

Clarification on NHI

National Health Amendment Bill, 2018 and Medical Schemes Amendment Bill, 2018

On 21 June 2018 the Minister of Health, Dr Aaron Motsoaledi, announced in a press briefing the simultaneous release of the two complementary Bills.

National Health Amendment Bill

The National Health Amendment Bill comprises 9 key segments: (1) NHI Fund; (2) Right to Health Care (eligibility as beneficiaries); (3) the Board of the Fund; (4) CEO of the Fund; (5) Ministerial Committees; (6) General provisions applicable to the operation of the Fund; (7) Complaints and Appeals; (8) Financing; (9) Miscellaneous.

This Bill and associated legislative changes becomes a key feature of Phase 2 of NHI implementation (2017-2022) and will involve amendments to 12 laws in total, including the National Health Act and the Mental Health Act.

The South African Medical Association (SAMA) considers a number of the proposals as reasonable and adhering to the principles of the universal access to healthcare, notably for the most vulnerable of the South African population.

For example, servicing according to need, mandatory prepayments and the provider-purchaser split, an **independent** Board (Section 13), and the determination to fight corruption are some of the progressive elements proposed. Additionally, the Bill is explicit that it legislates both the public and private sectors, that it has allowance for a medical schemes industry through complementary cover, and that it holds both sectors equally accountable for various aspects of service implementation, such as quality and costs of services. Some aspects of the Bills are unfortunately vague and require further engagement.

At this juncture, SAMA's major concerns with the **NHI Amendment Bill** are:

- a) **Quality of care:** there are no assurances that the intended right to expand access refers to access to HIGH QUALITY care. Further, to achieve its full goals, the NHI must not result in quality of care lower than currently experienced by medical scheme beneficiaries. Instead, NHI should seek to address the quality of care currently not enjoyed by non-medical scheme beneficiaries. Complementary medical scheme cover will only be fair if the NHI Fund purchases healthcare in public and private sector and consistently provide good quality healthcare. Currently, the state has not proved that it is competent to provide good quality healthcare and there is no certainty that NHI Fund will be able to contract services with Private Providers and Private Healthcare Professionals. This may necessitate duplicative medical scheme cover to avoid violation of rights to quality healthcare.
- b) The intention to 'contract both public and private' must not end as lip service. Strategic purchasing must be impartial (NOT biased towards the public) but

must draw on the full capability of the private sector. The private sector has capability to bring competition and improve quality of care especially if reimbursement mechanisms emphasise and reward performance. Involvement of the private sector will assist the government to progressively realise the right to healthcare rather than seeing this sector as some impediment to this ideal.

- c) The emphasis on 'gatekeeping' (appropriate use of lower levels of care) must not unduly restrict higher levels of care for patients who genuinely need secondary, tertiary and quaternary services.
- d) The Bill encourages Healthcare providers and Doctors to provide services at the 'lowest possible price' (Sec 6.2(e)). SAMA reiterates that Doctors will accept the imposed tariffs only to the extent that such tariffs are reasonable and consistent with realistic costs of service provision. Price determination must be evidence-based, transparent and procedurally fair.
- e) The omission of Medical Professional Associations on the Benefits Advisory and Stakeholder Committee (Section 25) is ill-considered and seems like an intentional but short sighted blunder.
- f) The Office of Health Standards Compliance (OHSC) needs to be capacitated to assess and accredit all the public and private sector facilities. The Office needs the same level of independence as the current Chapter 9 institutions.

The Medical Schemes Amendment Bill aims to harmonise the medical schemes industry with an NHI environment. The Bill comprises 10 fundamental amendments, summarised below with our initial comments:

1. Abolishment of Co-payments:

SAMA would be willing to support the abolition of co-payments, on the premise that any agreed Doctor tariffs are appropriately negotiated and pegged to realistically cover the costs of healthcare. The abolition, based on the 25% reserves funds, must remain as per legislation and any change in this regard would require a change in this regulation. It is important to note that these reserves provide a critical buffer for scheme members.

