Hospital Association South Africa
Advancing Healthcare

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Portfolio Committee on Health
Parliament of South Africa
c/o
Ms Vuyokazi Majalamba
vmajalamba@parliament.gov.za

29 November 2019

Re: Written Submission by the Hospital Association of South Africa on the National Health Insurance Bill [B 11-2019]

The Hospital Association of South Africa ('HASA') welcomes the opportunity to provide written submissions on the National Health Insurance Bill ('the NHI Bill). to the Portfolio Committee on Health.

HASA's submissions reflect the views of the private hospital industry in South Africa. The HASA membership consists of:

- the three stock exchange listed private hospital organisations in the country – Mediclinic, Life Healthcare, and Netcare;
- the National Hospital Network, a voluntary association of 220 privately owned, independent hospital facilities; and
- independent hospitals such as Wisani Medical Centre and Joint Medical Holdings.

HASA members provide a range of hospital facilities, from acute care hospitals, to sub-acute day hospitals, to ophthalmology outlets, mental health facilities and rehabilitation centres.

The economy wide impact of HASA's membership includes employment of close to 250 000 employees, and constitutes 1.8% of capital stock, and 1.3% to the GDP (R55.5bn) in South Africa.[1] HASA's members make up approximately 30 500 of the 40 500 licensed private hospital beds in South Africa, across over 500 facilities. It is a high capital and labour intensive industry, relying heavily on new technologies and capable, skilled professionals to advance improved health care outcomes for patients.

HASA's purpose is to represent its members and serve the interests of patients in private health care by promoting quality care and patient safety. It is with this purpose in mind, that HASA makes these submissions on the National Health Insurance Bill ('the NHI Bill').

[1] Econex (2018). Economic contribution of the three JSE-listed private hospitals.

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General Comments on the NHI Bill

1. HASA unequivocally supports the objectives of the NHI Bill recognising that the realisation of universal health is, not only a bedrock of our Constitution, but it is inextricably part of achieving our social and economic developmental potential and aspirations as a country. Access to quality health care by all South African's will fundamentally contribute to self-determination, dignity and realisation of human rights. Achievement of universal health will strengthen our society, and determine our human capital potential to advance our economy.[2] It is therefore imperative that the NHI provides the necessary framework and provisions to realise universal health care..

2. It is a fact that many South Africans do not have access to quality care. This lack of access to public or private quality health care is largely skewed along racial lines, and perpetuates the persistent effects of Apartheid. It is in this context that HASA acknowledges the necessity for health care reform. A radical and fundamental shift is required towards a **human-centred approach**[3] to health care. This must put the person's best interests first and foremost in the vision of universal health care for all South Africans. HASA notes and endorses the move towards implementation of a NHI thereby expanding access to universal health care. Indeed, the move towards a universal health insurance system, albeit with a range of different funding models, is a worldwide phenomenon given its obvious benefits.[4] Further, HASA endorses the approach of the NHI to include private health care, and, in particular, private hospitals in the delivery of this vision.

3. A human-centred approach recognises that more efficient processes, systems and funding mechanisms are required to achieve universal health care. The current system lacks sufficient resources, efficiency and accountability to drive the necessary health care outcomes. It also recognises that there are competing priorities and current constraints that will determine the pace at which universal health care can be achieved. Fundamental thereto is the availability of: trained specialists, doctors, nurses and hospital administration; infrastructure and equipment; operational and information systems; and the fiscal space and financial resources to invest in and purchase services from the health care sector.

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[2] World Bank Human Capital Index quantifies the contribution of health and education to the productivity of the next generation of workers. In doing so it recognizes that human economic potential is a function of education and health outcomes. https://www.worldbank.org/en/publication/human-capital

[3] International Labour Organisation Centenary Declaration for the Future of Work, adopted on 21 June 2019. https://www.ilo.org/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_711674.pdf

[4] IFC, a division of the World Bank presentation on 'The Private Sector and NHI: Lessons from Other Countries', October 2019

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4. Given the constraints and competing priorities, it is incumbent upon policy makers to design the NHI in a manner that takes cognisance of both the vision of universal health care and our resources as a country to achieve same. HASA is of the view that the NHI Bill lays a credible basis for the achievement thereof, provided certain unintended consequences are addressed and that it is designed in a manner that is unambiguous and certain.

