South African Private Practitioners' Forum

Submission on Draft NHI Bill to the National Department of Health

SAPPF

SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM

9-20-2018

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Introduction

1) The South African Private Practitioners Forum (SAPPF) is a voluntary association of private practitioners working in the South African private health sector. The organisation has a membership base of approximately 3000 specialists representing most specialist disciplines, as well as 3500 other practitioners, including General practitioners and ancillary healthcare practitioners. SAPPF acknowledges the transformative elements in the Constitution and the Constitution's commitment to improve access to health care. Furthermore, our humanity compels us to work towards quality universal access to health care for all of our citizens, within the constraints of resources in Government.

2) The National Department of Health (DOH) published the draft National Health Insurance (NHI) Bill in the Government Gazette 41725 on 21 June 2018 (the Draft Bill). SAPPF (and the medical professionals it represents) is an important stakeholder in the healthcare industry, and accepted the opportunity to submit comments. Given the fact that the draft Medical Schemes Bill, 2018 (the Draft MSA Bill) was published at the same time as the Draft Bill, SAPPF requested an extension of the time period to submit comments. SAPPF unfortunately did not receive a response to its request. The extension would have enabled SAPPF to have made more detailed submissions but it has managed to compile these high level submissions in the limited timeframe afforded to it. It is vitally important that the Department of Health considers this submission in the light that it is made – In support of achieving Universal Health Coverage in South Africa.

3) Before we turn to set out our submissions, we note that it is of great concern to SAPPF that the Socioeconomic Impact Assessment (SEIAS) that preceded the Draft Bill, only makes reference to three alternative scenarios that were considered for healthcare in South Africa, with the current NHI proposal being the suggested option. The proposed options of retaining the *Status Quo* and of *Full Privatisation* contained in the SEIAS as alternatives to NHI are not being considered or proposed as alternatives by any stakeholders in South Africa and therefore it is of great disappointment that these are the only alternatives considered in the SEIAS for comparative purposes. There have been several alternative suggestions to NHI and these should have been considered in the SEIAS as alternatives to NHI and not scenarios that no-one is proposing or supporting.

4) SAPPF is conscious of the fact that both the public and private health care sectors face significant challenges and are in need of reform, and we intend to participate constructively in the debate as to how these challenges are best addressed. SAPPF supports a pragmatic approach to health care reform and believes that any proposal which seeks a radical overhaul of the health care

system should be carefully considered and empirically researched prior to implementation. Any such proposal should also be subject to a comprehensive consultative process with all affected stakeholders.

5) The future of health care in this country is vital, not only to our membership and other participants in the health care industry, but to all South Africans. SAPPF would like to positively contribute to the debate and in doing so makes the following submissions on the Draft Bill. SAPPF accordingly structures its submissions as follows:

   i. *First*, SAPPF traverses its proposed alternative model which critically has been designed to achieve Universal Healthcare (UHC) in South Africa, at much lower costs than the current NHI.

   ii. *Second,* SAPPF makes its submissions on the financing and costing of the NHI Fund as currently proposed in the Draft Bill, which raise very real questions in relation to the affordability and ultimate sustainability thereof; and

   iii. *Third*, SAPPF makes its submissions on the contents of the Draft Bill.

SAPPF'S ALTERNATIVE COMPREHENSIVE UHC MODEL — NATIONAL HEALTH INSURANCE PLAN (NHIP)

Synopsis of the NHIP

6) Motivated by desire to find a model which will realise the need to achieve UHC for the benefit of all South Africans and troubled about the appropriateness, affordability and sustainability of the proposed **NHI single payer** model, SAPPF has invested considerable time and effort into developing and stress testing an alternative model which it is enormously excited about because it truly believes that it presents a solution which:

- permits of an **affordable and sustainable** healthcare system based on the economic realities we face;
- will be **accessible** to all South African residents;
- will be of **reasonable quality;** and
- facilitates the **integration** of all existing public and private structures.

7) As will be appreciated when reviewing the detail of its proposal:

- the SAPPF model does not require a massive re-engineering of the healthcare services and **leans heavily on existing infrastructure** and in so doing realises significant cost savings;

- the two problems of **public service quality** and **private service cost** are both dealt with in a logical and sustainable manner that will improve competition between the services;
- the need to introduce a **Certificate of Need** is obviated, alternatively substantially reduced;
- it makes quality healthcare **more affordable** within our current economic constraints.

8) The risk of failure of the current proposal are simply too great and the unintended potential consequences so grave that we urge the authorities to carefully consider this alternative. We note in this regard that the World Health Organisation (WHO) recommends that each country develops its own UHC model based on the unique circumstances of each state. There is no "one model fits all" blueprint.

9) The NHIP is discussed under the following headings in the paragraphs below:

1) Background;
2) Mandatory Low Income Medical Scheme (LIMS) cover for all Employees;
3) Mandatory Gap Cover for all employees;
4) The Revised NHI Fund;
5) Public-Private Health Partnerships;
6) Reforming the private sector;
7) Integrated Practice Units;
8) Emerging technologies;
9) Current White Paper and Draft Bill Proposals to be kept active;
10) Funding of the NHIP; and
11) Conclusion.

Background

10) The WHO states that "*Universal health coverage (UHC) means that all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation and palliative care.*" The position of the WHO continues, by saying that "*If people have to pay most of the cost out of their own pockets, the poor will be unable to obtain many of the services they need and even the rich will be exposed to financial hardship in the event of severe or long-term illness. Forms of financial risk protection that pool funds*

(through tax, other government revenues, and/or insurance contributions) to spread the financial risks of illness across the population, and allow for cross subsidy from rich to poor and from healthy to ill, increase access to both needed services and financial risk protection." There is a categorical statement in the WHO policy document that "***UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.***" The WHO continues to say that an important component of UHC is health financing, where attention needs to be paid to raising sufficient funds, minimising out of pocket payments through pre-payment and pooling and using available funds efficiently and equitably.

11) The WHO is thus quite clear that the UHC system needs to be affordable to the country. It does not specify free healthcare for all and does not specify a single payer system. SAPPF believes that the NHI model is not the correct one for the South African context, as it would prove unaffordable and would not achieve universal healthcare objectives. SAPPF would like to propose an alternative model to achieve UHC, which will incorporate some of the work already done in preparation for the NHI, but not the NHI funding model or the proposed radical (expensive) changes to the entire South African Healthcare system.

12) The SAPPF Proposal of a NHIP is based on the implementation of a number of policies that were previously tabled, but now discarded, along with a number of other changes to the funding environment, including changes to the Labour Relations Act, 1995; the Medical Schemes Act, 1998 (the Medical Schemes Act); the Compensation for Injuries and Diseases on Duty Act, 1993 (COID Act) and the Short Term Insurance Act, 1998. These changes can happen concurrently, as is the case in the current amendments of several bills included in the Draft Bill, which will provide an environment conducive to enabling Universal Health Care in South Africa. As is indicated in the section dealing with finances of NHI, Public funding is unlikely to prove a successful funding model for the NHI and this proposal focuses on increasing discretionary spend on healthcare.

13) The basis of the proposal is the expansion of the utilisation of Private Health Services and increased membership of private, discretionary medical funding mechanisms, without the alienation of private providers and without creating an unaffordable system to the country. The proposal will be described by addressing the following :

    a. Introduction of Mandatory LIMS cover for all Formal Employees
    b. Introduction of Mandatory Gap Cover for all employees
    c. Introduction of a revised NHI Fund

d. Introduction of Public Private Health Partnership and Private Sector Reforms

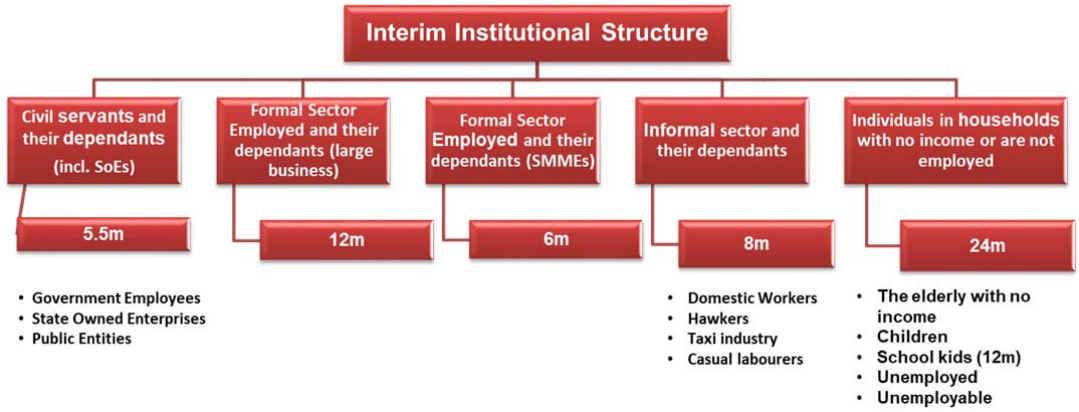
e. Selected White Paper Proposals to be kept active

f. Funding of the NHIP

Introduction of Mandatory LIMS cover for all Employees

14) The first step to the NHIP will be mandatory enrolment of all currently uninsured employees and their dependents in LIMS.

Figure 1 – DoH Demographic Structure[1]



15) According to the DoH Stakeholder presentation (Figure 1) this step will lead to a total of 23.5 million South African citizens covered by some form of medical scheme membership. The LIMS members will also be able to access services through the NHI Fund. The indication from medical schemes at the Health Market Inquiry is that this step should lead to a decrease of up to 20% in medical scheme premiums across the population, due to enlarged risk pool and cross subsidisation of the sick by young and healthy members. The process is, of course, not quite this simple and there would be various other factors involved in this process. The introduction of the *Risk Adjustment Mechanism (RAM)* advocated by the HMI in their interim report, for medical schemes will also help to pool risk further, further reducing the costs of underwriting. These steps would require changes to the Medical Schemes Act, as the Service basket in LIMS will look different from that in the current scheme environment. It will also require changes to the Labour Relations Act, to enforce the mandatory enrolment and funding of this benefit by employers. The RAM mechanism will create a virtual pooling of funds amongst these 23.5 million medical scheme members, without the need for physical infrastructure of the proposed Single Payer NHI Fund.

[1] DoH NHI Stakeholder presentation

Introduction of Mandatory Gap Cover for all employees

16) The second step would be for all employers to provide all employees with a mandatory gap cover insurance product, which will cover any further unforeseen medical expenses and costs in hospitals that could potentially lead to financial hardships and co-payments, if medical expenses are at a higher level than that covered by current medical scheme rates. This will broaden the risk pool further and will create and additional funding mechanism, which will further decrease co-payments, improving the UHC concept and access to affordable health services for South Africans. A general overview of currently available gap cover products in the market show these can be acquired for as little as R80 per month per employee. This will require changes to the Labour Relations Act and the Short Term Insurance Act.

The Revised NHI Fund

17) As previously indicated, the introduction of LIMS and RAM should reduce premiums in the medical scheme market by up to 20%. In order to realise a progressive taxation system, in concert with the transformative elements in the Constitution that concurrently improves access to quality healthcare for all, this 20% saving in premiums will not be passed on to medical scheme contributors, but will be pooled using a Medical Scheme Levy in a revised NHI fund. This fund will be utilised for the express purpose of funding healthcare for poor and indigent members of society that are currently utilising public sector health services, by funding services provided to these vulnerable South Africans in the private provider sector. At the latest available medical scheme contribution figures (2016 CMS Report), a 20% contribution would lead to an annual income of R32.8 billion for the revised NHI Fund. This is also a progressive payment model, with the rich subsidising the poor, without an increase in taxation. The R32.8 billion budget would be equivalent to 39% of all Government spending on *District Health Services* in 2017/18 (R84.2 billion).

18) The revised NHI (RNHI) Fund will also be further expanded by contributions from employers that are paid to the Workmen's Compensation Fund for medical costs, which will be paid over to the RNHI Fund. This would lead to an additional R 3 billion in annual contributions to the RNHI Fund. The Workmen's Compensation Fund would cease to fund medical care for injured employees and treatment for Injury on Duty (IOD) claims will be administered by the RNHI Fund. The administration of the RNHI Fund will be put out to tender on a 5 yearly basis and all Medical Scheme Administrators would be invited to tender for administration of the fund. This is similar to the administration tenders for Cataracts, Mental Health, Women's Health, Oncology and School Health currently out from the DOH. This would lead to the most efficient and cost-effective way of administering the RNHI Fund, as well as management of IOD treatments.

19) Medical treatment of victims of road accidents will also be funded by the RNHI Fund. The cost of any claims where the Road Accident Fund is liable for medical expenses, will be pre-funded by the RNHI Fund and the costs will be claimed back from the Road Accident Fund.

20) The revised NHI Fund will enhance access to private healthcare for the poor and indigent, as the R32.8 billion budget is equivalent to 39% of public sector spend on district health services in 2017/18 (R84.2 Billion). The primary focus will be on access to primary healthcare, by contracting private providers of primary healthcare services with the revised NHI Fund. This contracting will happen on a capitation fee basis and will greatly increase access to primary healthcare of all South Africans. Patients will thus be able to utilise private sector primary healthcare services in their area, and will be referred on to secondary and tertiary services in the public sector as required, or these services can be bought from the private sector by the RNHI Fund.

21) Savings with the utilisation of capitation payments will also allow for further contracting to happen with specialists to provide vital services such as gynaecological consultations as well as radiology services. Public Service in-patients could thus be transported to a radiology department at periods of low utilisation (night time), and MRI scans etc., for which there are currently long waiting periods, could be administered. Procedures for which there are currently long waiting periods in public health facilities, such as hip replacements surgeries and cataract surgeries, could also be contracted with private providers utilising Global fee arrangement. Some of the current reserve funds from the Compensation Fund (Estimated at R58 billion) that are being administered by the Public Investment Corporation, can also be transferred to the RNHI Fund for utilisation as reserves.

22) In order to establish this RNHI Fund, changes would have to be made to the Medical Schemes Act; the COID Act; the Road Accident Fund Act and the National Health Act. The Draft Bill which is currently under consideration can be amended to accommodate this proposal.

