Supply Chain-, Legal-, Finance- and Human Resource staff requirements of these Provincial Health Departments would be radically reduced.

The Final component of the system is Medical Schemes, which will continue to be funded by Private Contributions from individuals. These schemes will only be allowed to pay for services not funded by the NHI. Schemes will pay for services from GPs (Although GP services would probably be fairly comprehensive in the NHI Service basket), Specialists and Private Hospitals.

It is stipulated that the NHI will not fund a service if proper referral pathways are not followed by a user, even for services normally covered in the NHI service basket and that such services would need to be funded by cash payments, medical schemes or private insurance.

This creates the opportunity for medical scheme members to skip referral pathways and directly access higher levels of care, with their medical scheme funding the bill for services that would normally be covered by the NHI Fund in such an instance (unless Medical Schemes refuse to do so).

The additional tax burden to fund NHI and general poverty will exclude 95% of the population from being able to afford Medical schemes and benefit from such an arrangement.

The affluent will therefore still have faster access to higher level services than the poor.