Achieving a Human–Centred Approach to Health Care

5. HASA is of the view that a human-centred approach, as outlined above, should be premised on the following basis:
   - No person should be left behind, the aim being to enable optimal access to quality health care services for all South Africans.
   - People's choice of health care provider and private funding thereof, while contributing to a national fund, should be respected wherever possible.
   - Maximum utilisation of available resources for health care – optimising the capabilities of both the public and private sector.
   - Driving efficiencies to secure the best quality care available from the public and private investment into health care.
   - Incremental and progressive improvement in quality of and access to health care, recognising the evolving contribution and necessity of new technology and skill sets.
   - Ensuring sustainable, long term outcomes.

6. It is without contention that South Africa needs both **more and better health care services**.[5] It is in this context that the capability of private hospitals to deliver, without the need for additional funding, to a portion of the health care system's growing needs should be recognised. Private hospitals supplement and fill some of the gaps in public health sector delivery, and thereby make a substantial contribution to serving the needs of South Africans for quality health care.

7. HASA notes and recognises the continued role of private hospitals, as envisaged in the NHI Bill, in contributing to delivery of a health care proposition for the future.

[5] Current per capita expenditure on health care in South Africa is 27% of OECD average (OECD, 2018), life expectancy in South Africa is at 63.4 years - 17 years lower than OECD average life expectancy at birth (OECD, 2018) and South African specialist staffing ratios are currently 10% of OECD average specialist-to-population ratio (OECD, 2015)

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Limited Fiscal Space to Enhance Health Care

8. One of the key constraints in achieving improved access of South Africans to quality care is the ability of the State to fund this.[6] Given competing priorities, a sluggish economy with subdued growth, low levels of formal employment and a significant debt burden from State Owned Enterprises, Government has, correctly, indicated that there is limited scope to raise taxes in order to significantly increase public funding for health care so as to expeditiously implement the NHI.[7]

9. Limited fiscal space for health care, while of considerable concern, is by no means unique to South Africa. Developing economies lack the formal employment tax base to provide comprehensive health care funding. This is generally because they have limited capacity to raise public revenue given larger informal sectors, higher unemployment levels, and higher levels of inequality.

10. It should also be recognised that even more developed economies, with well-established publically funded national health systems, struggle to keep pace with the rising cost of health care,[8] and experience periods of time (such as during recessions, or economic downturns), when they are unable to adequately fund public health care. The impact thereof is that the health care budget is reduced, yet the need and demand for health care does not. It is for this reason that **voluntary private health care and medical insurance exists alongside the public health system** in the design of virtually all national health systems worldwide.[9]

11. It is therefore imperative, given both the fiscal ability of South Africa to fund health care, as well as the recognition that even once such fiscal ability is in place that is by no means guaranteed, that there alternative, supplementary forms of funding available for health care. This provides a 'pressure-release valve' in the event that the public sector cannot fund all needs, and recognises the **additionality role that voluntary private funding** can play in continued resourcing of a national health care system. In the absence thereof, access to health care will be impeded, eroding the objectives of the NHI.

[6] Refer in this regard to Davis Tax Committee Report, Financing a National Health Insurance for South Africa, 2017.
[7] 2019 Medium Term Budget Policy Statement, page 26, 26 and 37. With weaker revenue growth, poor employment outlook, reduced corporate profitability and weaker household consumption, the ability to raise additional tax revenue through raising taxes is constrained. This is reflected in the reduced tax buoyancy figures.
[8] Rising Costs is a worldwide phenomenon due to a combination of factors, such as: increased burden of disease (communicable and non-communicable illnesses); impact of more demands as a result of ageing populations living longer; price increases by suppliers; increased utilization (drugs, surgical equipment and devices); and the cost of new and improved health care technologies. All these factors enhance patient care.
[9] Examples of this can be found in Brazil, Chile, Turkey, UK and Thailand, amongst other countries.

