



The Portfolio Committee on Health

Attention: Ms. Vuyokazi Majalamba

Per email: vmajalamba@parliament.gov.za

RE: NATIONAL HEALTH INSURANCE BILL, 2019 [B11-2019]

Please find set out below our general comments on the National Health Insurance Bill, 2019 [B11-2019] (the Bill). Kindly note that the National Health Act, 2003, is referred to as "the NHA" and the Health Act, 1977, as "the 1977 Act". The expression "National Health Insurance" is referred to as "NHI".

1. Introduction

The Western Cape Government (WCG) supports the objectives of Universal Health Coverage (UHC) and the development of a mechanism to reallocate resources from both the private and public sectors in order to equitably address the health needs of the total population and remove financial hardship at the point of care. The notion that the challenges faced in the health sector are wide-ranging, significant and require urgent attention is supported. The cumulative effect has been described as resulting in a dysfunctional health system and precipitating a crisis in the health sector. However, there are numerous concerns about how NHI, as envisaged in the Bill, is proposed to be implemented. Health is a complex, adaptive system in which any change has ripple effects throughout the system. The Bill envisages major and complex health system reforms. The main concerns of the WCG centre around those aspects of the Bill that relate to the centralisation of power, governance and accountability of the National Insurance Fund (NHI Fund), the role of the provinces, legal concerns and the potential of the Bill to jeopardise the creation of a unified, strategically aligned health system. Addressing these concerns will strengthen the reforms envisaged in the Bill, and if implemented correctly, will lead to a healthcare system that best serves the health needs of the public. Given our concerns regarding the implementation of NHI as envisaged in the Bill and for the reasons that follow, the WCG does not support the model of NHI proposed in the Bill to achieve UHC.

2. The model of NHI as envisaged in the Bill

- 2.1. The Bill proposes the establishment of a centralised fund, the NHI Fund, to pool resources and purchase and pay for services. The NHI Fund will be funded from, amongst other things, the shifting of the equitable shares from provinces. This will reduce provincial budgets by about 34%. The equitable share of a province is intended for the citizens of that province. Service delivery output in tandem with efficient management and strong governance is commensurate with input funding. With a reduced budget, due to the reallocation of conditional grants during phase 1 and as explained in paragraph 8.10.7, integrated intersectoral-connected service delivery will be negatively affected.
- 2.2. It is common cause that the service delivery track record of provinces differs. Should the equitable shares of provinces be redirected to a central fund, funds from a well performing province will also be redirected to support the one-size-fits-all approach adopted in the Bill. The Bill does not give clarity on how exactly the funding mix will work. This creates overwhelming uncertainty and confusion on how the funding will work on a practical level. For example, large metros in the country contribute their own revenue for the rendering of primary health care. It is unclear whether the funding mix envisaged in the Bill will also involve the redirection of municipal health funding.
- 2.3. The Bill establishes the NHI Fund as a single purchaser and payer in a scheme where it will be responsible for the strategic purchasing of services that will be reimbursed by the NHI Fund. It is not clear from the Memorandum on the Objects of the Bill whether the World Health Organization's considerations on strategic purchasing which proposes regional purchasing for UHC were considered when the role of the Fund as a strategic purchaser was developed in the Bill.
- 2.4. The Bill develops unclear governance structures around the NHI Fund. In any scheme seeking to give effect to UHC the effective exercise of health system governance is a critical enabler for strategic purchasing. It is submitted that cohesive governance arrangements between the National Department of Health (NDoH), National Treasury and provinces are needed to support the NHI scheme proposed in the Bill.