Introduction of Public-Private Health Partnerships

23) The Public-Private Health Partnership will be the vessel which is utilised for private practitioners to contract with the RNHI Fund to render services to the public, based on capitation fee payment arrangement. This capitation fee arrangement must take into account actual practice costs of private practice and the proposed population to be covered. This will increase access to healthcare for all citizens, without imposing an additional cost burden on government, while concurrently reducing the burden on public health facilities and staff. Certification for service delivery will still occur under the ambit of the OHSC. After the funding of capitation agreements

with primary healthcare providers, surpluses in the revised RNHI Fund will be utilised for contracting with medical- and surgical specialists, which will occur on a "needs" basis on a regional level, based on the required speciality needs and the waiting periods for specialist services in a specific area. This will lead to a managed care approach of purchasing private specialist and hospital services in specific areas with specific providers and hospitals.

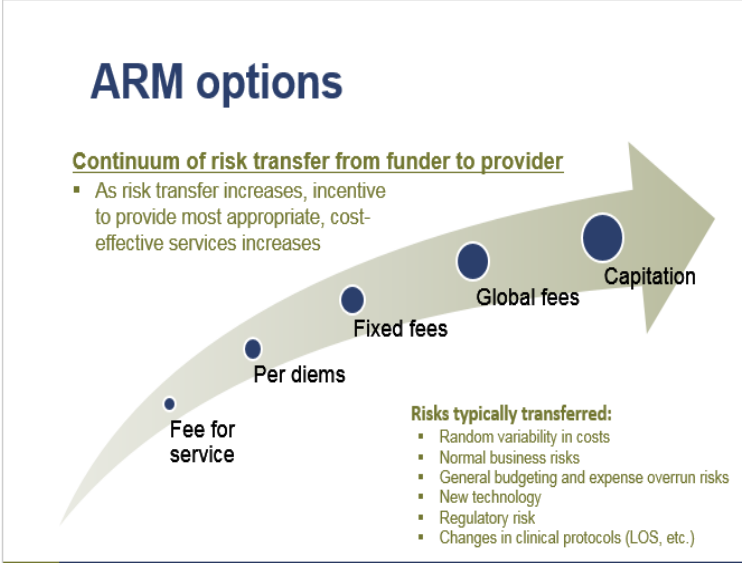
Reforming the private sector

24) SAPPF contends the private sector is a National asset worth protecting. That is not to say that the sector is not in need of reform. This fact has been acknowledged previously by SAPPF and forms an important element in the SAPPF submission to the Health Market Inquiry (HMI), which is publically available.

25) Some examples of reforms that will make private healthcare more affordable and accessible include the following:

- Integrated practice units
- Emerging Technologies
- Alternative Reimbursement Models

Figure 2 Alternative Reimbursement models



Integrated Practice Units

26) The WHO describes integrated practice units as a basic requirement for a UHC system. The systems envisaged by Michael Porter *et al*[2] will require amendments to both the NHA and the HPCSA Ethical Rules but hold clear opportunities for developing strategies that will create economies of scale and structural benefits that will allow closer integration between state and private healthcare services.

Emerging technologies

27) Another area that will undoubtedly bring down costs is the increasing use of emerging technologies to bring healthcare services within reach of rural communities.

Current White Paper and Draft Bill Proposals to be kept active

28) There are various proposals in the White Paper that will help to improve the quality and provision of healthcare services to all South Africans. The OHSC is one of the current proposals that will definitely help improve quality of public health services. There will have to be a major increase in the number of inspectors, to deal with the burden of inspecting all public and private facilities every four years. Current inspection rates indicate that the OHSC will have to employ between 910 and 1 938 inspectors to have the necessary inspection capacity. The introduction of Municipal Ward-Based Primary Health Care Outreach Teams to strengthen public primary health care is an important measure that is not reliant on the introduction of the NHI. The School based health system and establishment of district clinical health teams will also improve primary health service delivery in the public sector. Centralised procurement and the decentralised distribution of medication could still occur, as well as the continued improvement and upgrading of public health facilities as was currently envisioned.

29) The current Competition Commission Health Market Inquiry is also necessary to be completed, so that competition in the private space can be normalised and that legislative measures that have been lacking, such as PMB review can be implemented.

Funding of the NHIP

30) The revised NHI Fund proposed in the NHIP will be funded by the funds that are saved by the purported 20% decrease in underwriting costs caused by mandatory enrolment in medical schemes for all employees, as well as the injury treatment contribution for IODs that were previously administered by the Compensation Fund. This would create a budget of R35.8 billion

[2] Porter, M.E and Kaplan, R.S. 2015. "How should we pay for Healthcare?". Harvard Business School Working Paper

annually, in 2017 currency. The fund could attempt to lay claim to a 33% portion of the R58 billion in Compensation Fund Reserves, leading to the reallocation of R19.3 Billion in reserves to the RNHI. The Government expenditure on all district health services in the 2017/2018 Financial Year, amounted to R84.27 billion for all provinces. 42.5% of district health services could thus be funded out of the RNHI Fund with this funding basis. This cost would not add any additional costs to the government budget and would essentially be funded by the private employers and private individuals, without adding to their individual expenditure. It would also not add any additional financial burden to individual contributors to medical schemes, as the savings due to risk pooling via mandatory enrolment will create this surplus.

31) Mandatory enrolment of all employees on medical schemes will be funded by employers and tax credits can be created for this. Research published in 2006 by Sharon Swanepoel[3] indicated that the costs for LIMS would be R200 for the main member per month. With an annual inflator of 6.7%, this would amount to R435 per member per month in 2018. The total costs to employers, to add the additional employees and their dependents (14.7 million) to LIMS would be R 76.7 billion per annum. A tax credit to reduce some of this burden on employers is an important part of this process, as the employees who will now be cared for by private healthcare providers, will not be burdening the public healthcare system. If employees contribute R100 per month towards their own LIMS, the total cost to employers would be R59.06 billion per annum. This cost can be alleviated by Government in the form of a tax credit. A further benefit to Government is that the cost to provide these individuals with access to healthcare is now capped at R59,06 billion, where it was previously an “uncapped” expense in public sector utilisation.

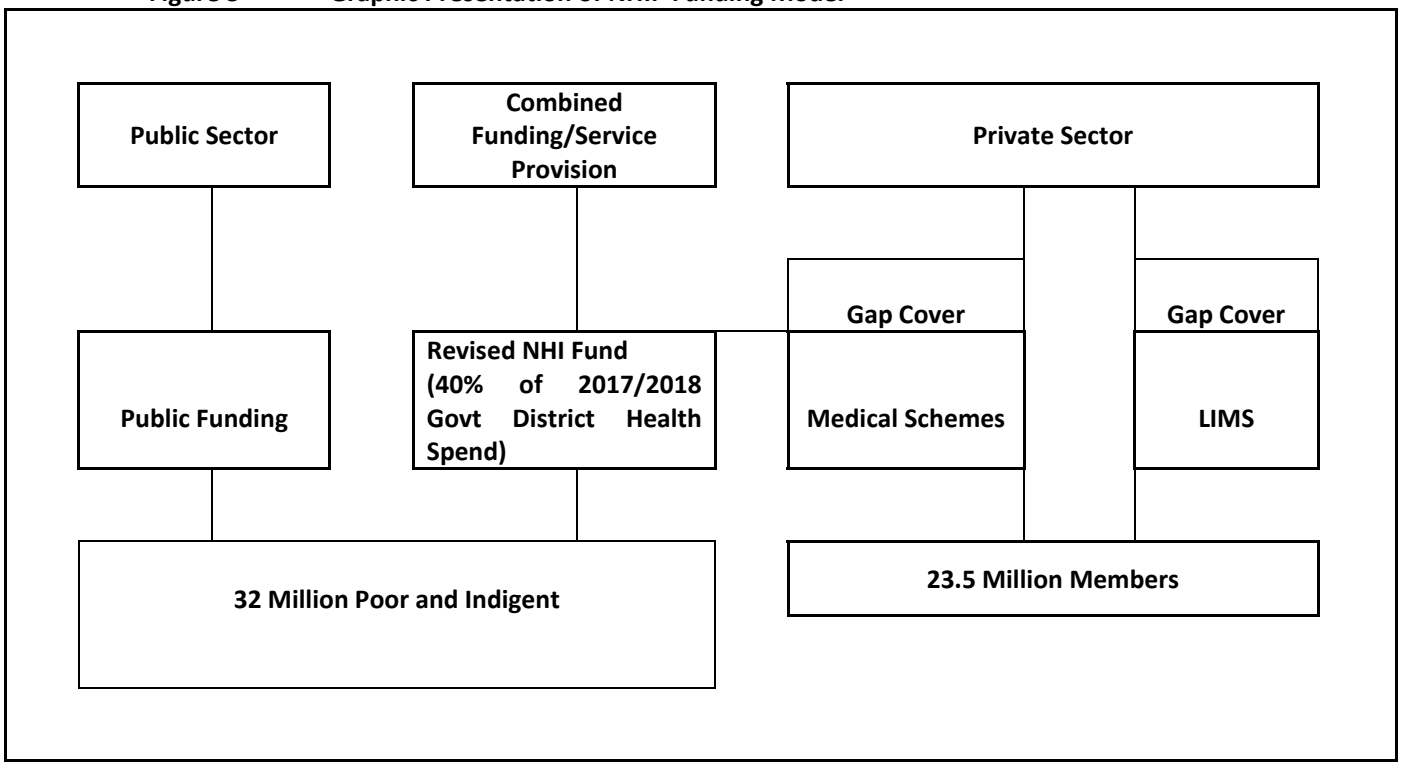
32) The outlays of providing gap cover for 23.5 million employees and dependents at a cost of R80 per person per month, would be a total of R22.56 billion per year. This would negate any co-payments in Hospitals and would also eliminate out of hospital co-payments. If employees fund 50% of the contribution, the cost to employers would be R11.28 billion per annum.

33) The public Health budget can also be reduced by R32.8 billion, due to the private sector now shouldering a larger portion of the patient care burden. Using these figures, one can introduce Universal Health Care at a maximum cost of R59.06 billion to Government, assuming a 100% tax credit for money spent on LIMS contributions and a R100 per month contribution by all employees. This will be offset by the smaller budgetary requirements of the Public Health System, as the revised NHI Fund, which is funded by a Medical Scheme Levy will contribute a

[3] Swanepoel, S. Healthcare for Low earners a step closer. http://ftp.bhfglobal.com/healthcare-for-low-earners-a-step-closer

further R32.8 billion in district health services. This R32.8 billion is equivalent of 39% of 2017/18 Government spending on district health services in all 9 Provinces combined. The RNHI Fund will not cost government anything and will further reduce the patient burden on the public sector by 50%. The public burden would amount to providing healthcare to 32 million poor and indigent South Africans, with a further potential 10 million of these patients being serviced in the private sector with the utilisation of the RNHI Fund. **The nett additional Government costs of the National Health Insurance Plan, would thus be R26 billion, assuming a 100% tax credit on employers' LIMS contributions (and the corresponding R32.8 billion reduction in district health spending). Employers will spend an additional R11.28 billion annually on gap cover, while employees will contribute R28.92 billion annually in LIMS (R100 per month) and Gap Cover (R40 per month) contributions. In the current scenario, where a minimum wage is mandated, Medical Scheme membership and contributions can also mandated.**

Figure 3 Graphic Presentation of NHIP Funding Model



Conclusion

34) SAPPF believes that this model addresses the Universal Health Care requirements of all South Africans, without placing an undue tax burden on the already small tax base and without any costly reorganisation of the entire healthcare system and healthcare funding environments. It also improves equity and provides access to the private sector for people that currently utilise the public healthcare system, through the RNHI Fund. This model would also remove a large

number of users form the public health system, allowing the Public sector to improve quality. A high quality public service will also serve as competition to the private sector, assisting with bringing down prices in the Private Sector.

SAPPF'S SUBMISSIONS ON THE FINANCING AND COSTING OF THE NHI AS PROPOSED IN THE DRAFT BILL

FINANCING OF THE NHI

35) It is with some disappointment that SAPPF takes note of the lack of costing or any indication of funding arrangements for the NHI Fund. We believe that NHI's impact on the economy, its likely cost and the details of the intended model must be substantively addressed by the DoH in partnership with National Treasury and other role players in the very near future. The implementation of far-reaching health care reforms will be costly and could have significant adverse consequences if not implemented successfully. It will also involve a significant commitment to- and from - the South African people. Reforms should thus only be pursued if they are practically implementable and affordable. The failure to update its cost models in the four years between the original Green Paper and the finalisation of the White Paper, with a total absence of any reference to costing in the Draft Bill, is especially concerning. We note in this regard that Ireland recently had to scrap their Universal Health Insurance proposal due to cost models that were completed 4 years after the publication of their White Paper, indicating that the proposed model of Universal Health Insurance, was in fact not affordable for Ireland[4].

36) The NHI policy further promises "Free healthcare for all". The concern is, that although *receiving* healthcare would be free, *providing* healthcare is not and it would have to be funded by some form of taxation or contribution. South Africa has 7.1 million taxpayers who, in some of the proposed NHI funding scenarios, would potentially need to fund healthcare for 57 million South Africans and the limited services offered to immigrants, including the 8.8 million medical scheme members who are currently privately self-funding their healthcare.

37) There have been several referrals in past Green and White Papers on NHI to the WHO and costing of NHI. Although the WHO is alluded to in the Policy documents as cautioning that while costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the exact number indicating the estimated costs. The DoH then seems to dismiss focusing on the question of "what will NHI cost", insisting that it is better to frame the question around the implications of different

[4] Irish Times. "An outstanding policy failure on universal health insurance". 23 November 2015

scenarios for implementing reforms that will achieve universal health care (UHC). Even though there is reference to different scenarios in this instance, the SEIAS did not reflect consideration of any alternative UHC scenarios to NHI. It is a concerning failing to assume that one does not need to do a costing of the NHI in order to implement it, as affordability cuts to the core of the implementation potential of the policy. The WHO clearly states that costing assumptions and scenarios may be useful for raising *core policy issues* regarding the sustainability of reforms and radically overhauling the entire healthcare system would constitute a *core policy issue*.