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Pricing of Private Hospital Services

12. In order for private hospitals to continue to play a substantial role in the delivery of health care, their participation under the NHI needs to be sustainable. A key element thereof relates to the pricing of private hospital goods and services, including those of medical professionals, under the NHI. It should be noted in this regard that public and private sector hospital costs cannot be directly compared. For example, private hospitals pay VAT and corporate tax; and are subject to higher supply costs for pharmaceuticals[10], consumables and technical devices (goods supplied to public sector are often priced below cost).

13. The NHI needs to be designed in a manner that takes into account that private hospitals:

    - Invest heavily in capital (buildings, medical equipment, systems, innovation and technology) that requires considerable investment. Funding to resource this needs to be serviceable, and repayable over time in order to be sustainable.
    - Depend heavily on the availability of skilled and capable medical professionals in order to operate efficiently and at optimal capacity.
    - Have an optimal hospital occupancy of up to 80%[11], when they are currently running at an approximate average of 65%[12], with some, although limited, spare capacity.
    - Have input costs that justifiably increase above inflationary rates.[13]

14. It is as a result of the above that of the fees charged by private hospitals to the NHI need to be **sustainable and sufficient in order to enable private hospitals to service their loans, repay debts and continue to invest in future development of the hospitals**.[14] In essence, pricing must be set at a level that enables private hospitals to take into account all the costs related to the delivery of services so that they can meet their obligations, remain sustainable, invest further so as to best serve the interests of the current and future patient.

15. Of considerable importance to the private hospital sector is the continued **availability of skilled medical staff**. The payment of medical professionals under the NHI needs to be sufficient to enable them to be remunerated for their services and to cover their costs, taking into account

[10] Helen Suzman Foundation, 2018. The Supply of Pharmaceuticals in South Africa.
[11] Space should always be kept open for admission of emergency patients. In addition, occupancy above 80% results in inefficiencies that have a detrimental impact on patient care. For example, Eurostat (2016) reports that the majority of European countries operate on 75% hospital occupancy, across the public and private sectors.
[12] This is based on billed occupancy rates which allows for half days using admission or discharge times. (with reference to licensed beds, not available beds). This approach produces lower occupancy rates than the date-difference approach (discharge date minus admission date plus 1).
[13] See footnote 6 above on rising costs.
[14] The 2009 process to determine a Reference Price List, provides a keen example of the dangers of setting prices at a level that is not sustainable.

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the additional costs that are borne by private professionals that would not apply in the public sector.[15] Medical professional skills, be they in the public or private sector, are highly mobile and attractive. It is imperative therefore that every effort be made to retain their services within the health care profession and in South Africa.

16. Within the NHI Bill there are a number of specific provisions that have considerable impact on the pricing of private hospital services. These include: the governance and implementation structures established for determination pricing; the role of medical schemes in contributing to affordability and sustainability of private hospital care; and transitional provisions to enable an incremental, yet certain implementation path. These are set out in more detail below, together with proposed alternative options where this is recommended.

Specific Comments on the NHI Bill in Relation to Private Hospital Services

17. Preamble – HASA endorses the objectives of the NHI Bill to advance universal health care. In particular, HASA notes the objectives of: '**creating a single framework throughout the Republic for the public funding and public purchasing** of heath care services, medicines, health goods and health related products, and to eliminate the fragmentation of health care funding in the Republic'; and 'promoting sustainable, inequitable, appropriate, efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system'.

18. Definitions – the definition of 'strategic purchasing' refers to the strategic purchasing of health care services by pooling of funds and purchasing from …' This definition is consistent with the objectives for public purchasing of health care as set out above in the Preamble.