2. Abolishment of Brokers:

SAMA supports this as the abolishment of brokers will aid in reducing non-health care expenditure. It is very important that the money saved from brokers be used to expand health services.

3. Abolishment of Prescribed Minimum Benefits (PMBs) and their replacement with Comprehensive Service Benefits:

The apparent basis for this shift is that current PMBs have been hospital based. Comprehensive service benefits will include Primary Health Care services like family planning, vaccination, screening, and wellness services. However, the Ministry and the Council for Medical Schemes (CMS) must recognise that secondary, tertiary (specialised) and quaternary (sub-specialised) services are equally essential, and successful primary healthcare will create demand for specialised services for about 20% of the population. We reiterate to the government that enabling sufficient specialised services will avert serious catastrophes such as Esidimeni tragedy and the Oncology crises.

4. Unfair and unequal benefit options:

Section 33 of the current Medical Schemes Act (MSA) is to be substituted. SAMA is deeply concerned that the proposed substitution will not achieve the fairness and equity objective. The provisions of the current MSA are very prescriptive and protective in terms of registration of benefit options. Mandatory provision of PMBs offers health and financial risk protection. Therefore, to protect the health of beneficiaries, all benefit options registered by CMS should include the newly proposed comprehensive service benefits.

5. Conducting business as a medical scheme by a person not registered as a medical schemes to be an offence:

This is in view of the proliferating Hospital Plans and Cash Back plans that are registered not with the CMS but with the Financial Sector Conduct Authority. This declaration is a welcome move that will ensure that risk pools are not further fragmented and beneficiaries are maximally protected.

6. Establishment of a central beneficiary registry and provider registry:

Presently medical schemes are unwilling to share information on beneficiaries or Healthcare providers and Professionals. The provider registry seeks to register all Healthcare providers and Professionals, and gives CMS powers to ascertain monies paid by the Medical Schemes. SAMA is examining Section 32 of the proposed amendment to understand impact of this on health Professionals and whether it violates their rights to privacy

7. Introduction of income cross-subsidies:

Income cross-subsidisation is a solidarity principle that SAMA supports, as this will reverse the currently experienced regressive cross-subsidy, i.e. the middle income/ plans cross-subsidising the elite plans. Even with this new measure in place, vigilance must still be maintained as medical schemes' design of benefit options can disproportionately attract and favour a particular socioeconomic class.

8. Compel medical schemes to pass back savings if a member uses designated service providers according to the rules of the schemes.

We support this intervention with its potential to provide relief to scheme beneficiaries in the form of affordable or lower premiums.

9. Cancellation of membership and waiting periods:

SAMA welcomes waiving of general waiting periods; however we are concerned about the expansion of the definition of a condition specific waiting period to include a further condition where a primary cause is the specified condition. This would be particularly difficult in terms of a condition of multiple causality.

10. Governance of medical schemes:

SAMA welcomes the provision for Governance of schemes however these provisions must also apply to managed care organisations and administrators. Managed care organisations make healthcare decisions at a population level. Their decisions have impact upon society, hence employees of managed care organisations should possess professional qualifications and be subject to professional regulation.

In summary, there are aspects to the Bills that are to be welcomed – much of this is tempered by the detail that remains lacking, notably with respect to the NHI scheme. Sadly, for many of our members, given the enormous challenges within the public sector, any grandiose ideas for healthcare are not shared as for most just having a functioning system would suffice. SAMA also remains very sceptical of the given timelines. We would hope government can present a clear and coherent plan for the revitalisation of the public healthcare system that is so desperately required. More especially, the human resources we have in our healthcare system, both public and private, are to be cherished and regarded as an asset to be utilised wisely for the benefit of our country. They are not a dispensable commodity as is unfortunately sometimes how they are dealt with.