NHI FUNDING CONCERNS

NHI Expenditure Projections

38) It was widely publicised that the Minister of Health (the Minister) admitted that the NHI cost projections contained in the NHI Green, and subsequently, White Paper, were merely an estimate by an accounting firm.[5] Although this is an estimate as far as the potential costs of its NHI is concerned, these projections were based on the *actual* Government spend in 2009 with annual inflationary adjustments. In order to get to the estimated R256 billion in 2025/26, the Green/White Papers indicated "*NHI expenditure increases by 6.7 per cent a year in real terms after 2015/16, resulting in a cost projection in 2025/26 of R256 billion in 2010 prices. These projections would take the level of public health spending from around 4 per cent of GDP currently to 6.2 per cent of GDP by 2025/26, assuming the economy grows at an annual rate of 3.5 per cent. This increase would be below the level of public spending (as a percentage of GDP) of many developed countries*." The South African GDP growth rate was established as 0.56% in 2016 and 1.32% for 2017 by the World Bank[6]. The GDP growth projection used for this NHI model is therefore highly optimistic and has not been updated to reflect current realities.

39) The current low GDP growth estimates will lead to a much larger spending shortfall, which will need to be financed. The 2010 baseline costs used, only indicate the public health budget for 2010. The NHI system will combine both public and private patients in one system, yet the estimated cost projections only included figures for Government spend on public healthcare. As private spending was similar to public spending in 2010, the assumption by this model to only include government spend, would provide insufficient funds for the number of users of the system, despite the indication in the Green Paper that increased demand and utilisation was considered in the process. This poses questions as to whether this is the correct model to utilise. The model, using 2010 terms, also does not include the fact that the South African Rand has

[5] https://businesstech.co.za/news/government/255495/r259-billion-nhi-figure-was-a-guess-we-dont-know-what-it-will-cost-motsoaledi/

[6] https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2017&locations=ZA&start=1961&view=chart

depreciated from R7.29/$ in 2010 to R15.14/$ in 2018 against the US dollar[7], which has a material influence on the cost of healthcare supply, where imported equipment, devices, consumables and medicines are often utilised. The recent 1% increase in VAT also added 0.87% to the cost of all healthcare services in South Africa. It is important to note that the funding scenario described in both the Green and White Papers will come to pass in 2025/2026 in the public healthcare space, *irrespective of whether NHI gets implemented or not*. Unless something drastically changes, the South African fiscus is going to be experiencing a funding shortfall in Healthcare as described in the costing estimates of NHI. This shortfall will already become prevalent prior to the estimated dates for implementation of the NHI and will need to be addressed in some way.

40) If one substitutes the actual 2015/16 Public Health spend into the table provided in the NHI White Paper (Table 1, Projected of NHI Costs adapted from the Green Paper) in 2017 currency, it creates the scenario illustrated in Table 2 of our submission. It can be seen by merely updating the values of the projection to actual figures, without changing any other variables in the scenario, the White Paper cost projection escalates to R342 billion in 2025/2026. The Projected funding shortfalls at 2% growth (which is above the current growth rate) in such a scenario escalates to R 194 billion, which would need to be funded by additional funding appropriation from National Treasury, which derives its income from taxes. The concern with this shortfall is that this position actually reflects the funding situation if NHI is *not* implemented, based on Government spend and inflation. In the current low growth constraints being experienced in the South African Economy, it is highly unlikely that additional tax revenue will be available to fund either the NHI or the increased Public Sector expenditure in the absence of NHI. This leads to the need to consider alternate ways to restructure healthcare funding, which is not reliant on taxes.

Table 1: White Paper projection of NHI costs adapted from Green Paper

	Average annual percent increase	**Cost Projection R m (2010 prices)**
Baseline Public Health Budget: 2010/11		**109 769**
Projected NHI expenditure:		
2015/16	4.1%	134 324
2020/21	6.7%	185 370
2025/26	6.7%	**255 815**
Funding Shortfall in 2025/26 if baseline increases by:	2.0%[6]	108 080
	3.5%[6]	71 914
	5.0%[6]	27 613

[7] https://www.poundsterlinglive.com/bank-of-england-spot/historical-spot-exchange-rates/usd/USD-to-ZAR-2018

Table 2: Projection of NHI costs, Utilising 2016 values

	Average annual percent increase	Cost Projection R m (2016 prices)
Baseline Public Health Budget: 2010/11		**113 088**[1]
Projected NHI expenditure:		
2016/17	6.7%[3]	191 166[2]
2020/21	6.7%[3]	247 781[4]
2025/26	6.7%[3]	**342 681**[4]
Funding Shortfall in 2025/26 if baseline increases by:	2.0%[6]	194 946[5]
	3.5%[6]	158 780[5]
	5.0%[6]	114 479[5]

Notes:

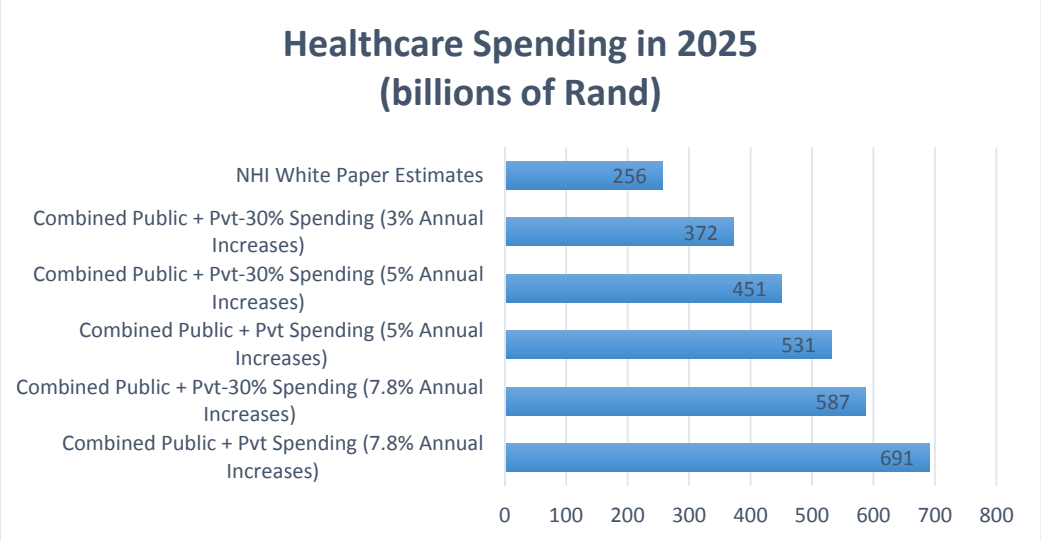
1. Base Value in 2016 Values
2. Actual Public Expenditure in 2017 values, including Health spending by RAF, Correctional Services, defence Local Government, Compensation Fund and Basic Education
3. DOH White Paper Projections
4. Figures based on DOH Growth Projections and actual 2016/17 spend
5. Shortfall based on restated 2025/26 spend
6. Indication of NHI funding shortfall at different rates of GDP growth

41) A second costing model often referred to, is that 8.5% of GDP is currently being spent on Healthcare in South Africa. Of this spend, 4.1% is being spent in the Public Sector (which, according to government, covers 84% of the population) and 4.4% in the Private Sector (which, according to the government, only covers 16% of the population). The assumption is that this 8.5% of GDP should be more equitably distributed to cater for healthcare for the entire population. What is noteworthy, is that taking tax credits out of the equation and the Government's contribution to Medical Schemes (Which is an employment benefit and not a healthcare allocation), leaves 3% of GDP, or R125 billion, being spent by private medical scheme members out of their own pockets on their access to private healthcare. This is discretionary private spend by members of the public on their private healthcare. This money is not available for allocation to a common funding pool for utilisation by the NHI Fund. If medical schemes are scrapped, this discretionary spend will revert back to the private finances of those private individuals. Should the government wish to access this funding for the NHI fund, it would have to happen as an additional tax of R125 billion, which roughly equates to a 33% increase in Personal Income Tax collection by Government. In the absence of this tax increase, government will only have approximately 5.5% of GDP available to fund NHI, taking current spend into consideration. It should be considered that Public Service Unions are unlikely to agree to employment benefits of union members being reduced if government stops contributing to medical schemes on behalf of employees and it is likely that these *Cost to Company* employment benefits will be demanded in cash, in order for government employees not receiving a substantial cut in their Cost to Company packages when NHI gets implemented. This would create a situation where

this money might be added to the NHI funding, but there will *not* be a concomitant decrease in the funding of public service wages, further adding to the financial pressure created by NHI.

42) Figure 4 illustrates the projected NHI spend, if one looks at different inflation figures. It can be seen that combined Public and Private spending at 3% annual inflation and a 30% discount on Private spending (attributable to a government control of private costs) will lead to estimated spending of R372 billion on Healthcare in 2025. A 3% annual inflation is, unfortunately an unlikely scenario. A 5% annual inflator in the scenario described previously will lead to R451 billion in Healthcare spend by 2025. In the worst case scenario, current private and public spending is combined with a 7.8% annual inflator, without any cost control discounts in the private sector, which will lead to spending of R691 billion in 2025. In our opinion, the most realistic cost estimate is combined Public and Private spend (minus 30% government cost control), with a 7.8% annual inflator. This estimates a cost of R587 billion for healthcare spend in 2025. None of these figures take into account the decline of the Rand exchange rate to the dollar and the effect this would have on costs. The rand has depreciated by 25-30% against the Dollar between 2010 and 2016. All of these figures are very likely to make for an unaffordable government funded NHI system.

Figure 4: Healthcare Spending Estimates with different scenarios



Funding of UHC Internationally

43) In SAPPF's point of view, there should be a distinction between *implementing the NHI* and *implementing Universal Health Care.* **Achieving Universal Healthcare in South Africa is not dependent on the NHI single payer model being implemented.** The NHI is only a funding model.

UHC will ensure access for all in an integrated system, without the costs of the NHI's proposed radical reorganisation of the health system, which will have to be funded by the government.

44) Affordability of healthcare reform for South Africa is indicated by comparison to various other developing, middle income countries in the past Green- and White Papers. In one version of the White Paper it stated that "*Previous attempts of health care reform worldwide that did not encompass reforms to health care financing have not always been successful in some countries whilst countries such as Mexico and Thailand are examples of countries where attempts to transform health financing have been positive.*"

45) The comparison of South Africa with other developing, middle income countries is an inappropriate comparison, as is illustrated in Table 3. This table illustrates the radical differences in unemployment rates between South Africa and the countries used for demonstrative purposes. There are also large differences between the GINI coefficients of South Africa and these countries. GINI coefficient is a measure to represent the income or wealth distribution of a nation's residents, and is the most commonly used measurement of inequality. A score of 0 is perfectly equal and a score of 1 is perfectly unequal. On average, South Africa's unemployment figures are 6.7 times as high (25.4% vs 3.8%) as the countries it is compared to and the GINI coefficient is 47.8% higher than these comparative countries.

Table 3: Country Comparison of Unemployment and GINI Coefficient

(2014)	Population	Taxpayers	Taxbase	Unemployment	GINI
Mexico	122.3 Mil[8]	46.3 Mil[9]	37.8%	4.75%[10]	48.1[11]
Thailand	68 Mil[5]	20 Mil[6]	29.4%	0.9%[7]	39.3[8]
Brazil	202 Mil[5]	50.5 Mil[6]	25%	6.8%[7]	52.9[8]
Korea (2011)	49 Mil[5]	13.5 Mil[6]	27.5%	2.7%[7]	31.3[8]
Average	**110.3 Mil**	**32.6 Mil**	**29.9%**	**3.8%**	**42.9**
RSA	55 Mil[5]	5.7 Mil[6]	10.3%	25.4%[7]	63.4[8]

46) Table 4 compares levels of employment in South Africa to other countries with tax funded UHC systems. In a previous version of the White Paper, Brazil, Canada, Finland, Norway, Sweden, Thailand, Turkey and the UK are specifically mentioned as countries that successfully implemented Tax funded Universal Healthcare. The average percentage of employed people in these countries, is 59.38%. It can be seen in this comparison that South Africa has 52% fewer

[8] www.worldometers.info
[9] https://www.oecd.org/tax
[10] https://tradingeconomics.com
[11] https://www.cia.gov/library/publications/the-world-factbook/rankorder/2172rank.html

employed people in the population than these countries mentioned in the White Paper. When one includes other countries utilising UHC, such as Denmark, Mexico, France, Iceland, Japan, New Zealand, Costa Rica, South Korea and Australia, a similar employment pattern can be noted. This creates a major barrier for funding of the NHI through tax revenue, as there are simply not enough taxpayers who can pay for the system.

Table 4: Employment percentages[12] in selected Countries with Universal Healthcare

Country	**2014 (%)**
Brazil	65
Canada	61
Finland	54
Norway	62
Sweden	58
Thailand	72
Turkey	45
United Kingdom	58
Average	***59.38***
Denmark	58
Mexico	59
France	50
Iceland	70
Japan	56
New Zealand	63
Costa Rica	58
South Korea	75
Australia	61
Average (ALL)	***60.28***
South Africa	**39**

47) Table 5 illustrates the current South African tax base[13]. The narrow nature of the tax structure in South Africa is a large concern when it comes to the public funding of Government projects such as the NHI. The bottom brackets of tax liable individuals, earning less than R350 000 per annum, amount to 60.7% of all tax payers, yet only pay 10.5% of all personal income taxes. In comparison, the top 6% of tax payers, earning more than R750 000 per annum, pay 46.9% of personal taxes. This top 6% of tax payers, also only amount to only 0.6% of the entire South African population. In total, 12.8% of South Africans pay 100% of the personal taxes collected by the South African Revenue Service (SARS). With such a narrow tax base, the proposed 4% increase in personal tax rates contained in the previous versions of the White Paper will be unlikely to increase the current R441 billion in personal taxes to the extent to cover any

[12] World Bank employment to population ratio. http://data.worldbank.org/indicator/SL.EMP.TOTL.SP.ZS
[13] 2016 National Treasury Budget Review

meaningful portion of the R194 billion shortfall illustrated in Table 2 of this SAPPF document at a 2% GDP growth scenario. It is also important to note that South Africa currently has 8.8 million Medical Scheme members who are funding their own healthcare with discretionary spend, as compared to 7.1 Million tax payers, who would be required to fund healthcare for all South Africans if taxes are to be used as a funding mechanism for NHI.