3. Non-compliance with procedural formalities before introduction into Parliament

- 3.1. Section 23(1)(b) of the NHA provides that the National Health Council must advise the National Minister of Health (the Minister) on proposed legislation pertaining to health matters prior to such legislation being introduced into Parliament. Paragraph 7 of the Memorandum on the Objects of the Bill indicates that the National Health Council was consulted. The Bill was tabled for discussion at the National Health Council on 25 July 2019 for the first time yet was approved for introduction into Parliament by Cabinet on 11 July 2019 prior to the council meeting.
- 3.2. The Western Cape Provincial Department of Health (the WCPDoH) was never consulted on the development of the Bill despite public health managers of the Western Cape requesting a meeting with the President to discuss the WCG's concerns about the lack

of consultation with public health experts, and to highlight concerns regarding the governance issues with the Bill as well as risks to the delivery of health services to the general population. The Premier of the Western Cape also corresponded with the President about the fact that neither of the policy papers nor the Bill was tabled at the National Health Council timeously. Please see the relevant correspondence in this regard, which is attached.

- 3.3. Any inputs by the National Health Council in July 2019 would seemingly have only been paying lip service to the requirement in section 23(1)(b). The result is that the consultation referred to in the Memorandum on the Objects of the Bill could certainly not have been meaningful. In the result, it is submitted that the consultation process was flawed and hence open to legal challenge.

4. Public participation

- 4.1. The development of the Bill has been characterised by haste and a lack of consultation as evidenced by the fact that the Bill was rushed through Cabinet for permission to introduce it in Parliament and the National Health Council presented with the Bill afterwards.
- 4.2. The Bill proposes to bring about the most radical restructuring of the South African health system since 1994. Its scope is broad and deep, affecting the entire country and every single component of the health system. The objective of UHC is commendable and supported. Proposed health care reforms need to enjoy wide support from informed and experienced policy makers and managers in the health service. South Africa has a rich reservoir of expertise and experience in the public sector, non-governmental sector, civil society, academic and private sectors. An inclusive process that involves a wide range of stakeholders, including provinces, with multiple perspectives, that tap into global expertise, is important in securing collective ownership of a new health system.
- 4.3. The Bill was published for comment at the end of August 2019. The Bill is substantial and not only provides for NHI but also amends 11 other Acts and in the case of the NHA, extensively so. The call for comment listed an initial closing date of 11 October 2019 which was extended on 1 October 2019, at the eleventh hour, to 29 November 2019. This late acquiescence to the WCG's request for an extension disrupted the ability of the WCG and commentators in general to plan accordingly. The initial period of 1 month and 1 week would have been far too short to comprehensively comment on the Bill because it is so substantial. Clause 55(2) of the Bill provides that the Minister must provide for a commenting period of at least 3 months when proposed regulations in terms of the Bill are published for comment. It is therefore concerning why such a short commenting period was initially provided for particularly when the Bill itself recognises that a much longer period is needed in the case of regulations proposed in terms of it. Furthermore, it is also important to consider the impact on the amendments to all the other legislation that is proposed. It is important to have sufficient time to consider the

entire scheme of what is being envisaged in order to provide meaningful comments and to understand the practical implications of the proposed legislation.

5. Legal concerns regarding the Bill

5.1. Vagueness

5.1.1. A theme throughout the specific comments contained in the clause-by-clause analysis of the Bill which is attached hereto is that crucial provisions in the Bill are vague. This is particularly apparent with regard to the role of provinces in the scheme of the Bill. Clause 31(2) provides that "the Minister must clearly delineate in appropriate legislation the respective roles and responsibilities of the Fund and the national and provincial Departments, taking into consideration the Constitution, this Act and the National Health Act, in order to prevent duplication of services and the wasting of resources and to ensure the equitable provision and financing of health services.". It can therefore be argued that the Bill itself is uncertain as to what role provinces must play in the scheme and defers the consideration of the issue to separate legislation. The clearest indication of the role of provinces is contained in clause 32(1)(c) which provides that one of the functions of the NDoH is co-ordinating health care services rendered by the NDoH with the health care services rendered by provinces, districts and municipalities, as well as providing such additional health services as may be necessary to establish an integrated and comprehensive national health system. In terms of clause 32(2), the Minister may introduce amendments to the NHA and may—

“(a) delegate to provinces as management agents, for the purposes of provision of health care services, and in those cases the Fund must contract with sections within the province such as provincial tertiary, regional and emergency medical services;

(b) designate provincial tertiary and regional hospitals or groups of hospitals as autonomous legal entities accountable to the Minister through regulation.”.