19. Purpose s2(a) – this clause provides for the NHI to be a 'single purchaser and single payer of health care services in the Republic order to ensure the equitable and fair distribution of health care services'. While HASA recognises that this is necessary for the NHI to operate with respect to the public sector, the ambiguity in relation to its application to the private sector creates considerable uncertainty that can undermine the successful implementation of the NHI. It is also inconsistent with the Preamble and Definitions, that confine the NHI to the public funding and purchasing, as identified immediately above.

    In order to create the requisite certainty and to align with the objectives set out in the Preamble, it is submitted that the word 'public' be inserted into the clause as follows 'single purchaser and single payer of public health care services in order to ensure the equitable and fair distribution of health care services'.

[15] For example, private practitioners need to include in their costs: staffing costs, rental, equipment, tax and the like.

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20. Rights of Users s6(o) – this section provides for the rights of users to purchase health care services that are not covered by the Fund through a complementary voluntary medical insurance scheme, or out of pocket expenses. It is submitted that this clause clearly contemplates the operation of NHI in conjunction with private medical schemes, insurance and personal payments, contributing thereto. This is consistent with the provisions of the Preamble and Definitions as highlighted above.

21. Cost coverage s8(2) – this subsection provides for private payment by a medical scheme in the event of non-coverage under prescribed circumstances by the NHI. However, while voluntary medical schemes or private insurance is provided for, there is no provision for private out of pocket payments. This is inconsistent with the rights of users set out above, and appears to be an unintended omission.

    Insert the words 'out of pocket payment' into the subsection so that the section reads as follows: ' a person or user, as the case may be, must pay for health care services rendered directly, through a voluntary medical insurance scheme or through any other private insurance scheme or out of pocket payment, if that person or user …'

22. Health Care Benefits Pricing Committee s26(1) – the subsection provides for appointment of the Committee by the Minister, in consultation with the Board. Pricing is a function of the product or service provided and the price set for such product or service. Given the **economic considerations** of supply and demand, as well as those pertaining to trade and industry, the appointment of this Committee should not be confined to those exclusively charged with improved health outcomes.

    In addition, international best practice provides that such a committee is clearly defined in terms of their function to objectively set prices and **independent** from the functions of the Board who are charged with the overall management of the fund.

    It is recommended that:
    - *the appointment of the Committee be made by the Minister in consultation with the Minister of Trade, Industry and Competitiveness.*
    - *The word 'independent' be inserted so that the subsection reads '… establish an independent Health Care Benefits Pricing Committee…'.*

23. Health Care Benefits Pricing Committee s26(2) – the subsection sets out the expertise required for setting of prices, but omits some key areas of expertise required for the discharge of such function.

    It is recommended that the required areas of expertise be expanded to also provide for those with expertise in: coding and costing of health care; the pricing of private sector provision

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(hospitals and medical professionals in particular); the cost of research and development and new health care technologies; cost of medical infrastructure, goods and services; and those with competition law and local health care supply chain expertise.

24. Role of Medical Schemes s33 – this section provides that once the NHI is fully implemented that medical schemes may only offer complementary cover. Besides the uncertainty of what is meant by 'fully implemented', this section has significant unintended and severe consequences that will, it is submitted, be counter-productive to the realisation of universal health care. Section 33 in its current form will serve to **increase the delivery burden on the State**; reduce the overall funding available for health care; unjustifiably restrict the operation of private health care providers and **jeopardise choice and access** to quality health care by many South Africans.

    In terms of s33 medical schemes will only be permitted to fund in circumstances that are not fundable under the NHI. Restricting medical schemes to a complementary role is virtually without precedent elsewhere in the world where national health insurance has been implemented. This is for sound reasons, set out below.

    Firstly, the fiscal capability of any State is limited, and supplementary forms of funding should always be envisaged so as to provide optimal health outcomes for the patient. Details in this regard are set out more fully above in the section relating to limited fiscal space to fund enhanced health care.