Table 5: South African Tax base[5]

Tax Bracket (R '000)	Number	Percentage of Taxpayers	Percentage of Population	Percentage of Taxes paid
70 - 150	258 3046	36.3%	4.7%	2.7%
150 - 250	1 733 463	24.4%	3.2%	7.8%
250 - 350	1 071 798	15.1%	1.9%	10.9%
350 - 500	800 990	11.3%	1.5%	14.6%
500 - 750	497 722	7%	0.9%	17%
750 - 1000	197 813	2.8%	0.3%	11.3%
1000 - 1500	136 782	1.9%	0.2%	12.1%
1500 <	94 578	1.3%	0.1%	23.5%
TOTAL	**7 116 192**	**100%**	**12.8%**	**100%**

48) The Davis Tax Commission, in 2017, indicated in their report on NHI funding that VAT should be considered as a funding mechanism for NHI. However, an increase in VAT to pay for the additional costs of funding the NHI will not necessarily be a socially just funding method, as VAT is generally regressive. Increasing VAT will lead to having to consider making additional food and basic living items VAT exempt, to minimise the impact on the poor. Something to consider is that making medicines VAT exempt will actually help to bring down the price of healthcare in South Africa. One has to only look at the recent protests caused by a 1% increase in VAT, to realise that further VAT increases are unlikely to prove a sustainable or socially acceptable mechanism for funding NHI.

49) It is important to note that the cost of increased taxation in the form of a payroll tax on employers will ultimately be passed on to consumers through higher prices. This will, in turn, result in a loss to consumer welfare through the erosion of disposable income. The additional burden imposed on employers will also increase the labour cost which will, in turn, limit job creation and place downward pressure on salaries. Such effects on the labour market may be detrimental to South Africa, given that we already struggle with high unemployment and where job creation is explicitly stated as one of government's main objectives. This increased taxation will also be added to any demands placed on the employer by the proposed minimum wages that are currently in the process of being implemented. One would hope that in future,

employer contributions to fund healthcare will be considered. If an employer can be expected to pay a minimum wage, there should be nothing to preclude an employer from contributing towards employee healthcare.

50) Consideration should be given to the fact that any increase in taxes for the purposes of funding the NHI, should be ring-fenced in the fiscus, for this purpose. Paying increased taxes to fund the NHI will serve to reduce the expendable income of tax payers, thus reducing their ability to pay cash for any further medical treatments or medical scheme membership. If this increased spend is not ring-fenced for healthcare purposes in the government budget, tax payers could be seriously prejudiced in that additional money spent, supposedly on healthcare, does not go towards healthcare, which may then require additional personal expenditure on their side.

51) It is indicated in previous NHI Green- and White Papers that the implementation of NHI will take into account other country's experiences and global lessons learnt in the development of UHC.

52) There are several examples of lessons learnt internationally regarding universal health coverage that appear not to have been taken to heart in the South African context. If one looks at the case of South Korea specifically14,National Health Insurance was implemented over a twelve year period. The government mandated medical insurance for companies with more than 500 employees and this was subsequently extended to the whole nation in 1989. This system ran smoothly until 1997, when a major economic crisis hit South East Asia. There was an increasing annual deficit in the NHI after this period. The South Korean government continued to raise the contributions to try and make up the deficit, but did not succeed in doing so. Increased government funding was not solving the problem, as South Korea was unable to control health care expenditure. The South Korean Government assumed exclusive control over medical care financing without including medical professionals in the policymaking process. Organised medicine complained that only 65% of customary medical costs were reimbursed by the government insurance system. 90% of the South Korean system was based on Private Fee for service consultations, with only 10% of services performed by public facilities, which contributed to raising costs. In 2009, there were 49 238 227 Koreans registered with the NHI. Of these, 57.7% (28.4 million) are employee insured members, who each contribute 5.08% of their annual income towards NHI, with their employer contributing the same amount. Self-employed, insured individuals amount for another 38.6% (18.9 million) members, who contribute various amounts. The government is responsible to provide coverage for the poor and indigent, who constitute

[14] Lee, J-C. 2003. "Health Care Reform in South Korea: Success or Failure". American Journal of Public Health 93(1)

3.7% of the population[15]. There is a co-payment system of 10% to 20% of inpatient costs and between 30% and 50% of outpatient consultation costs. This research indicates that the South Korean Government is struggling to fund healthcare for the 3.7% of the population that cannot afford to self-fund.

53) To compare with South Africa, South Korea has 47.4 million users of the NHI that self-fund at a rate of between 6% and 10% of their annual income along with co-payments ranging from 10% in-hospital to 50% of outpatient costs. Despite this massive funding base, the government is struggling to fund the 3.7% of the poor and indigent in the NHI. South Africa has 7.1 million taxpayers who will be funding healthcare for 55 million South Africans, without any co-payments, at a government suggested rate of a 4% tax increase. Based on the Korean model it is concerning that the South African funding approach to the NHI is insufficient, making the NHI system unaffordable. Further lessons from the Korean system for the implementation of NHI in South Africa includes that utilising an NHI based system in periods of financial crisis does not work. South Africa is undoubtedly experiencing a financial crisis with twin deficits, low growth and a domestic currency which serves as a proxy for emerging market currencies and hence is subject to extreme volatility. Trying to implement a tax funded NHI in such circumstances is unlikely to succeed. A second lesson from the South Korean case study is that not including medical professionals in the policy making process, such as the NHI Fund and a Minister unilaterally determining reimbursement amounts for services, could create various implementation problems.

54) Similar to South Africa, the Republic of Ireland published a Universal Healthcare Insurance (UHI) White Paper in 2011[16]. This White paper did not allude to any costing of the UHC system and did not describe the basket of services that would be offered under the Universal Healthcare Insurance. In 2015, it has come to light that Ireland could not actually afford the system, following costings and analysis from the Economic and Social Research Institute (ESRI). The ESRI study, which was based on the White Paper details, showed the [Irish] Government's proposed model "is not affordable now or ever". UHI proved a vote winner in the 2011 general election. However, the [ruling] party's failure to cost its own proposals then, and the Government's subsequent failure to do so until 2015 represented the "outstanding policy failure of the Coalition administration".

[15] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*
[16] Irish Times. "An outstanding policy failure on universal health insurance". 23 November 2015

55) There are two prominent countries that utilise a single payer model, such as that proposed by the NHI. These are Canada and Taiwan.

56) Looking at the situation in Canada[17], it is seen that Canada has the second most expensive healthcare system as a share of the economy and adjusting for age. Long waiting times in Canada have also been observed for basic diagnostic imaging technologies that many countries take for granted, which are crucial for determining the severity of a patient's condition. In 2013, the average waiting time for an MRI was over two months, while Canadians needing a CT scan waited for almost a month. These waiting times are not simply "minor inconveniences." Patients experience physical pain and suffering, mental anguish, and lost economic productivity while waiting for treatment. One recent estimate (2013) found that the value of time lost due to medical waiting times in Canada amounted to approximately $1,200 per patient. There is also considerable evidence indicating that excessive waiting times lead to poorer health outcomes and in some cases, death. Dr Brian Day, former head of the Canadian Medical Association recently noted that14 "delayed care often transforms an acute and potentially reversible illness or injury into a chronic, irreversible condition that involves permanent disability." New research also suggests that waiting times for medically necessary procedures may be associated with increased mortality. One of the important statements of this report, was that it was important to recognize that a single-payer model is not a necessary condition for universal health care. There are ample examples from OECD countries (The Organisation for Economic Co-operation and Development is an intergovernmental economic organisation with 36 member countries) where universal health care is guaranteed without imposing a single-payer model.

57) Research by the Fraser Institute published in 2015, on the cost of Healthcare insurance for Canada18, illustrates that Canada consistently applies 23.9% of personal taxes that get paid towards Healthcare Insurance for individuals. The healthcare taxes of Canadians are quite progressive, with the lowest earners spending 3.5% of their income on health while the highest earners spend 13.2% of their income ion health. They all receive equal health services. Between 2005 and 2015, the costs of Canadian healthcare has increased 1.6 times faster than income, 1.3 times faster than the cost of housing and 2.7 times faster than the cost of food. Healthcare costs increased by 48% in the 10 year period, while the CPI increased by 17.3%. The CPI average increase for the period was 1.7%, while Healthcare inflation was 4.8% or a 2.8 multiple of the CPI Inflation. Although healthcare inflation under the single payer system in Canada is in line with a

[17] Clemens J, Barrua B. "If Universal Health Care Is The Goal, Don't Copy Canada". Forbes Magazine, 13 June 2014

[18] Palacois, M; Barua, B and Ren, F. (2015) *Fraser Research Bulletin – The Price of Public Healthcare Insurance*

2-3% above CPI expectation, the low base CPI makes this 2.8 times multiple quite high. Discovery Health illustrated at the health market inquiry that their premium inflation is currently 11.4%, where the SA CPI is 6.3%. Healthcare inflation in the South African Private Sector, which is branded as expensive in the NHI white paper, is only 1.8 times that of CPI. The proposal from the NHI White paper is thus to move from the current "expensive" two tier system to a single payer model, such as Canada, which could be considered even more expensive. This decision is difficult to justify based on available research data.

58) The other single payer healthcare system is found in Taiwan[19]. Taiwan has 23 million people on their NHI. The Taiwanese government pays 23.2% of NHI costs, while 76.8% of it is funded by individuals and employers. Every service delivered in the Taiwanese NHI has a co-payment of between R20 for GPs and R115 for hospitals and specialists. Taiwan spends 6.2% of its GDP on healthcare. Out of Pocket Expenses in Taiwan amounted to 35.8% of all healthcare spend in the country. The administrative costs of the Taiwanese NHI are only between 1% and 2% of the NHI budget, indicating a highly efficient administrative system. In comparison, as discussed earlier, SA Medical schemes run at costs of 10.9% of scheme premiums and COID/RAF staff costs are between 5.3% and 5.8% of COID/RAF annual income, while these funds only managed to pay between 41% and 61% of annual claims. Waiting times in Taiwan are considered very low. This can be attributed to Taiwan having 17 doctors per 10 000 population in 2015, while South Africa had 6 per 10 000 in 2013[20]. The concerning flip-side of low waiting times is however, poor quality of care. Taiwanese GPs see 50 patients in a morning shift. The other reason for the low waiting times is that Taiwan had 70.2 hospital beds per 10 000 population in 2014. South Africa, in comparison only had 24.1 beds per 10 000 population in 2016[21]. The funding concern for the Taiwanese government is that healthcare costs often run over national budget and the government needs to pay extra to keep the system running. Despite the NHI system, the consumer satisfaction rate in Taiwan is 70-80%, which is actually less than SA's current public satisfaction levels of 81%[22].

59) Having examined both the Canadian and Taiwanese single payer NHI models, it is not clear why these two countries were used as a motivation for South Africa to choose a single payer NHI model. Canada's healthcare inflation and costs are much higher than South Africa's, despite having a single payers system, while in Taiwan, 35.8% of Healthcare is provided for by out of

[19] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*
[20] Econex Report. August 2015. "Identifying determinants of and solutions to the shortage of doctors in South Africa: Is there a role for the private sector in Medical Education".
[21] Health Market Inquiry Interim Report, 5 July 2018
[22] StatsSA Annual General Household Survey, 2015

pocket payments. South Africa also does not have the administrative capacity to administer a single payer system at the same 1%-2% costs shown by Taiwan, as was illustrated earlier.

60) The affordability of the NHI is definitely a core policy issue. One cannot ignore considering the costs involved, nor can one accept the statement by the DOH in both the Green- and White Papers that cost consideration is "the wrong approach". In SAPPF's opinion, South Africa cannot afford the NHI system in its current format. This does not, however, mean that South African cannot afford to implement some form of UHC. What it does imply, is that a different, more appropriate funding model needs to be considered. The low levels of employment and the small base of tax payers in South Africa compared to other countries using tax-funded public health systems is an indication that one needs to have higher levels of employment to sustain such a system. The need for sustained increased economic growth being necessary prior to implementation of NHI was expressed by the Davis Tax Commission in their Report on NHI Funding which was issued in 2017. This recommendation needs to be considered. The only way to effectively increase availability of Healthcare funding in South Africa would be to increase the discretionary healthcare spend, as is happening when individuals pay for membership of Medical Schemes out of their own pockets. This forms the premise of the alternative funding model for NHI, as proposed by SAPPF later in this document. SAPPF would encourage the government to compare the Socio Economic Impact of the proposed SAPPF model against the NHI, in a proper SEIAS analysis where alternatives for UHC are compared and not an exercise where the most unlikely of alternatives, such as *Maintaining the Status Quo* and *Full Privatisation* are considered for comparison with the model of choice.

Administration costs of the NHI

61) The Draft Bill is lacking in information regarding the potential costs involved with public administration of the NHI Fund and the number of state employees it might require for its administration. When one looks at possible scenarios for the costs involved with the public administration of the NHI Fund, one could use the current efficiency levels of the Compensation Fund for comparative purposes. The Compensation Fund employs 1630 employees who pay out R4.1 billion[23] annually in claims. From the Draft Bill, it is clear that most government and private facilities will be contracted to provide services to the NHI as cost centres, with their claims being paid out of the single purchaser NHI fund. If the Compensation Fund claims paid are multiplied to the projected R256 billion budget of the NHI White Paper in 2025, it would require 101 775 Compensation Fund staff members to administer the NHI Fund. This does not account for any

[23] Compensation Fund Annual Report 2014/15

economies of scale, but these seem to be absent in the Compensation Fund as well, when compared to efficiencies of private medical scheme administrators. The 2015 cost per staff member of the Compensation Fund was R273 000[24]. The administrative budget of the NHI Fund would thus amount to R 27.78 billion, using the current efficiency levels of the Compensation Fund as a measure. The Compensation Fund employees only paid 61% of all its claim liabilities in the 2014/15 year. This could have negative implications for the administration of the NHI fund and the continued delivery of healthcare services if service providers are not paid timeously and in full.