Clause 32(2) seems to suggest the possibility of at least a limited co-ordinating role for a province. The NHI Fund would contract with the province as a provider. However, that hope is offset by the fact that the possible future management role of provinces is subject to future legislation and clause 32(2)(b) which suggests the NHI Fund will contract directly with autonomous hospitals or groups of hospitals.

Clause 32(3) provides that "Without derogating from the Constitution or any other law, the functions of a provincial Department must be amended to comply with the purpose and provisions of this Act, subject to the provisions of section 57.". This envisages a change in the role of provincial departments of health without indicating what their new role will be.

All these clauses read together do not indicate a clear role for provinces. It is imperative that clarity is provided in the Bill in respect of the role of provinces in order to prevent confusion and uncertainty at implementation stage.

5.1.2. The Bill is also vague on the role of medical schemes. Clause 33 provides that "Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund." It is not clear whether "not reimbursable" means services that fall outside those paid for by the Fund, or if it includes a service that the Fund covers, but will not fund for that particular patient. Clause 8(2) adds to the confusion. This clause suggests that medical schemes can cover services ordinarily provided by the Fund, if the user does not follow the referral pathways. Further, it suggests that it is compulsory to pay for the services referred to in the provision through a health insurance scheme i.e. a person or user "must" pay through a voluntary medical insurance scheme or other private insurance scheme. Payment by the user personally is not contemplated. This would effectively impose compulsory private medical insurance on anyone who wishes to obtain services outside those provided by the NHI Fund. Clause 6(o) takes matters no further, other than to add to the confusion. While clause 33 uses the term "not reimbursable", clause 6(o) refers to services that "are not covered by the Fund". It is not clear whether these different terms are meant to refer to the same set of services. And unlike clause 8(2), it does contemplate out of pocket payment by the user. Considering clause 8(2)(b), the best interpretation appears to be that a user can purchase services, including through a private insurance scheme, merely by refusing to follow the referral pathway. But if that is the case, it would seem to undermine the general purpose of ensuring a single-payer system. It would be relatively easy for a user to "opt-out" of the NHI (at least for specialist services) by simply refusing to follow the prescribed referral pathways. It is proposed that clarity is provided in respect of the role of medical schemes.

5.1.3. The Bill does not provide detail on how the NHI project will be funded. Clause 59 read with clause 3(4) show that the details of how the NHI will be funded will be determined in future legislation.

5.1.4. Whilst the Bill is clear as to how central hospitals are to be positioned and operate within the NHI scheme, the position for other hospitals is less clear. Clause 32(2)(b) envisages legislation that will allow the Minister to designate other hospitals as autonomous legal entities accountable to the Minister through regulations. It is not clear, whether beyond this point of designation, those other hospitals will remain under the control of the relevant province in which they are located.

5.2. Conflict between the Bill and the 1977 Act:

5.2.1. As pointed out above, the role of provinces in the Bill is unclear. It appears from the provisions of the Bill that the NHI Fund together with the NDoH and the District Health Management Offices (DHMOs) will be responsible for, amongst other things, not only the purchasing of health services but also for the management

of the health system and the co-ordination of health services. This serves to show that the Bill intends to dilute the role that provinces currently perform in terms of the NHA by removing the responsibility to plan, co-ordinate and monitor health services, to plan, manage and develop human resources for the rendering of health services and to plan the development of public and private hospitals.