    Secondly, this section creates large scale uncertainty for the future of private hospitals and doctors as it means that once the NHI is fully implemented that private hospitals will only be funded by the Fund. This is a major concern for the future sustainability of private hospitals that wish to participate in delivery of services to publically funded patients, but in order to do so, need to be able to cross subsidise the lower prices of provision to public patients, with higher, market related[16] prices that can be charged to private patients. This section provides no guarantees for return on investment and sustainability and will undoubtedly lead to reduced investment and contraction of the private health care sector. Given the shortage of hospital facilities and doctors in South Africa, and the capabilities of the private sector to provide world class hospitals, this is an outcome that should clearly be avoided.[17]

    A preferred approach would be to clarify this section and adopt the dominant model applicable in many countries across the world, namely: to have a single public payer together with

[16] Note the findings of the Health Market Enquiry (2019), page 101, where it indicates after consideration of pricing in relation to cost structures that "we conclude that based on profitability analysis, the profits of all three is not excessive …'.

[17] It should be noted that the argument made by some, to the effect that private hospitals will remain financially viable under s33 is fatally flawed. Those that argue this viewpoint do so on the basis that the volume of public patients will be sufficient to offset the lack of income from private patients. However, those arguing this viewpoint fail to acknowledge the full costs of delivery and the fact that there is, in any event, insufficient capacity to achieve the volume of patients contemplated

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supplementary voluntary insurance and out of pocket payments. This formulation would be consistent with the clear intention and wording of the Preamble to the NHI Bill which states that the objective is to create a 'single framework throughout the Republic for the public funding and public purchasing of health care …'. It would also address similar concerns raised about the single payer model in the 2019 Socio-Economic Impact Assessment.

Given the above, HASA fails to understand the underlying purpose of inserting this section. One possible purpose could be that this section was inserted to avoid double claiming (under both the NHI and a medical scheme) or forum shopping at the expense of the NHI (where private patients are pushed to the front of the queue, but pay NHI rates).

It is recommended that s33 be deleted in its current form.

Alternatively, s33 should be amended to provide that '… individuals may not claim from the NHI and the medical scheme for the same service'.

25. Purchasing health care services s35 – continued provision of hospital services to the Fund will only be feasible in a system where **payments are fairly, transparently and efficiently managed.**

The section fails to adequately provide for: timeframes for payment, guarantees of payment for services, remedies for disputes and principles as to how purchasing decisions will be made. The Medical Schemes Act provides protection for services providers through provisions pertaining to the rendering of accounts, **payments within 30 days** and recovery in the event of overpayment. Similar provisions should be placed in the NHI Bill to provide the necessary assurances and certainty for service providers.

Furthermore, the section provides no guidance on what is meant by 'strategic purchase of health care services'. It is submitted that this section should be explicit so as to ensure that the **quality, affordability and sustainability** of services are taken into account when determining pricing. A key consideration in this regard would be to ensure that prices are set at a level that supports localisation of the health supply chain, as well as enabling the sustainability of supply of health care providers and products.

It is a well-established principle that where there is a single monopsony buyer (such as envisaged under the NHI) that there is a risk of it setting prices too low. While this may appear to be attractive and achievable in the short term, it soon becomes counter-productive as suppliers cannot afford to continue to supply at such prices. Further, it has a negative impact on the quality of service that can be provided. Another consideration is that pricing should be able to be adjusted to promote the objectives of local procurement so as to build local health

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care supply chains that will result in a more robust and sustainable health care system, as well as contributing more generally to South Africa's economic and social wellbeing.