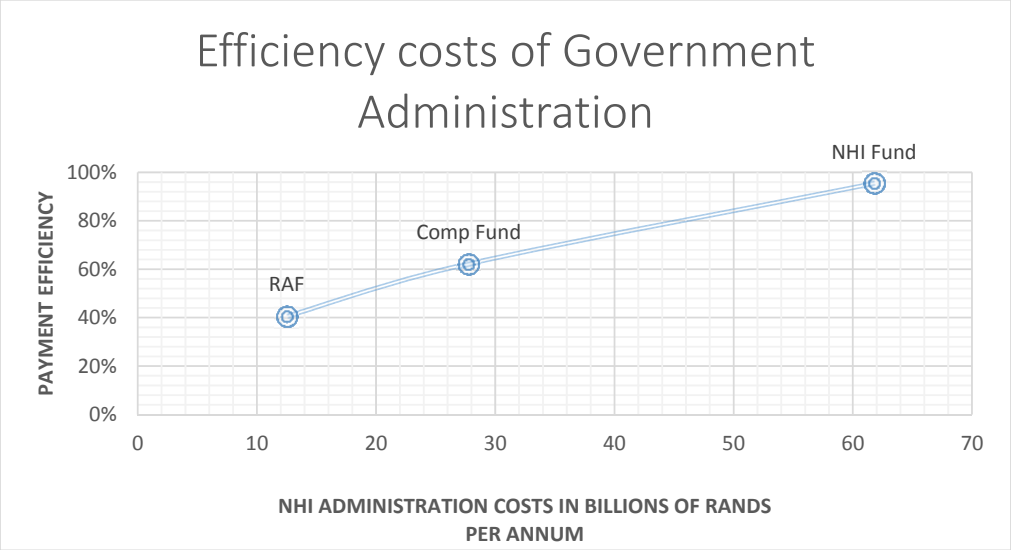
62) The Road Accident Fund (RAF), employs 2555 employees. They paid out R 23 885 453 000[25] in claims during 2014/15. Taking the proposed NHI budget at R256 billion, it would require 27 384 RAF staff members to run the NHI Fund. Based on the monetary value of claims paid out, RAF staff is more efficient than Compensation Fund staff. It is also indicated in the RAF annual report8 that RAF staff are, on average, remunerated at higher levels than Compensation Fund employees. The cost of the RAF staff is an average of R456 000 per employee. This would amount to a total expenditure of R12.49 billion in administrative costs, if the NHI fund was run at the efficiency levels of the RAF, using the projected NHI Budget. It is important to note, that RAF staff only managed to pay 41% of liabilities in any given year.

63) The costs of administering the NHI Fund privately at a premium of 4.5% (the premium paid by GEMS26 to its administrators for administration without managed care being included) would amount to R 11.52 billion per annum. If the private healthcare industry average of 10.98% for administration costs27 is used to determine potential administration costs of the NHI Fund, this will amount to R28 Billion (Of the projected R256 billion NHI budget). Although the costs of staffing the NHI Fund at the efficiency of the RAF will cost R12.49 billion per annum, the biggest concern is that only 41% of claims could be paid in any given year, as is happening in the RAF. At a cost R27.78 billion, the NHI Fund could run as efficiently as the Compensation Fund, with 61% of claims being paid in any given year. To reach the efficiency levels of private scheme administrators, where 96.4% of claims get paid annually, the government run administrative costs could escalate to R61.78 billion (See Figure 5), when exponential equations are used. This would mean that the government administration of the NHI Fund at levels that equal the efficiency of private medical administrators could cost 24.1% per year and require 226 300 staff members, as opposed to the 4.5% - 10.98% costs of private medical scheme administration.

[24] Compensation Fund Annual Report 2014/15
[25] Road Accident Fund Annual Report 2014/15
[26] GEMS Annual Statutory Return (Section 37) Report 2013
[27] Council of Medical Schemes Annual Report 2014/2015

64) In the absence of documented research used by Government to decide on a single payer/purchaser NHI model in the NHI White Paper, one has to assume that one of the government considerations was the 1 - 2% administration costs of the Taiwanese NHI[28] in making this decision. Considering the South African situation, it is clear that even the most efficient private medical scheme administrators cannot run the administration of the NHI at such low administration figures and government administration is even less efficient. This administrative cost burden appears to have remained unconsidered in the costing models of the NHI and in the decision of utilising a single payer model.

Figure 5 Projected Efficiency costs of Government Administration of NHI Fund



Costs of Running the OHSC to fully function as proposed in the Draft Bill

65) A further unconsidered cost in the NHI White Paper is the potential escalation in the costs of running the Office of Health Standards Compliance once the NHI is implemented. In clause 38(2)(a) of the Draft Bill, it is indicated that Health Facilities that wish to contract with the NHI Fund would need to be certified by the OHSC in order to do so. According to 2015 claims data from a major medical scheme administrator, there are currently a conservatively estimated 600 clinics in the private sector and at least an additional 32 600 private healthcare practice facilities[29] that would need to be inspected in a four-yearly cycle by the OHSC. Figures provided by Medpages[30] indicate that there are 12 390 Hospitals and clinics registered on their database, with an additional 62 168 registered private practices.

[28] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*
[29] Major Medical Scheme Administrator 2015 Claims Figures
[30] Medpages figures. www.medpages.co.za/stats

66) In 2014/2015, the OHSC inspected 417 government facilities. The number of employees at the OHSC was 96 in 2015/16 and will be increased to 137 in 2017/18[31]. There is no indication in the OHSC Annual Performance Plan document, which extends to 2020, of the creation of inspectorate capacity to inspect the approximately 33 200[27] to 74 558 private facilities for inclusion in the NHI. No inspection of private facilities has commenced to date in 2018 and the Healthcare facility norms and standards that were promulgated in 2017 create certain requirements for facilities wishing to comply. The OHSC would have to inspect between 8 300 and 18 640 private facilities annually in the 7 years between 2018 and 2025 for possible inclusion and accreditation in the NHI. This is due to a certification from the OHSC only being valid for 4 years.

67) With their current staffing complement of 7 inspection teams of 5 inspectors each, this would entail that each team will have to inspect between 5.2 and 11.07 facilities in every working day (of which there are 229 per employee annually). In 2014/15, each team was on average, able to inspect one facility every 4-5 work days. In order to do the necessary inspections, there would have to be between 182 and 388 teams of 5 inspectors employed by the OHSC, giving it a staff complement of between 910 and 1 938 inspectors. There is currently no indication in the budget of the OHSC, which is projected up to 2020 in their annual performance review, of the necessary budget availability to increase their inspectorate capacity to these levels. The current inspectorate budget is R28 million per annum, which would need to be expanded to between R227 million and R484 million (average CTC of R250 000 per inspector), which only includes salary costs and does not address the potential escalation in travel and accommodation costs for this inspectorate force.

68) There is currently no indication in either the projected NHI costs or the OHSC strategic budget to 2020 of inclusion of these additional funding requirements for the inspectorate to operate as required in the White Paper.

Summary

69) SAPPF is of the opinion that it is not feasible to fund NHI by utilising tax revenue, as the South African Tax base is just too narrow.

70) South Africa does not have a large enough employed population in the working age groups to fund a UHC model exclusively through taxes. Comparisons with other developing countries show that South Africa has a much smaller employed population, much higher unemployment rate,

[31] Office of Health Standards Compliance. Annual performance plan 2015/16 to 2019/20.

lower tax base and much higher GINI Coefficient, making a wholly tax funded UHC model unsustainable in South Africa.

71) Experience in countries such as Korea shows that UHC is difficult to fund, even with much larger tax bases and contribution percentages.

72) At 26.4%, South African unemployment levels are too high for a tax funded UHC system. Other UHC systems in middle income countries are based in economies with an average unemployment rate of 3.8%.

73) The only way to effectively increase availability of Healthcare funding in South Africa would be to increase the discretionary healthcare spend, by increasing Medical Scheme membership numbers. Individuals pay for membership of Medical Schemes out of their own pockets and this is not funded by taxes.

74) The potential administration costs of a large, government administered, single payer NHI Fund have not been considered in the Draft Bill, Green- or White Papers. The costs involved with government administered funds of a similar nature would indicate that private administration of the NHI fund would be the most cost effective option. The administration cost requirements of increasing the capacity if the OHSC to inspect the private sector remains unaddressed.

SAPPF'S SUBMISSIONS ON THE CONTENTS OF THE DRAFT BILL

75) Before commenting more substantively on the contents of the Draft Bill, we point out that there are a number of inconsistencies between the Draft Bill and the Draft MSA Bill which, among other things, makes it unclear how the national health insurance (NHI) regime and the medical scheme regime will function together. It is thus strongly recommended that the Bills be aligned to ensure a more consistent and co-ordinated regulatory framework.

76) SAPPF's submissions on the contents of the Draft Bill are thematically structured as follows:

i) NHI Regulatory Issues;
ii) Operations;
iii) Service Delivery; and
iv) General Comments.

Preamble of the Draft Bill

77) The Preamble to the Draft Bill sets out several laudable goals including the Constitutional obligations on the state to take reasonable legislative and other measures within its available

resources to achieve the progressive realisation of the right of access to healthcare services. The Preamble further states that one of its objectives is to ensure access to good quality personal healthcare services for South African citizens and permanent residents, yet the Draft Bill contains surprisingly few references to the quality of healthcare and the focus appears to be primarily on ensuring financial protection from the costs of healthcare.

78) This protection from the costs of healthcare is, according to the Preamble, to be achieved by the consolidation of public revenue for the active and strategic purchasing of healthcare services based on the principles of universality and social solidarity. While the preceding statement sets out an admirable objective, the Draft Bill contains no provisions relating to the consolidation of public revenue, in fact the converse is true in clause 2 which does not, at least in the interim, allow for any change in the current funding of organs of state in respect of health services.

79) While reference is made to the concept of "strategic" purchasing throughout the Draft Bill, there are no provisions which either define the concept or describe how strategic purchasing is to be implemented and undertaken by the Fund.

NHI REGULATORY ISSUES

Definitions

80) The definitions contained in the Draft Bill refer extensively to other legislation in which concepts are defined. There are, however, references to provisions in the National Health Act, 2003 (NHA) which are yet to be implemented or where the context of such concepts is different from what is intended in the Draft Bill.

81) "Certified" – a health establishment or health agency must be in possession of a Certificate of Need (sec 36 of the NHA). As yet, this provision and its related sections in the NHA have not been implemented. The regulations required for the implementation of the Certificate of Need, in terms of section 39 of the NHA have yet to be published for comment. In essence, the administrative infrastructure and prescribed fees and documentation to issue and deal with the Certificate of Need is yet to be established.

82) "Healthcare Provider" includes the registered practitioners under the Acts referred to in the National Heath Act but does not include other healthcare professionals who provide services in the healthcare sector. The concept "health worker" referred to in the Draft Bill is also not defined as it is in the NHA.

83) "Health Establishment" refers to the same definition contained in the NHA, 2003 (NHA). The NHA defines "health establishment" as "the whole or part of a public or private institution,

facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services." This definition is exceptionally broad and includes both private and public institutions, facilities, buildings or places. The definition also includes private medical practices, whether or not such medical practice forms part of the NHI. We submit that this unintended consequence arising from the breath of the definition should be addressed in the definition of "health establishment", specifically excluding establishments electing not to form part of the NHI.

84) "Health Related products" – This definition is exceptionally broad. Plain interpretation of the wording of this definition would mean to include any product used in traditional medicine or alternative medicines.

85) "Health Services" – differs from the definition of the same concept in the NHA in that reference is also made to provincial and district healthcare services. We submit that the terms used in the various pieces of health related legislation must be defined consistently to ensure conformity in the industry.

86) "Hospital" refers to a health establishment classified as such by the Minister in terms of section 35 of the National Health Act, which is yet to be implemented.

87) "Primary health care services" refers to services that "include" health promotion, disease prevention etc., but does not actually define the concept. In the NHA, this concept is defined as "such health services as may be prescribed from time to time by the Minister". No such prescriptions have been made by the Minister and therefore this concept actually remains undefined.

88) "User" is described as a person and dependents registered as users in terms of clause 8. However the same concept is described differently in the National Health Act. Such conflicting definitions in related legislation require rectification.

89) Several important and integral concepts referred to in the Draft Bill are not properly defined. These include concepts such as services (not) "medically necessary", "health workers", "medical insurance scheme", "universal purchasing", "active purchasing", "executive management" of the NHIF, "non- personal health care services", "personal health services", "horizontal networks", "Contracting Unit", "national pricing regimen", "supplier".

90) It is necessary for the purposes of clarity and the correct interpretation of this Bill that these concepts be properly defined.

Application of the Act

91) The Draft Bill states that it applies to public and private health establishments, but not to military health establishments.

92) It is unfortunate that the wording of clause 2 refers only to public and private health establishments and not to the individuals who are involved in rendering healthcare services. It is clear that the Draft Bill is intended to be applicable to healthcare providers as well as healthcare establishments and this omission from clause 2 should be rectified to reflect this

93) Further, it is unclear why military health establishments have been excluded from the application of the Draft Bill. In terms of the NHA, there is no such exclusion. In fact, the composition of the National Health Council includes the head of the South African Military Service.

94) Given the fact that the stated objective of this Bill is to achieve the right of all to have access to healthcare, it seems peculiar to exclude the rights of those citizens serving in the South African Military.

95) The Draft Bill does not make any reference to how the establishment of the Fund will impact on existing collective agreements between trade unions and the public service. Most notably PSCBC Resolution 1 of 2006, which established the Government Employees Medical Scheme. These collective agreements, as defined in section 213 of the Labour Relations Act, cannot be varied, amended or rescinded in the same way that legislation is amended. Proper consideration must be given to this aspect.

Application of the Act: Funding

96) Clause 2 of the Draft Bill states that there is no change to the current funding and functions of organs of state pending the process referred to in sub-clause 2 whereby sections 77, 214 and 227 of the Constitution are involved. This process is lengthy in nature and prescribes a consultative process with provincial governments, organized local government as well as the Financial and Fiscal Commission.

97) Clause 46, which deals with the sources of income for the Fund states that the Minister must in consultation with the Minister of Finance determine a budget and allocation of revenue to the Fund on an annual basis. It is clear that the allocation of revenue is in line with the principle that the Fund will be publicly funded.

98) Clause 3(4) of the Draft Bill also makes reference to the Fund being a mandatory prepayment health services system. Public funds almost all originate from taxes. These taxes include personal

and company tax, VAT and employer levies. In order for public funds to be utilized to provide finances for the Fund, a portion of these public funds would need to be allocated to the Fund.