- 5.2.2. The Western Cape Province, under section 16 of the 1977 Act has an obligation to provide hospital services, to provide personal health services and with a view to the establishment of a comprehensive provincial health service, to co-ordinate the various health services. Under the 1977 Act, the Western Cape Province is the primary provider and manager of health services in the province.
- 5.2.3. The provisions of the Bill and the 1977 Act conflict. If the Bill is enacted in its current form, the Western Cape Province would still be required by the 1977 Act to co-ordinate a provincial health system while the Bill, once enacted, would make it impossible for the province to perform that role.
- 5.2.4. Any potential resolution of this conflict is dependent on the Minister passing the legislation envisaged in clause 32(2)(a) of the Bill to delegate powers to the provinces as management agents. There is however no certainty that that will transpire, particularly because the clause is subject to the transitional arrangements in clause 57. The result is that in the absence of the legislation envisaged by clause 32(2)(a), the provisions of the Bill as they stand conflict with those of the 1977 Act. This conflict, on a practical and operational level, creates confusion as to how the Western Cape Provincial Department of Health (WCPDoH) must perform its functions.

5.3. Medico-legal contingency

The design of the Bill is such that tertiary and regional hospitals or groups of hospitals will be designated in regulations as autonomous legal entities accountable to the Minister. What type of legal entity this will be is uncertain. Conferring juristic personality on hospitals has attendant risk. Once designated, the hospital will then be exposed to the burden of having to provide for its contingent medico-legal risk. A party who sues in respect of medico-legal matters will have to sue the hospital directly and/or the Minister to whom the hospital is accountable and no longer cite a provincial member of the executive council (MEC) as a nominal defendant. This means that tertiary and regional hospitals will have to carry the full burden of all medico-legal contingent liability in claims instituted against it. In the current legal framework, the risk is borne by the provincial department and the MEC who is cited as a nominal defendant in litigation. The Bill will therefore shift this risk to the hospitals. With the current levels of medico-legal contingent liability against provincial departments of health, it may very well be that the funds allocated to hospitals by the NHI Fund for service delivery purposes may be depleted when these hospitals must settle medico-legal claims.

5.4. Establishment of government components

- 5.4.1. The Bill employs the tool of establishing national government components in respect of central hospitals and DHMOs. Clause 7(2)(f)(i) provides that the Minister must, by regulation, designate central hospitals as national government components in accordance with section 7(5) of the Public Service Act, 1994 (PSA).
- 5.4.2. Section 7A(1) of the PSA provides that an executive authority may only request the President to establish a government component in terms of section 7(5)(c) of that Act if the prescribed feasibility study is conducted and its findings recommend the establishment of such a component. Even though the designation envisaged in clause 7(2)(f)(i) must be done in accordance with the required processes of the PSA, the clause pre-empts that favourable feasibility studies will be conducted in respect of all central hospitals. How is it envisaged that the Minister must comply with the obligation in clause 7(2)(f)(i) if a feasibility study conducted in respect of a specific central hospital yields a recommendation that the government component should not be established? The clause therefore pre-empts the PSA processes and may be seen to render those processes nugatory.
- 5.4.3. The proposed new section 31A of the NHA provides that DHMOs "are hereby established as national government components". In contrast to clause 7(2)(f)(i), the establishment of the DHMOs are not required to be done in accordance with the PSA. They are simply proposed to be established as such by the NHA. The proposed new section 31A of the NHA therefore completely bypasses the requirements of the PSA.
- 5.4.4. It is submitted that the tool of establishing national government components as proposed in the Bill is flawed and should be reconsidered.

5.5. Non-conformity of the Bill with accepted legislative drafting practice

- 5.5.1. The Bill is not drafted in accordance with generally accepted Commonwealth legislative drafting practices. For example, in clause 40(3)(d) the term "prescribed", although defined in clause 1 of the Bill, is used in its ordinary sense. This may lead to confusion as it may create the impression that health care providers and health establishments could make regulations which clearly cannot be the intention because the making of regulations is the remit of the Minister. The section heading of clause 57 is "transitional arrangement" when the content of the clause relates to operational issues. Clause 57 is not appropriate for a Bill and should rather be dealt with in an implementation guide and explained in the Memorandum on the Objects of the Bill. The Memorandum on the Objects of the Bill fails to include an analysis of the amendments in the schedule to the Bill.