It is recommended that:

- *s35(1) be amended as follows: 'The Fund must actively and strategically, with reference to quality, affordability and sustainability, as well as with the secondary purpose of supporting the development of the South African health care supply chain, purchase health care services on behalf of users in accordance with need…'*
- *The conditions, timing and guarantee of payment to providers be clearly set out, as per s59 of the Medical Schemes Act, in order to protect the rights of patients and sustain the delivery of health care goods and services to the Fund.*

Specific Comments on the Bill in Relation to General Provisions

26. Application of the Act s3(5) – this clause provides that the Competition Act is not applicable to transactions concluded under the NHI. We submit that greater consideration should be given thereto, as the operation of competition leads to greater efficiencies, participation of previously excluded participants in the market, it encourages participation of small and emerging businesses and improved delivery of health care. The recent Health Market Enquiry is testament to the important considerations that competition raises.

    It is submitted that the Competition Act should not be excluded, but rather that exemption should be sought for specific aspects of operation of the NHI, if required.

27. Population coverage s4(2) – while we recognise the burden that asylum seekers and illegal foreigners place on the health system, it is unclear whether the services they are provided can be limited to such an extent in terms of the Constitution that creates a right for 'everyone'.

28. Registration of users s5(1) and (3) – the section allows for registration of users and children that have not been automatically registered at birth. It is understood that this will, over time, require considerable administration and there may be gaps between registration and provision of services under the NHI.

    Transitional provisions should be included in the NHI Bill in order to enable provision of services in the event of delay or lack of registration for justifiable reasons.

29. Functions of the Fund s10(s) – this subsection includes the function to enforce compliance with the Act. This wording potentially implies that the Fund has criminal enforcement rights, which cannot be intended.

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It is suggested that the word 'enforce' be replaced with 'encourage' or 'ensure'.

30. Powers of the Fund s11(1)(h) – the subsection provides for the Fund to investigate complaints against itself. This does not provide for the requisite checks and balances, and will not be regarded as credible by users, providers, health establishments or suppliers.

    It is recommended that that this subsection be amended to provide for the establishment of an independent Ombud, or independent investigation function outside of the Fund.

31. Powers of the Fund s11(2)(e) – the subsection provides that the NHI should 'negotiate the lowest possible price for goods and health care services without compromising the interests of users …' It is unclear what factors should be legitimately considered, and prioritised in giving effect thereto.

    It is recommended that the NHI Bill outline the principles that should be considered when giving effect to the discharging its functions in terms of this subsection. This should include quality, affordability, and sustainability of suppliers and also consideration of how to support local supply chain development.

32. Establishment of Board s12 - transitional provisions are required in order to sequence the establishment of the Board prior to other sections that depend on the functioning of the Board to operate.

    It is recommended that:
    Transitional provisions should provide for the establishment of the Board in advance of other operational provisions in the legislation.

33. Constitution and composition of the Board s13(5)(b) – the subsection provides for the skills and expertise required of Board members of the Fund.

    HASA supports the effort to ensure that Board members are independent and appointed on the basis for their expertise, rather than their affiliation. The public nomination; establishment of an ad hoc panel to assist in the process of appointment of the Board; and provisions for removal of Board members are all welcomed. Clear, unambiguous recruitment and appointment for all Board members and executives is required to retain the independence of the Board, guard against interference in governance matters and best serve the stated objectives of the Fund.[18] Given the mandate and scale of the NHI Fund is recommended that the National Assembly be charged with the final appointment of the Board.

    It is recommended that:

[18] Legal Framework of SOE Boards, Dullah Omar Institute, page 49.

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- *the following areas of expertise be inserted: large scale fund management and administration, public procurement and the PFMA, strategic purchasing and pricing, international, public or private sector best practice, human resources, legal and governance.*
- *in line with governance best practice, that the National Assembly, as a representative of the public, be charged with appointment of the Board after consultation with the Minister.*

34. Constitution and composition of the Board s13(5)(d) – the subsection excludes individuals employed by the State from serving on the board of the Fund. Presumably this is in order to avoid a conflict of interest, and ensure the independence of the Fund's Board to perform its oversight function. The same considerations should similarly apply to those employed or serving in health statutory bodies.

    It is recommended that the clause be amended to read as follows 'not employed by the State or as an employee or governor of one of its agencies'.