99) Until such amending legislation contemplated in sections 77 and 214 of the Constitution is enacted, and the constitutionally prescribed processes are followed, the current allocation of funding to organs of state will remain in place. This will now, at least in the interim, mean that additional funding for the NHI Fund will need to be sourced, either through a mandatory prepayment system, which is only referred to once in the Draft Bill and no other provisions for such a system are made or through the imposition of additional taxation – which would necessitate the introduction of a money Bill by the minister of Finance. Money Bills allocate public money for a particular purpose or impose taxes, levies or duties. They can only be introduced by the Minister of Finance and they must be introduced in the National Assembly. A money Bill must be considered in accordance with the procedure established by section 75. Once it has been passed by the NA, it must be sent to the National Council of Provinces (NCOP). In this case, delegates in the NCOP vote individually and the Bill must be passed by a majority of delegates present. If the NCOP rejects a Bill or proposes its own amendments, the Bill is returned to the NA which will pass the Bill with or without taking into account the NCOP's amendments or it may decide not to proceed with the Bill.

100) It should be noted that, in our view, the cancellation of tax credits on medical scheme membership would not present a viable part of a possible solution to the funding problem. Private contributions by individuals or their employers to private schemes are not part of public funding and the reserves held by medical schemes are subsequently also not part of public funding. Similarly, government's contribution to the private medical schemes of public service employees is an employment benefit and not public funding.

101) It is extremely concerning that the Draft Bill contains no indication of the potential costs of the system, which we anticipate to be extensive given the services to be purchased and the infrastructure that will need to be established in order to administer the Fund and its numerous functions.

102) We have further reservations in respect of the sourcing of funding for the Fund. The process to be followed in drawing up the budget for the fund is to be contained in regulations to be issued by the Minister at a future stage according to clause 52(1)(c). Similarly, matters relating to the fees payable to or by the Fund, Fund reserves, and Fund investment of moneys, nature and level of reserves to be kept within the Fund are all to be clarified in terms of regulations yet to be drafted. This is a critical shortcoming within the Draft Bill and we submit that draft regulations

dealing with these matters should have accompanied the Draft Bill in order for meaningful comment and submissions to be made.

Establishment of the National Health Insurance Fund

103) In terms of clause 3(1) the National Health Insurance Fund is established as a juristic person. In law, a juristic person is capable of suing and being sued in its own name. This would include litigation related to malpractice where an incident of malpractice related to the unavailability of funds, which in turn relates to the benefits and/or the availability of services and/or goods, or related to the accreditation and contracting of service providers, as well as potential litigation arising from the complaints and appeals process in contained in clause 40.

104) Clause 3(2) states the Fund is a national public entity in terms of the Public Finance Management Act, 1999 (PFMA). As such, with reference to the definition of a "national public entity" in the PFMA, the Fund must be fully or substantially funded either from the National Revenue Fund, or by way of a tax, levy or other money imposed in terms of national legislation.

105) The Fund will be the only purchaser of health services, and the only financier of health services. Given the provisions of clause 2(2), it is unclear what the funding for health allocated via the equitable share will be used for, and how other types of healthcare funded elsewhere, will be covered.

106) The Fund is described as a mandatory prepayment health services system. Aside from this clause, there is no mention in the remainder of the Draft Bill of prepayments. Clause 46 which deals with sources of income lists a number of sources from which the Fund may derive income. However, there is no mention in clause 46 of prepayment of contributions by any party. Given the fact that the Fund is a national public entity, as referred to above, we submit that if there are to be mandatory prepayments, these must vest in the National Revenue Fund.

Objectives of the Act

107) Clause 4 of the Draft Bill states that the objective of the Act is to establish the Fund. The Fund must consolidate revenue to protect users against financial risk. Regrettably the Draft Bill does not elucidate precisely how this consolidation of revenue is to be achieved.

108) The Fund must further serve as the single purchaser of health services. This is a concept which is repeatedly referred to in the Draft Bill. However, the Draft Bill makes provision for the users funding healthcare services not covered by the Fund either out of pocket or by medical schemes or insurance products. There are clearly other parties involved in the purchasing of healthcare services and the Fund is therefore not the single purchaser and financier it purports to be.

109) The Draft Bill provides no clarity with respect to the service offering or funding mechanisms which will form part of the NHI system and no provision is made in the Draft Bill to ensure continued sustainability of the Fund. We submit that the Draft Bill should contain provisions regarding the operation of the Fund in a financially sound manner to ensure the continued sustainability of the Fund.

Functions of the Fund

110) Clause 6 describes the powers of the Fund. At clause 6(1)(g) reference is made of the Fund having the authority to insure itself against loss damage risk or liability. As a juristic person this would be necessary, as referred to above, there is the potential for the Fund to be the subject of civil litigation.

111) Clause 6(1)(h) states that the NHIF may (not must) purchase healthcare service, medicines, health goods and related health products of reasonable quality. The use of the term "reasonable quality" is not consistent with the stated objective of the Draft Bill to provide good quality healthcare.

112) Clause 6(1)(i) refers to the function of the Fund to implement best practices in respect of, amongst others, the purchase of healthcare services and procurement of medicines, health goods and health related products. It is unclear what impact this will have on existing legislative provisions contained in the Medicines and Related Substances Act, particularly the role of the Pricing Committee. Clarity is sought on whether the intention is for the Fund to determine the prices of medicines, health goods and health related products in terms of the price determining duties referred to in clause 5(1)(f).

113) In clause 6(2) reference is made to the contracting by the Fund for the purchase, procurement and supply of health services. This clause states that the supplier must be certified in terms of clause 38. However, there is no mention of the accreditation of suppliers in clause 38.

114) Clause 6(1)(p) states that the Fund must enforce compliance with the Draft Bill. However, the Draft Bill does not contain provisions for any mechanism by which such enforcement is to be conducted.

Transitional Arrangements

115) The Transitional Arrangements are set out in Clause 54 of the Draft Bill. A three phase implementation of the Act is described and the details of what must be accomplished in each phase are listed.

116) Clause 54(2) contains the three-phase implementation of the Draft Bill. The first phase of implementation, according to the Draft Bill, encompassed the period 2012-2017 which is already in the past. We respectfully comment that it is perplexing to refer to a time period that has already passed and purport to report on what was accomplished in that period. In addition, as this is a phase of implementation of this "Act", it would have pre-supposed that the "Act" existed prior to the first implementation phase, which it did not. There is thus no rational reason to contain this provision in the Draft Bill.

117) The second phase of implementation of the "Act", is to run from 2017-2022. Conveniently, it includes the development of National Health Insurance legislation which is the same legislation that is being implemented. Interim purchasing of personal health services for vulnerable groups is also to be included in this phase. It is unclear under what legal framework this interim purchasing would take place. Alignment of the human resource models is also envisaged. It must be noted that, apart from the staffing of the Fund, the Draft Bill makes no mention whatsoever of the fate of administrative staff whose roles related to the funding and purchasing of healthcare goods and would become redundant under the Fund.

118) The Draft Bill also makes no mention as to the human resource requirements that may be required by the public sector to ensure service provision, nor where educational institutions would function with the NHIF legislation. The only indication is that the "National Tertiary Health services Committee" would develop a framework governing the "tertiary services platform".

119) At clause 54(4) the objectives that must be achieved in Phase 2 are listed. These objectives present a checklist of the structures and processes that are to be put in place to allow the Fund to function. In addition, this clause provides a list of legislation that will require amendment. We respectfully submit that a more complete description of the proposed amendments to these Acts should already have been included in the Schedule to this Bill. As the Schedule to the Draft Bill contains some, but not all of the required legislative amendments. The result will be a piecemeal and drawn out process of legislative amendments which, it is anticipated will extend far past the state time period of Phase 2.

120) At clause 54(2)(c), describing Phase 3 of the implementation of the "Act", it is unclear what is meant by the term "mobilization of additional resources". The reference to selective contracting of private providers for healthcare services is equally vague. No mention is made on what basis such contracting will occur or how such private providers will be selected.

121) It is presumed that the various interim committees referred to in clause 54(3) which were established in terms of the White Paper would remain in place until the end of Phase 2 (2022) but there is no certainty on this contained in the Draft Bill. It is not clear whether it is the envisaged that the Health Technology Agency or Fund will ultimately be responsible for the assessment of health technologies.

Regulations

122) The Minister is afforded extensive scope, in clause 52, to make regulations on an array of matters. There are 30 sub-clauses which each deal with a particular aspect that the Minister may issue regulations. It is noticeable that there is no reference whatsoever to regulations relating to the determination of prices.

123) Clause 5(1)(f) states that the Fund (not the Minister) must determine prices annually after consultation with healthcare providers, health establishments and suppliers in the prescribed manner which would imply that regulations must be issued to govern this consultative process.

Offences

124) Clause 51 deals with the offences for which fines and/or imprisonment can be imposed. Of concern here is clause 51(3) which states that any penalty imposed under this clause is a debt due to the Fund. We submit that, given the fact that the Fund is to be publicly funded, it may be prudent for such penalties to be paid into the National Revenue Fund as the National Revenue Fund is likely to be principally responsible for providing financial resources to the Fund.

OPERATIONS

Administration of the Fund: Board

125) Clause 13 of the Draft Bill establishes an independent Board to govern the Fund. This Board is accountable to Parliament.

126) Clause 14 states that the Board, not consisting of more than 10 persons, is to be appointed by Cabinet on recommendation of the Minister. It is noteworthy that other pieces of legislation, for example, the Road Accident Fund, 1996, only provides for the appointment of Board members by the Minister, not Cabinet on recommendation of the Minister. The rationale for the deviation is not clear and the impression may be created that the appointees to the Board of the Fund may only be political appointees. It is also noted that the Minister has the power to dissolve the Board but there are no guiding provisions relating to the exercise of this power. We submit that the appointment of the Board should mirror similar pieces of legislation in that members should be appointed by the Minister. Furthermore, the Draft Bill must provide guidance in respect of

the Minister's power to remove Board members, for example, where a Board member is guilty of misconduct, such member may be removed.

127) The qualification requirements for persons to be appointed to the Board are stated in very broad terms. It is notable that there is no requirement in the appropriate technical expertise prescriptions for the person to have any qualification or expertise in healthcare. Similarly, there is no stated requirement for the Board to have a person with expertise and experience in relevant legal fields applicable in healthcare procurement processes.

128) In comparison, the Draft MSA Bill places far greater prescriptive requirements on the composition of the board of trustees for medical schemes than the Fund, as the proposed single purchaser and financer of healthcare services in South Africa. It is therefore imperative that the Board, which in terms of the Draft Bill, has extraordinarily broad ranging powers, must contain individuals of the highest competence and independence.

129) It is submitted that the Draft Bill be amended to make provision for specific positions requiring appropriate professional qualifications. As it stands, there is a severe weakness in the technical requirements for Board Members of the Fund, which in turn, lends the Fund to governance concerns even before it is established.

130) The delineation of the Board and the Minister's respective powers require clarification to ensure accountable and responsible decision-making at all levels.

Administration of the Fund: Chief Executive Officer

131) Part 4 of the Draft Bill deals with matters pertaining to the Chief Executive Officer (CEO). Clause 21 only makes reference to the requirement that the CEO has sufficient experience and technical competence. Given the importance and authority vested in the CEO it is recommended that greater specificity be included in the Draft Bill regarding the level of skills and experience to be held by this individual.

132) The CEO enjoys the responsibility to perform the duties referred to in clause 5 and to take all decisions in clause 6. However clauses 22(2), (3) and (4) states that all functions and responsibilities contained therein are subject to the direction of the Board.

133) Clause 22(3) refers to the establishment of units by the CEO to ensure efficient and effective functioning of the Fund. What is alarming is the absence of reference to a unit which deals specifically with health outcomes and quality of healthcare services provided. The focus here and throughout the Draft Bill, is primarily on cost considerations. It is suggested that more formal attention be given to the quality of health services and the measuring of these outcomes.

Significant public funding will be expended in the pursuance of the National Health Insurance, yet there is minimal reference to the quality of the healthcare that the Fund will be purchasing on behalf of eligible users. This clause presents an ideal opportunity to provide for a unit to be established that considers this crucial component.

Ministerial Committees: Benefit Advisory Committee

134) Clause 25 permits the Minister to establish the Benefit Advisory Committee. It is unfortunate that the wording "may establish" is contained in clause 25(1). This renders the establishment of such a committee as discretionary in the hands of the Minister.

135) It is disappointing, and with respect, short-sighted that there is no prescription in clause 25(2) for representation on the committee of bodies representing the medical profession. There is also no provision for representation by the private medical funding industry. Given the fact that the health services are ultimately rendered by healthcare practitioners this omission is significant.

136) Similarly, there is no representation of the private healthcare industry on the advisory committees. It is unfortunate given the important supportive role the private healthcare industry via the CMS has to play in providing information to the NHI Fund. Further the provision of healthcare, albeit it in a supplemental fashion to the NHI, is nevertheless a crucial component provision of access to healthcare to all.

137) It is of grave concern that this Committee has the responsibility to determine whether or not a service is medically necessary and yet there is no provision for medical expertise in the composition of the committee. Irrespective of which sub-committee may be advising the committee, representation of healthcare practitioners on the committee is vital.

Ministerial Committees: Health Benefits Pricing Committee

138) Unlike the Benefit Advisory Committee, clause 26 compels the Minister to establish a Health Benefits Pricing Committee. This again emphasises the Draft Bill's bias towards concentrating primarily on the costs of healthcare services.

139) It is interesting to note that this is the only ministerial committee where the Minister must appoint a chair and deputy chair from amongst the members of the committee.

140) This Committee is tasked with recommending the prices of health services to the fund and, as such, it is submitted that persons referred to in clause 26(1) not be employees in any government department. There is a concerning lack of detail on how pricing and tariffs will be

addressed in the NHI and whether differential cost bases of rendering services in the public and private sectors will be considered in the setting of tariffs.

Ministerial Committees: Stakeholder Advisory Committee

141) Clause 27 permits the Minister to establish a Stakeholder Advisory Committee. It is unfortunate that the wording "may establish" is contained in clause 27(1). This renders the establishment of such a committee as discretionary in the hands of the Minister.

142) The composition of this committee is predominately made up of representatives from various statutory councils in the health sector. Provision is also made for representation from organized business and labour, tertiary institutions, civil society and NGOs. Again, it is disturbing that there is no provision made for representation of healthcare provider representative organisations or the private medical funding industry.

143) Healthcare professionals themselves are not represented as stakeholders in the Stakeholder Advisory Committee and are thus clearly and, one would assume, deliberately omitted. It should be noted that bodies such as the HPCSA and Nursing Council are not representative bodies for Healthcare professionals but rather tasked with the regulation of the profession. It is not the mandate or function of these statutory councils to represent the interests of healthcare professionals, but rather to ensure compliance with standards of the respective professions, protection of the public etc.