- 5.5.2. Not all consequential amendments to the proposed amendments in the schedule have been considered and effected. The referencing of legislation is in some instances incorrect.
- 5.5.3. Clause 32(2) provides that subject to the transitional arrangements in clause 57, the Minister may introduce to Parliament proposed amendments to the NHA. The underlined part of the introductory sentence of the clause is redundant. The Minister does not require Parliament to authorise him or her to introduce legislation into Parliament. This power is conferred on him or her by the Constitution.
- 5.5.4. Clause 32(3) provides that without derogating from the Constitution or any other law, the functions of a provincial department must be amended to comply with the purpose and provisions of the Bill, subject to the provisions of clause 57. It is not clear who is to amend the functions of the provincial department and how that amendment is to be effected given that it is not to derogate from the Constitution or any other law which infers that someone other than Parliament must amend the functions by some unknown means.

5.6. Impact assessment

The Bill is substantial and comprises a complete review of the current health system both at an operational and funding level. Given the extensive regulatory impact that the provisions of the Bill would have not only on users and provincial governments but also on private health care providers and medical schemes, we enquire whether the NDoH conducted a socio-economic impact assessment on the Bill. If so, we require a copy thereof.

6. An optimal health system

- 6.1. The World Health Organization advocates for the development of an integrated health system where patients experience continuity of care along optimal care pathways. The premise for this thinking is that of an interconnected delivery system that provides for a seamless experience along referral lines through various providers.
- 6.2. The Bill proposes a health care system that will be delivered through a range of providers vertically contracted by the NHI Fund, each with its own performance requirements and incentives. This will lead to significant fragmentation of the current health system with serious implications for the continuity of patient care.
- 6.3. Private general practitioners, public health sector providers and district hospitals are already part of the district health system run by provinces and central hospitals form an important component of this integrated health system. As mentioned above, health system governance is an essential requirement for UHC. That system governance will become fragmented along with the system amongst hospitals, the NHI Fund, district management offices, contracting units for primary health care and provinces.

7. Affordability of the Bill

- 7.1. The Medium-Term Budget Policy Statement (MTBPS) 2019, prepared by National Treasury includes a statement on the updated cost estimates for NHI. The statement reads as follows:

“Updated cost estimates for national health insurance

The NHI policy aims to provide healthcare more equitably in South Africa. Originally, NHI costs were projected to increase public health spending from about 4 per cent to 6 per cent of GDP over 15 years. However, given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable. The National Treasury assisted the Department of Health to develop an actuarial model with updated fiscal costs and limited policy reforms to strengthen the current healthcare system. The revised model estimates that rolling out NHI would require an additional R33 billion annually from 2025/26. These amounts are not budget commitments but indicative cost estimates.”¹

- 7.2. In the foreword of the MTBPS, the Minister of Finance notes that the path to restoring public finances to a sustainable position will involve expenditure reductions. He further notes that the state must be a good steward of the country's resources. The impact that the cost of the Bill, as estimated by National Treasury, will have on the already stressed South African economy must be a foremost consideration in the pursuit to enact the Bill. Drawing on the research and modelling work of National Treasury, it is submitted that the Bill is not affordable.
- 7.3. It is proposed that a model for the achievement of UHC is developed that is funded in a sustainable manner, where the debt to GDP ratio is kept under control, and where funding through taxation does not compromise the ability of the economy to create wealth through growth and investment.

8. Policy concerns regarding the Bill

The WCG has the following critical policy concerns regarding the Bill:

- i. The role of the provinces as a provider of health care services;
- ii. Implications of changing the role of provinces;
- iii. Whether the NHI Fund will have the administrative capacity to manage multiple contracts;
- iv. The proposed role of provinces in the implementation of NHI;
- v. Governance of central hospitals;
- vi. Governance of the NHI Fund as provided for in the Bill;
- vii. The impact of the Bill on the current provincial mandate;
- viii. The strategic purchaser role of the NHI Fund;

¹Page 37, Medium Term Budget Policy Statement 2019, National Treasury.