35. Conflict and disclosure of interests 16(1) and (3) – subsection16(1) correctly provides that a Board member may not engage in any paid employment in conflict with the proper performance of his or her functions. It is submitted, however, that this clause is too narrowly framed to sufficiently protect the Fund. Similarly, subsection 16(3) only provides for the prevention of direct material interests of a monetary nature. Given the vast resources of the Fund, and the risk to the fiscus and patient care, if this is not properly managed, this section should be carefully constructed so as **to guard against conflict, corruption and capture**.

    It is recommended that:
    - *The subsection 16(1) be redrafted to include any direct or indirect conflict of interest, including paid employment, that may be in conflict with the proper performance of his or her functions.*
    - *Subsection 16(3) should be amended to include indirect interests, and it should not be confined to monetary interests alone.*

36. Stakeholder Advisory Committee s27 – the section lists all stakeholders, other than business. Business is a key stakeholder that should legitimately form part of the stakeholder grouping. It is worth noting that but for business, the list of stakeholders appears to mirror all those stakeholders that were signatories to the Presidential Health Compact 2019. No reasons have been advanced for excluding business and it can only be assumed that this is an unintended omission. It is important that business be recognised and engaged as a stakeholder.

    The wording should be amended to include business as a stakeholder to the Committee.

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37. Office of Health Products Procurement s38 – the function and role of the Office is well articulated. It is important that the section also provides for the expertise required to perform such function.

    The section should set out the expertise required to serve in the Office. This should include expertise in changes in burden of disease, product availability, price changes and disease management, as well as existing and advancing technologies and development of health products.

38. Accreditation of service providers s39 – this section provides for the conditions and requirements for accreditation. However, there are no time periods to guide the accreditation or renewal of accreditation. This creates uncertainty. Furthermore, it will be important to conclude accreditation and contracting prior to implementation of the operation of the NHI.

    It is recommended that:
    - *Time periods should be included for the accreditation, and consideration of renewal of accreditation to provide for certainty.*
    - *Transitional provisions should provide for the accreditation of providers and contracting prior to other provisions of the Act coming into operation.*

39. Chief source of income s49(2)(a)(ii) – this subsection provides for reallocation of medical scheme tax credits. Currently, this is an important contributor to the affordability of private medical schemes. While reallocation thereof to the Fund may take place, it is recommended that this be done over time and with a clearly communicated timeframe communicated to users, providers and schemes in order to make the necessary adjustments.

    It is requested that the subsection be amended to include wording such as 'in line with a transparent and incremental programme as to the conditions that should be satisfied for such reallocation will apply'.

40. Assignment of duties and delegation of powers s52(a) – this subsection provides that the Minister may delegate any power in terms of this Act, other than that of making regulations. This is undesirable for the Minister to delegate powers of appointment to structures and committees constituted under the Act to the Fund, as this blurs the lines of accountability and the role of the Minister as executive authority.

    The subsection should be deleted, alternatively, the Minister should not be empowered to delegate his or her appointment powers under the Act.

41. Transitional Arrangements s57 – while the section specifies that the gradual implementation of NHI is subject to financial resource availability, it is self-contradictory in that it also provides set

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timeframes for various phases of implementation. The problem with pre-set timeframes is that they are subject to change, requiring a legislative amendment each time circumstances change.

The current transitional arrangements provided for in the NHI Bill appear to be better placed in the explanatory memorandum of the NHI Bill, as they refer to project phases of implementation, rather than consecutive, transitional, steps required for implementation

Instead, the transitional arrangements should provide for a number of areas to be brought into operation before the NHI can begin operating, such as:

- Registration of users, s5
- Establishment of the board, s12
- Appointment of the Chief Executive Officer, s19
- Appointment of Committees of the Board, s23
- Appointment of Benefits Advisory Committee, s25
- Establishment of Health Benefits Pricing Committee, s26
- Development of coding and costing under the Diagnosis Related Groups system, s35
- Establishment of Office of Health Products Procurement, s38
- Accreditation of service providers, s39

Further, the sequencing of legislative reforms contemplated under s57(4)(h) should be carefully considered in order to ensure that reforms only take effect when required and that there is certainty as to when this will take place. For example changes to the Medical Schemes Act would only become necessary on 'full implementation' of the Fund, whereas others, such as the Health Professions Act may need to be initiated sooner.