144) Moreover, the heads of these statutory bodies are all appointed by the Minister and therefore 9 of the 18 appointees on the committee answer directly to the Minister in their daily employment function, leading to a severe lack of independence of members of this committee.

145) This committee must, in terms of clause 27(2)(c) provide comments and advice from a public and private healthcare provider perspective. Yet no representation is permitted from such healthcare providers. Strangely there is provision for two representatives from tertiary institutions involved in the training of healthcare professionals.

146) There are also no representatives from the Medical Schemes or medical scheme administrators on this committee. The CMS is a regulator and not a representative body for Medical Schemes.

147) The omissions of the private healthcare providers and the private medical funding industry must be corrected and it is submitted that at least two representatives from both sectors should be included as members of this committee.

Ministerial Committees: Technical Committee

148) Clarity is required on why, in terms of clause 28, the Minister must consult with the National Health Council and not the Board of the Fund when establishing technical committees. The Board of the Fund would presumably be in a better position to advise the Minister on what technical committees may be required from time to time.

Roles: Minister of Health, Departments of Health

149) In terms of clause 32, The Minister of Health will have a governance and stewardship role in respect of the Fund. However, in the remainder of the Draft Bill, many administrative functions and decisions are in the hands of the Minister so the role, in respect of the Fund is far more active than supervisory.

150) Clause 33(1) essentially repeats the role and functions of the DOH which are contained in the National Health Act.

151) Clause 33(2) contains descriptions of services that the Fund will purchase from the Provincial Departments of Health. It is not clear whether there are any accreditation requirements for the purchase of these services.

National Health Information Repository and Data System

152) The inclusion in the Draft Bill of the obligation of the Fund to contribute to the development and maintenance of a National Health Information Repository and Data System as contemplated in section 74 of the NHA is problematic.

153) Section 74 of the NHA states that the DOH must facilitate the creation of a comprehensive national health information system. The Draft Bill seeks to transfer that legislative responsibility from DOH to the NHI Fund. To do so would require an amendment to the NHA which is not referred to in clause 53 of the Draft Bill.

154) To date this System has not been established and the Minister is yet to publish regulations in terms of section 74(2) of the NHA which would prescribe the details of the data to be compiled collated and submitted to the DOH.

155) Clause 5(1)(i) states that he Fund must "contribute towards the development and maintenance of the (NHIRDS)". This statement leads to the conclusion that this system will not be managed by the Fund but rather by some other entity, presumably the DOH.

156) Reference is also made to the "independent data company" which will be responsible to compile and store the data submitted. No provision is made for the minimum standard requirements of

data security that must be complied with, nor is there any reference to the procurement processes required to secure the services of this company. In addition, no mention is made of the term of appointment of such a company. As these matters are not addressed in the Draft Bill, we would expect such matters to be dealt with, in a particular amount of detail, in policy to ensure that that the critically important function of data compilation and storage is conducted appropriately and securely.

Protection of Confidential Information

157) Clause 50 states that the Fund is bound by all legislative provisions regulating the disclosure of personal or other sensitive information. It is notable that there are no references whatsoever in the Draft Bill to the Protection of Personal Information Act (POPI), whereas the Draft MSA Bill expressly provides for the protection of a person's identity, including his or her names, date of birth, address, identity number, medical scheme membership number or health status of the beneficiaries. We submit that a similar protection must be provided for in the Draft Bill.

158) Clause 9(m) states that the user must grant written permission for the disclosure of personal information in possession of the Fund. This excludes instances where the information is shared amongst healthcare providers for the lawful purpose of serving the interests of others; required by accredited healthcare providers for the lawful purpose of improving healthcare; or is utilised by the Fund for any other lawful purpose related to the efficient and effective functioning of the Fund. This latter circumstance is inconsistent with the protections in POPI, and with sections 14 and 15 of the NHA.

Purchasing of Healthcare Services

159) Clause 35 states that the Fund will purchase healthcare services from the public and private healthcare providers. Both the heading and the wording of this clause make it clear that this clause deals only with the purchase by the Fund of services and not health goods and health related products. Although these are both defined in the Definitions clause and are repeatedly referred to in the Preamble and clauses 4, 5 and 6, the Draft Bill contains no other reference to the mechanisms for the purchasing of health goods and health related products.

160) In clause 35(2) an obligation is placed on the Fund to transfer funds directly to certified, accredited and contracted hospitals Funds will be transferred at national level directly to all hospitals based on Diagnostic Related Groups (“DRGs”), set by the Minister in consultation with the National Health Council and the Board.

161) At the provincial level, the Fund must transfer funds based either on a global budget or on DRGs to provincial, regional, specialized and district hospitals. It is unclear why there is an option to use either the global budget or DRGs and the Draft Bill does not specify the basis upon which this determination will be made.

162) However, as is stated in Clause 2 of the Draft Bill, the provisions of section 214 of the Constitution in respect of the province's allocation of the equitable share of revenue remains unaffected (at least until amending legislation has been enacted). There is no reference or mention of this equitable share being transferred to the Fund. There is thus a lack of clarity on precisely how the allocation of funds to the provincial, regional, specialised and district hospitals will occur. The mechanism by which the Fund will collect and allocate monies to provincial hospitals is not clear.

163) With the exception of emergency medical services, there is no provision in clause 35 for the purchasing of healthcare services from certified, accredited and contracted private health establishments. Clause 35 also makes no provision whatsoever for payment to healthcare providers outside of the hospital context, nor is there any mention of the payment of private healthcare providers despite the obligation of the Fund to actively and strategically purchase healthcare services from private healthcare providers. It is concerning that, as the Draft Bill presently stands, there is no provision for, or mechanism whereby private health providers are paid directly.

District Health Management Offices

164) Clause 36 refers to the District Health Management Office that is established by an amendment to the NHA intended to be brought about in terms of clause 53 of this Bill and is tasked with facilitation, coordination and management of non-personal public health care programmes which programmes are undefined. It is unclear how "non-personal" healthcare programmes, which do not form part of the healthcare services that the Fund purchases on behalf of users, relate to the functions or duties of the Fund. There is also a requirement to clarify where the funding for "non-personal" healthcare services will originate, as the Fund will not pay for these.

Contracting Unit for Primary Care

165) Clause 37 refers to the Contracting Unit for Primary Health Care (CUP). It is unclear how this CUP is to be established and what legal status it enjoys. This is a critical lack of clarity as the Fund, in terms of this clause will, amongst others, contract with the CUP for the provision of primary health care.

166) The CUP is ostensibly to be comprised of district hospitals, clinics and or community health and ward based-outreach teams. In addition to these public entities, the CUP is also to include private primary service providers organised in horizontal networks. There is thus a grouping together of both public and private entities. With regard to the public entities, these form part of the provincial departments of health and are not independent juristic persons that have the capacity to enter into contracts. Similarly, the private networks are themselves not necessarily entities that have contractual capacity.

167) Assuming that these legal obstacles are overcome, the clause is confusing in respect of the nature of this contractual relationship. Clause 37(1) states that the CUP is the organisational unit with which the Fund contracts to provide primary health care services, but it is not the CUP which will provide the primary healthcare services in the specified geographical sub-district areas. The CUP appears rather to fulfil a monitoring and enforcement function for the Fund. It will, in terms of clause 37(2), be responsible to assist the Fund in an array of functions that the Fund (and not the CUP) will perform. The CUP can therefore be regarded as a functionary of the Fund performing a supportive role, but not an entity with which the Fund contracts for the provision of primary healthcare services.

168) It is submitted that the CUP as described in the Draft Bill does not have contractual capacity to enter into any agreements with the Fund and a revision of the clause is required.

Accreditation of Service Providers

169) Clause 38 refers to the accreditation by the Fund of both public and private service providers. Such providers must deliver services at an appropriate level of care. The use of "appropriate" may refer to the quality of care, but this is unclear, particularly in the absence of any mechanisms within the Draft Bill to determine quality of care and health outcomes.

170) In order to obtain accreditation from the Fund, the service provider must be in possession of certification by the Office of Health Standards Compliance as well as proof of registration with the relevant statutory council.

171) Accreditation is also dependant on the provision of the "required range" of "personal health care services". A difficulty that arises here is that the "personal health care services" is a concept that is undefined. Clause 38(b)(i) merely refers to the Minister, in consultation with the Fund, publishing the required range of these services from time to time as required. This is an untenable requirement. Should the required range of services be amended or changed from time to time, it is conceivable that the healthcare provider may not be in a position to render the

new required healthcare services and, this would, in terms of this clause result in their accreditation being withdrawn. We submit that the healthcare provider's accreditation must not be dependent on the provision of the "required range" of “personal health care services”.

172) A further requirement that must be met for accreditation is the allocation of the appropriate number and mix of healthcare professionals to deliver the specified healthcare services. The HPCSA, for example, discourages group practices across statutory health councils. The legislation and guidelines relating to group and multi-disciplinary practices must be reviewed and, if necessary amended before such a requirement is enforceable to obtain registration.

173) The further criteria for accreditation listed in clause 38(2)(b) (iii-vi) relating to adherence to treatment protocols and guidelines, health care referral networks, submission of information and adherence to the national pricing regimen cannot be complied with until the accreditation has been granted and the healthcare provider has been contracted to render services. These criteria should, it is submitted, be placed under the requirements to retain accreditation.

174) The Draft Bill, in the Schedule to clause 53, seeks to amend the NHA by inserting the requirement to be granted a Certificate of Need that a health establishment or health agency must be accredited in terms of section 36 of the National Health Insurance Fund Act. (There is clearly a numbering error here as accreditation occurs in term of section 38 of the NHIB and not section 36). Additionally the Certificate of Need will now be withdrawn if the health establishment or health agency has their accreditation with the Fund withdrawn or not renewed.

175) This amendment has significant consequences for all healthcare providers in that they will have no alternative but to obtain accreditation with the Fund in order to obtain a certificate of need, without which such practitioners cannot operate their practices. The same would hold true for private health establishments. It also creates an unintended consequence of being unable to comply with either requirement in a vicious circle of non-compliance: one cannot contract with the Fund without a Certificate of Need and one cannot obtain a Certificate of Need without contracting with the Fund.

176) The difficulty arises from the broad definition of “health establishment’ in the NHA, which is taken over in this Bill. The definition in the NHA reads as follows:

> ***“health establishment”*** *means the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to*

provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services;"

177) It is clear from this definition that a specialist medical practice would fall under this definition and therefore require a Certificate of Need in terms of the National Health Act, and consequently under the Draft Bill.

178) It is important to note that sections 36-40 of the NHA (Certificate of Need) have not yet been implemented. They are applicable to both public and private health establishments, so there will be a requirement for every single health establishment, public or private, to apply for and obtain a Certificate of Need.

179) On 23 March 2014, a Proclamation 21 of 2014 was issued by the then State President activating these sections as of 1 April 2014 which was met with significant resistance on legal and logistical grounds. Ultimately, the Constitutional Court set this proclamation aside. Significantly, it was argued, that in order to issue Certificates of Need, it would be necessary to publish regulations to create the administrative infrastructure.

180) Without the necessary administrative infrastructure, the Certificate of Need cannot be issued and therefore health establishments and health agencies will not be able to obtain this particular certification. In addition, the NHA at section 39 provides for a 24 month period for health establishments to obtain a Certificate of Need.

181) In the event that section 36-40 of the NHA are brought into force, whether or not the proposed amendments to these sections made in terms of this Bill are included, it will be necessary to first publish the required regulations to establish the administrative infrastructure and determine the prescribed forms and fees in order to consider and grant or refuse applications for certificates of need. Section 36(1)(d) states that no one may continue to operate a health establishment or health agency after the expiration of a twenty four month period from the date that the sections take effect.

182) It is therefore submitted that the amendments to section 36 of the NHA proposed in terms of clause 53 of this Bill be reconsidered.

Payment of Service Providers

183) A critical component is in respect of the payment of service providers. In clause 39, it is stated that service provider payment mechanisms must be determined by the Fund in consultation with the Minister. It is of grave concern that this fundamental function of the Fund being the

purchaser of health services has yet to be regulated. It is not clear whether due consideration has been given to the payment of providers.

184) The Fund must also adopt mechanisms to ensure that the providers and establishments are properly accredited. Clause 38 of the Draft Bill deals with the accreditation of service providers that are healthcare providers and establishments as defined in the Draft Bill. Clause 38 does not, however, deal with the accreditation of suppliers. Unfortunately, "suppliers" is one of the concepts used frequently in the Draft Bill but is not defined. It is assumed that the term supplier refers to entities that manufacture, distribute or sell health products and health related goods, but the fact remains that there is no reference to the accreditation process for such suppliers in clause 38 or elsewhere in the Draft Bill.

185) In terms of clause 39(2), specialist- and hospital- services will be all-inclusive and based on the performance. Quite how this performance will be assessed is unclear. It is also not apparent form the wording of the Draft Bill how this reimbursement will occur under the Diagnostic Related Grouper (DRG) system of funding, similar to provincial hospitals in the public sector. It is important to note that implicit in a DRG payment is that a Specialist is employed by the facility receiving the DRG payment or has some other fee sharing arrangement in place, both of which would require review of HPCSA rules.

186) Clarity is sought on what is meant by accredited primary service providers being at health establishments. The inference may be drawn that those primary service providers who are not physically present at health establishments are not to be reimbursed on a risk-adjusted capitation basis and we trust that this is not the intention of the drafters of the Draft Bill.

187) Clause 39(4) states that primary service providers must be contracted by the CUP. However, as pointed out, the CUP as it is presently envisaged in the Draft Bill will not have contractual capacity and will thus not be able to enter into any agreements with primary service providers.

188) The provisions of clause 39 make no allowance for direct payment of service providers, especially as it pertains to specialist care required outside of hospitals.

Reimbursement for Services Rendered

189) Clause 6(2)(e) places a requirement on healthcare providers to render services at the "lowest possible price". This imposition implies a generalisation that healthcare providers have not, in the past, given due regard to the costs of the services that they render. Such implication is both unfair and untrue, as shown by the recent publication of the Health Market Inquiry interim report, not naming excessive pricing as a cost driver in the market. Further there is an

implication that there are those healthcare providers who are not "able" to provide services at the lowest possible price. It is submitted that this sub-clause be removed from the Draft Bill.