- ix. Duplication of functions between the District Health Management Office and the Contracting Unit for Primary Care;
- x. Changes to the conditional grants, equitable share and revenue retention by provinces;
- xi. The role of regional and specialised hospitals;
- xii. The role of intermediate care facilities;
- xiii. The package of care and benefits envisaged in the Bill;
- xiv. The social determinants of health;
- xv. The whole-of-society approach; and
- xvi. The regulator function of the NHI Fund.

8.1. The role of the provinces as a provider of health care services

8.1.1. Health exists in a complex, adaptive system. Managing a health system involves the coordination of multiple levels of care, with multiple local partners, to deliver a cohesive health service. This is built on a network of relationships, governance structures and years of experience of the local provincial health setting. The province is the health provider and the co-steward of health together with the Minister. The Bill proposes a complete systemic shift in this functioning and instead proposes a direct relationship between the NHI Fund and service providers that include public and private health establishments, providers and suppliers.

8.1.2. The NHA and the 1977 Act, empower provinces to plan, provide, manage and coordinate health services within their provincial boundaries. By contrast the Bill proposes the following changes to the role and authority of provinces:

- (a) The NDoH will be responsible for coordinating health services rendered by it with the health care services rendered by provinces.²
- (b) Primary health care services will be governed by a national government component, namely, the District Health Management Office (DHMO).³
- (c) A Contracting Unit for Primary Health Care (CUP) ⁴ will manage the provision of primary health care in a specific geographical area. The CUP will consist of a district hospital, clinics or community health centres, ward-based outreach teams and private providers within a specified geographical sub-district area. The CUPs will contract directly with the NHI Fund for the provision of health care services.
- (d) Central hospitals will be designated as national government components⁵ and will not report to provincial governance structures.

² Clause 32(c) of the Bill

³ Clause 36 of the Bill

⁴ Clause 37 of the Bill

⁵ Clause 7(2)(f)(i) of the Bill

- 8.1.3. The role of provinces is unclear in the Bill. Clause 32(2) of the Bill empowers the Minister to delegate functions to provinces as management agents of the NHI Fund, but this is subject to the transitional arrangements contained in clause 57 of the Bill and subject to when the Minister proposes amendments to the NHA for the purpose of centralising health funding.
- 8.1.4. In summary, the Bill proposes the centralised management of health services to the NHI Fund and the NDoH with local governance through DHMOs. The province will therefore have a markedly reduced role in health care governance and service delivery.
- 8.1.5. While not explicitly stated in the Bill, the restructuring of health care governance appears to be based on the belief that the provinces are not capable of providing health services and that consequently the current system needs to be completely overhauled. It further appears to assume that centralised governance of the health system with power effectively located with the Minister and the governance board of the NHI Fund is the best system to provide health care to the public. The WCG disagrees with this view for the following reasons:
- (a) It is unclear why the role of provinces need to change to give effect to the purpose of the Bill which is UHC. Provinces have already progressed far with establishing UHC and collectively serve 85% of the population. Systemic underfunding of approximately R9 billion over the past MTEF together with a lack of leadership poses critical challenges to the provincial project.
 - (b) The WCG submits that the NHA contains a clear framework that is sufficient to establish UHC. The head of a provincial department of health and the MEC together have a stewardship role for health in the Western Cape Province. The provincial project currently includes the private sector.
 - (c) There is no existing evidence to suggest that the NDoH will manage health systems better than provinces. There are provinces like the Western Cape Province that manage health services well and may prove more competent at managing health systems than the NDoH. There are numerous reasons to conclude that provinces are better suited to manage provincial health systems including knowledge of local conditions and existing local partnerships with other government sectors, the private sector and civil society. The provinces as a collective have increased the life expectancy of the population over the past 10 years, and together run the largest antiretroviral programme in the world. In the Western Cape Province, the life expectancy for women is already more than 70 years and for men 68 years. These comply with the targets set out in the National Development Plan.
 - (d) While there are benefits to the strategic purchaser function, this can still be done using provincial structures. In those provinces where the management of health services is efficient and effective, it would be

appropriate to allow those provinces to continue managing services. Quality concerns related to the public sector are noted, and are symptomatic of the systemic underfunding and limited leadership skills, but it must be borne in mind that provincial health departments are ideally positioned to facilitate inter-sectoral collaboration amongst fellow provincial departments, and to link such collaboration with those of municipalities to address the social determinants of health.