Transparency and a clear plan of action for the implementation of transitional provisions is regarded as paramount in in order to build trust in the NHI system and create as much certainty as is possible in the circumstances.

It is recommended that:

- *the transitional provisions be amended so as to sequence the stages of progressive implementation required to bring the NHI Bill into effect. These should take account of the human resource and financial capabilities required to implement.*
- *Provisions under subsection 57(3) for establishment of interim committees should be more carefully drafted so as to identify requisite expertise, structures, governance, accountability, budgeting and scope of operation.*
- *Timelines and project phases should be removed.*
- *Legislative reforms under s57(4)(h) should be specifically linked to the achievement of certain milestones so that they are appropriately sequenced with the intended roll-out of the Fund.*

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- *A clear and measurable definition should be provided as to what is meant by 'fully implemented'. Two options can be considered:*
  - *'fully implemented' means for example that human capital at all levels of professional status should at least equate to the minimum levels indicated in the OECD countries; access to public health care consultations per person per annum equate to at least 75% of the current levels of the OECD countries; and waiting lists should be published for all major categories of surgery and should not exceed 18 months, or*
  - *'fully implemented' aligns with the current definition of Prescribed Minimum Benefits under the Medical Schemes Act, as a measure of full implementation of comprehensive health care.*

Concluding Comments

42. In summary, HASA is of the view that the NHI Bill forms a credible basis for moving forward on the NHI in the interests of progressively funding and achieving universal health care in South Africa.

43. However, there are some areas of the Bill that require rethinking in order to ensure that outcomes are consistent with the objectives of the Bill. HASA's key concerns with the Bill relate to pricing structures and mechanisms that, if not well designed, could negatively impact on the sustainability of the sector, and its ability to provide quality health care services to the patient. Integral to this concern is the adjustment of s33 so that medical schemes can provide voluntary funding for both complementary and supplementary services. This will not only ensure that South African's can continue to purchase health care services; it will also ensure sustainability of operations for private hospitals that will be able to cross subsidise services to the public as a result of the higher, market related, revenue received from private patients.

    In summary, HASA's concerns can be addressed through:

    - Clarification and reframing of identified provisions relating to funding and pricing;
    - Ensuring various governance structures are appropriately constituted with the requisite expertise and independence; and
    - Restructuring of transitional provisions so as to enable incremental implementation and certainty.

44. Addressing the above concerns will also provide the requisite certainty and enabling conditions required for the effective implementation of the NHI. In this regard, HASA has taken note of the multiple legal critiques on the NHI Bill as aired in the public domain, and submits that the above areas, if not addressed, could render the Bill subject to legal challenge that would unduly hamper the implementation of the Bill. This will serve to undermine the quest for universal health care.

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45. HASA reaffirms its commitment to a human-centred approach to health care in South Africa, and it stands ready to contribute to the realisation thereof in a manner that is sustainable and achievable for the sector and the country. In making these submissions, it should be noted that while HASA is a member of Business Unity South Africa (BUSA) and supports the broad submission made by BUSA, that this submission focuses on the specific ramifications of the NHI Bill to the private hospital sector. This submission will also be augmented by separate submissions of HASA members in order to address or focus on specific concerns.

46. HASA's submissions have been made in an effort to make a constructive contribution towards the achievement of the objectives of the NHI. HASA appreciates the opportunity to provide input to the NHI Bill and **hereby requests the opportunity to make oral representations in support of this submission to the Portfolio Committee on Health.**

Yours sincerely

Dumisani Bomela (CEO)