190) The tariffs set by the NHI Fund in terms of this Bill must take into account the realistic and reasonable cost incurred by healthcare providers in rendering the service. The methodology to be followed in determining the tariffs must be transparent, inclusive and procedurally fair.

191) Failure to adhere to a reasonable tariff determination process will undoubtedly have significant consequences and long-term effects on the sustainability and availability of healthcare providers in South Africa.

192) Clause 10(1) is, with respect, poorly worded. It refers only to the reimbursement of healthcare providers and while the intention may not have been to exclude reimbursement for health establishments, this is precisely what the content of this clause implies.

193) Clause 10(3) provides that treatment will not be funded if a healthcare professional can show that there is no medical necessity or no cost-effective intervention for the service provided. Should there be an investigation into the medical necessity of a service rendered to a user, then that investigation must be properly regulated and conducted by appropriately qualified and experienced healthcare practitioners. The determination of the necessity of the service cannot be made by a single "healthcare professional". Similarly, the refusal to fund treatment on the basis of the absence of a cost-effective intervention subjects the user's right of access to healthcare to cost considerations alone. The term cost-effective is further disturbing and there is no metric by which cost-effectiveness is established.

194) Where the Fund refuses to provide treatment, in terms of clause 10(4), a user would be entitled to be informed of such decisions and be entitled to make representations to such a refusal and be informed of the decision of the Fund. Clause 10(5) affords the user the right to lodge an appeal in terms of clause 40. There is no provision, either in clause 10 or in clause 40 for an expedited appeals process in instances where any delay in receiving medical treatment would be significantly prejudicial to the user concerned. This deficiency in the Draft Bill must be rectified.

195) Clause 10(3) implies that reimbursement will follow a process of scrutiny on a case by case basis and that care will be reimbursed on a case by case basis. However, reimbursement in the form of DRGs and capitation will not necessarily pick up on individual instances of care being rendered in these prohibited circumstances.

196) The Draft Bill contains no clear provisions on how reimbursement of healthcare providers will be managed. Clause 35(2) and (3) clearly provides that funds will be transferred directly to health

establishments, but no such certainty is present with regard to healthcare professionals. Clause 39 merely states that the Fund, in consultation with the Minister must determine the nature of provider payments at some point in the future.

197) Reference is made in clause 6(1)(ii) to the payment of healthcare providers and "health workers". It is unclear who "health workers" will be in this Bill. In the NHA they are defined as persons excluding healthcare providers, who are involved in the provision of healthcare services. The phrase "health institutions" is assumed to be the same as "health establishments".

SERVICE DELIVERY

The National Health Insurance Fund

198) Clause 5 of the Draft Bill refers to the duties of the Fund. The Fund will not only be responsible for the financing and purchasing of healthcare, it will determine the benefits to be provided, and enter into contracts with healthcare providers and suppliers.

199) Clause 5(1)(f) states that the Fund will determine prices on an annual basis, following a yet to be prescribed, consultation process with healthcare providers and establishments. This process has similarities to the processes previously followed in terms of section 90 of the NHA in determining a National Reference Price List. Of concern here is the nature of the consultation process. It is not, as yet, clear to what extent healthcare providers and establishments will be permitted to submit information relating to their costs of services or to actively engage in a negotiation process.

200) In terms of this Bill, the Fund will strategically purchase healthcare services and goods. An annual determination of prices limits the Fund's flexibility in negotiating prices and follows the same processes as the Road Accident Fund and Compensation Fund. It is not clear what is meant by the term "strategically".

201) The Fund must, in terms of clause 5(1)(g), take measures to ensure appropriate funding consistent with "the concepts" of primary, secondary, tertiary and quaternary care. It is assumed that this means that no level of care will be excluded from the NHI benefits. However, the Constitutional concept of taking measures, means that not all care within these levels are likely to be covered, but that there should be some progressive and incremental process to increase cover. In this regard, the amendments proposed for the medical schemes sector is very relevant: if the medical scheme's mandatory benefits mirror the NHI benefits, the provision of other, non-mandatory benefits, become discretionary. As the funding pools underpinning the current

medical schemes, and those which will underpin the NHI, will differ, it is unclear what will happen to care that is required, but remain unfunded as a mandatory component in either system.

202) Several functions, in terms of other legislation, are effectively being taken over by the Fund. In respect of the National Health Information Repository and Data System, the clause 5(1)(i) assigns the duty to "contribute towards the development and maintenance" of this system, yet it is the Fund that will appoint the independent data company to administer this function which implies that the fund is not contributing, but rather taking on the responsibility of facilitating and administering the system (albeit on an outsourced basis). Section 74 of the NHA assigns this responsibility to the DOH.

Eligibility and Registration as Beneficiaries of the Fund

203) Clause 7 of the Draft Bill describes those individuals who are eligible to have comprehensive health service benefits purchased on their behalf by the Fund.

204) Of concern is the limitation on refugees and asylum seekers who have not been granted refugee status in terms of the Refugees Act to access only emergency healthcare service, services for notifiable conditions of public health concern and primary health care level paediatric and maternal services.

205) The Bill of Rights provides for the right to have access to health care. Section 27 of the Constitution states that: (1) Everyone has the right to have access to— (a) health care services, including reproductive health care; and (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. Section 39(1) of the Constitution provides that when the Bill of Rights is interpreted, international law must be considered. Under international human rights laws such as the Convention relating to the Status of Refugees, Geneva, 28 July 1951 and its accompanying protocol, refugees are entitled to the same treatment as is accorded to South Africans in respect of, inter alia, employment injury, occupational diseases, maternity, sickness, disability, and old age. The Refugees Act, 1998 also provides that a refugee is entitled to the same basic health services as South African inhabitants (section 27). There is no distinction between citizens and refugees and asylum seekers made in the Constitution and this would, if not addressed by the drafters of this Bill, potentially leave the Draft Bill open to a constitutional challenge.

206) It is notable that refugees and asylum seekers are afforded the constitutional right to receive emergency medical treatment, but are excluded from the commensurate right to have access to

healthcare. This is exacerbated by the absence of any other reference to access to or coverage for healthcare for this group of individuals.

207) According to clause 8, any eligible person must register themselves and their dependants as users with the Fund. This registration must take place at an accredited public or private healthcare establishment.

208) It is clear that there is an administrative structure that must be in place to regulate and issue proof of such registration. This will necessitate further costs to run such a system.

209) In order to access healthcare services, the user must present proof of registration. No provision is made for a system that allows healthcare establishments/facilities to verify the registration in instances where the user no longer has the required documentation or verification process for the establishment to verify that the bearer of the documentation is, in fact, the registered user.

Health Services Benefits Coverage

210) Clause 11 of the Draft Bill empowers the Fund to purchase "comprehensive health service benefits" for the benefit of registered users. Regrettably, the term "comprehensive health service benefits" is not defined in the Draft Bill and there is no indication of what these services would include. Registered users are obliged, in terms of clause 2(2)(a), to be registered with a provider of primary healthcare services, which provider will be their point of entry to access services purchased on their behalf by the Fund.

211) In terms of clause 11(2)(a), users are required to be registered with a provider of primary health care services of their choice, who is the first point of call for health services. In terms of clause 11(2)(b), a user will not be allowed to seek the services of specialists and hospitals without first obtaining a referral from his or her health care provider, except in cases of emergency. The Draft Bill does not specify whether covered health service benefits are reimbursable in these instances.

212) A further difficulty here is that the "provider of primary healthcare services" is not clearly defined. In terms of the definition of "primary healthcare services" contained in the definitions clause, these are services that include health promotion, disease prevention, curative, rehabilitative and palliative services. The implication of this registration requirement is that the user would be bound to register with a particular service provider who may not be in the field of services which the user, at a subsequent stage, may require.

213) We also note that the Draft Bill does not define "medical insurance scheme" or "private insurance scheme", but "medical scheme" is defined to mean "a medical scheme as

contemplated *by the Medical Schemes Act.* The use of the term "*other private [health] insurance schemes*" in clauses 9(o) and 12(2) and 52(1)(n) suggests that it covers any health insurance scheme that falls outside the meaning of medical scheme. The fact that reference is made to "*private [health] insurance schemes*" as opposed to individual policies or gap cover is confusing, as not all providers of these products are necessarily "schemes" as this word is ordinarily understood. We submit that without affording clear meanings to undefined terms used in the Draft Bill, it is difficult to meaningfully engage with the provisions.

214) The inconsistent use of terminology in these two sub-clauses needs to be rectified.

215) Of particular concern is the provision in clause 11 for the Benefits Advisory Committee to make determinations, albeit in consultation with the Minister and the Board, on the health service benefits to be provided by the Fund. Additionally, this Committee must further make recommendations on how the services will be accessed as well as treatment guidelines and protocols. It is necessary to reiterate that there is no representation of healthcare professionals whatsoever on this Committee which would be able to give guidance on treatment guidelines and protocols. No process is provided for to ensure that the treatment guidelines and protocols are evidence-based and of the highest quality. It is further unclear from the wording of the Draft Bill how the existing Essential Medicines List and Standard Treatment Guidelines will be integrated, if at all.

216) The only guidance given to the committee in respect of determining the comprehensive health service benefits is that the amount of potential funds available must be taken into account. There is disappointingly no reference to the minimum standards or quality of the health services to be included.

217) The Benefits Advisory Committee has wide ranging powers in respect of determining whether or not the services being sought by the person are “medically necessary”. Again, without appropriate clinical expertise being present on the committee such determinations would be open to challenges either within the appeals process of the Draft Bill or by a competent court.

218) In clause 12(2)(b) reference is made to the referral pathways determined by healthcare providers or health establishments referred to in clauses 11(1) and 11(2). Clause 11(1) makes no reference to referral pathways and clause 11(2) only refers to the referral requirement to obtain the services of a specialist. It is unclear whether there are other referral pathways which have been omitted from clause 11, but clarity on this issue is required.

Cost Coverage

219) Clause 12 deals with beneficiaries and users obtaining the health services purchased by the Fund at no cost, provided the beneficiaries/users adhere to the various obligations imposed on them in terms of this Bill. Should the user/beneficiary not adhere to these requirements, the clause states that they will be required to pay for the services themselves, either through voluntary medical insurance scheme or private insurance products. The Draft Bill fails to define a "private medical insurance scheme" and further fails to take into account that the medical scheme legislative framework outlaws insurance schemes carrying on the business of a medical scheme.

220) It appears that the intention is for the NHI regime and medical schemes or private health insurance regime to exist in parallel, however, the interrelation and possible overlap between the Fund, medical schemes and private health insurance is never explicitly addressed in the Draft Bill. The Draft Bill also does not specify whether a user may "opt out" of using the Fund entirely and elect to fund medical expenses falling within the scope of the Draft Bill by contracting with medical schemes or private health insurance schemes.

221) We reiterate our concerns regarding the Benefits Advisory Committee's lack of appropriate expertise to determine whether or not a service is medically necessary – a ground upon which a user/beneficiary and be denied cost coverage.

Complaints and Appeals

222) The complaints process described in clause 40 does not adhere to the principles of administrative justice. The process, in short, consists of the complainant lodging a complaint followed by an investigation by the Investigating Unit and the ensuing recommendations made by the Unit to the CEO of the Fund. The complainant is then informed of the decision of the Fund. The difficulty arises in that the decision is taken by the Fund before the complainant has had the opportunity to make representations. These representations will then be considered by the Fund, whereupon the complainant will be furnished reasons for the initial decision. This process is incorrect as the complainant is only provided with reasons or the decision after having made representations, no further opportunity for representations after these reasons have been furnished is available. The clause does not allow the Fund to change its initial decision.

GENERAL COMMENTS AND OBSERVATIONS

223) The Draft Bill seeks to attain the constitutional objective of achieving the progressive right of access to healthcare services to all and to ensure protection from the costs of healthcare. These

are commendable ideals and are to be supported. However, we hold the view that the Draft Bill, in its present form, falls short of this objective.

224) We have described numerous points of concern with this Bill in comments above, and, no doubt other interested parties will echo these concerns and raise concerns of their own.

225) The Draft Bill appears to be, for the most part, a statement of policy and extensively defers important tasks to yet undrafted regulations.

226) The Draft Bill does not adequately address the issue of the funding of the NHI. This critical aspect is deferred to a later, undetermined stage. The alternative funding options that are available and that are not included in the Draft Bill, may need to be considered and this, in turn may lead to a fundamental revision of the Draft Bill. Further should it be decided to levy an additional tax in order to obtain funding, the Draft Bill will become a section 77 Money Bill which must be introduced by the Minister of Finance and follow the legislative process anew.

227) The impact of the establishment of this Fund on existing administrative structures and personnel in the healthcare sector, particularly the public health sector, is not addressed in the Draft Bill.

228) Of particular concern, to the SAPPF is the omission of reference to healthcare provided by specialists. The focus of the Draft Bill appears to be primarily on primary healthcare and this focus disregards a crucial component of healthcare services.

229) As referred to in our comments above, the Draft Bill contains numerous terminological inconsistencies and lack of proper definitions of fundamental concepts. These must be remedied in order for the correct interpretation of the Draft Bill.

230) The Draft Bill proposes extensive legislative amendments, only some of which are contained in the Schedule to the Draft Bill. There is no indication of when, and to what extent other legislation will be amended but it is our view that it is unlikely that these amendments can be effected in the time frame envisaged in the transitional arrangements portion of the Draft Bill.

231) The Draft Bill also does not take into account the current legislative framework in respect of procurement.

232) The outsourcing of the National Health Information Repository and Data System to an independent company is, with respect, ill-considered.

233) It appears that the intention is for the Fund, medical schemes and private health insurance to exist in parallel, however, the interrelation and possible overlap between these regimes are not explicitly addressed in the Draft Bill. This must be rectified.

234) The Draft Bill, while allowing the purchase of "complementary health service benefits," does not specify whether a user may "opt out" of using the Fund entirely and elect to fund medical expenses falling within the scope of the Draft Bill by contracting with medical schemes or private health insurance schemes. The position must be made clear in the Draft Bill.

235) In conclusion, it is submitted that the Draft Bill, in its present form will not achieve its stated objectives.

Yours sincerely,

Chief Executive Officer

20 September 2018