- (e) The Bill does not recognise the need to address the social determinants of health.
- (f) The Bill proposes the establishment of DHMOs, and Contracting Units for Primary Care (CUPs). These new structures will presumably perform the governance role currently performed by the provincial departments of health. It is our view that this new system lacks coherence and strategic alignment and will lead to a fragmented health system. The NHA is geared towards decentralised decision-making. The Bill and its scheme of centralised decision-making is counterintuitive to the NHA. The Bill proposes complex decision-making in 52 districts and approximately 180 CUPs. If the premise of the Bill is that the capacity to take decentralised decisions is a problem, then that aspect needs to be addressed without resorting to embarking on a scheme that is counterintuitive to the NHA. Section 3(2) of the NHA provides that the Minister must establish a health system for the population. If provincial health departments do not perform optimally the Minister is already empowered by the NHA to address such problems.

8.2. Implications of changing the role of provinces

- 8.2.1. A change in the role of provinces will affect staff employed by provinces and have consequences for buildings, properties and equipment that provinces own in relation to a particular public health establishment.
- 8.2.2. The WCPDoH has at least 32 000 public servants in its employ. The labour relations processes that will be required as a result of the change in the legal status of hospitals and the envisaged system of contracting in the Bill will be far reaching and administratively complex.
- 8.2.3. Provinces employ scarce skills in the form of public health specialists, epidemiologists, business analysts, legal experts, and strategy experts. These skills are required for the public sector. With the changes envisaged in the Bill, it is unclear where these skills would shift to. Being highly mobile, the risk to the country is that these skilled individuals might not see a future and leave.
- 8.2.4. Provinces currently manage the district health system and district offices. In the Western Cape these units have extensive autonomy and the WCPDoH consistently works on strengthening their systems of support. In the Western Cape, for example, these structures have the necessary delegations to fulfil their

mandate and roles. This delegation framework provides for decentralised decision-making in respect of central hospitals and regional hospitals.

- 8.2.5. The reality is that provinces, as pointed out above, have been systematically underfunded. The Bill simply redirects the same available funding with a possible increase made up by increased pay roll taxes. In short, the funds allocated to provinces will not increase. The tax credit changes envisaged in the Bill can be implemented now and does not require the establishment of the NHI Fund for it to happen.
- 8.2.6. There is no reason to believe that the NHI Fund under the executive control of the NDoH would perform better than provinces. An example of capacity challenges at the national level is illustrated in paragraph 8.3 below where the failure of the NDoH in the management of national medicine contracts has led to an untenable situation where there is a national shortage of certain medicines.

8.3. Will the NHI fund have the administrative capacity to manage multiple contracts?

- 8.3.1. Clause 38(2) of the Bill deals with the establishment of an Office of Health Products Procurement to be located within the NHI Fund. This entity will be responsible for the public procurement of health-related products including, but not limited to, medicines, medical devices and equipment. Our concern with such an entity is its capacity to deal with the multitude of contracts it will be responsible for.
- 8.3.2. To put the impact of failure into perspective, the current situation with national medicine contracts must be considered. As certain medications are used in high volumes across the country, it makes sense for these to be purchased through national contracts, managed by the NDoH. In order to guarantee supply of such massive quantities of medication it is important to conclude contracts at least six months before the expiry of the current contract. Despite this knowledge, the NDoH has persistently not been able to conclude medication contracts timeously to prevent the disruption of medication supply. Presently in 2019, at any given time a stock-out of at least 100 line-items of medication is experienced. This includes anti-depressants, anti-psychotics and contraceptives and the most commonly used drugs for hypertension. The impact is felt by patients who are unable to access critical medication for their health conditions.
- 8.3.3. Presently, the NDoH is responsible for a limited number of contracts but is unable to conclude medication contracts timeously. The Bill proposes that all contracts will be dealt with nationally by the Office of Health Products Procurement. We are concerned that the current problems experienced with national medication contracts will be magnified many times over, leading to consistent stock-outs of medication, consumables and equipment across the country.

8.3.4. We propose that this issue is carefully considered and that sufficient and appropriate staff, systems and processes are put in place before attempting a centralised procurement process. This should not be attempted unless assurance can be given that the proposed Office of Health Products Procurement has the capacity to deal with its mandate. Anything less will harm patients.

8.4. The proposed role of the provinces in the implementation of NHI

8.4.1. The WCG's view is that the policy objective of the Bill i.e. UHC, can be achieved through a strong, collaborative partnership between the NHI Fund, the NDoH and provinces. This must be a partnership based on trust and the common goal of improving the lives of the public. The design of the Bill to establish the NHI Fund, resourced by a new taxation regime, to ensure the provision of quality health services free at the point of care does not turn on who the NHI Fund purchases services from and is not central to the operation of NHI. What appears to be central is that the NHI Fund remains the sole purchaser. The WCG submits that there does not seem to be any reason why the identity of the provider of health services must be the same in all provinces. Having different providers will not affect the beneficial gains of the NHI Fund if it were to purchase services directly from the Western Cape Province and from DHMOs and CUPs in other provinces. The WCG therefore proposes the following roles and functions for provinces:

8.4.1.1. It is acknowledged that the Bill provides in clause 32(2)(a) that the Minister may delegate functions to provinces as management agents of the NHI Fund for the provision of health services. However, this envisaged delegation is subject to the transitional arrangements of the Bill which clearly envisages a direct contracting relationship between DHMOs and CUPs under the auspices of the NHI Fund. It is also subject to the Minister initiating amendments to the NHA. It is therefore proposed that provinces are accorded a clear role in the scheme of the Bill whereby provincial governments, that have capacity and a track record of good performance, should become the NHI Fund's contracting units. Funds should flow through the provinces, who will develop and manage contracts with a mix of public and private providers.

8.4.1.2. Provincial governments should be responsible for all service provision within their provinces, including central hospitals and public and private providers, and should put in place appropriate governance arrangements. The WCG supports the idea that secondary and tertiary services are subjected to national oversight to ensure equity of access to services across provinces. It is proposed that the Bill should expressly without qualification provide that the NHI Fund contracts directly with provinces and that provinces are responsible for the planning, provision and coordination of health services in the

relevant province. This would be a unified health system following a unified strategy to achieve UHC.

- 8.4.1.3. Provincial governments must operate within the norms and standards and policy frameworks developed at the national level.
- 8.4.1.4. It is acknowledged that the capacity and functionality of provinces differ and the WCG proposes that the Minister adopts an approach that permits differential treatment of provinces to ensure service provision where a province has demonstrated that it is unable to do so.
- 8.4.1.5. It would be possible to pool resources by means of the NHI Fund and achieve UHC whilst retaining the functions of provinces as set out in the NHA currently. There is therefore no need, in our view, to amend the functions of provinces in the NHA. The objectives of NHI can be achieved within the framework of the NHA in its current form and in partnership with provinces.

8.5. Governance of central hospitals

- 8.5.1. Clause 7(2)(f)(i) and (ii) of the Bill provides that "In order to ensure the seamless provision of health care services at the hospital level the Minister must, by regulation designate central hospitals as national government components in accordance with section 7(5) of the Public Service Act, 1994.". Furthermore, it provides that the administration, management, budgeting and governance of central hospitals must be made a competence of national government.
- 8.5.2. The WCG is of the view that the Bill provides no reason why central hospitals should be made a national competence. The rationale offered in the Bill that it is "to ensure [the] seamless provision of health services" is a statement without any supporting evidence. Additionally, we do not believe that changing the governance arrangement in respect of central hospitals is necessary to achieve the policy goal of the Bill. UHC can be achieved irrespective of the functionary that central hospitals report to. The intention to change the governance arrangements relating to central hospitals is based on the assumption that the NDoH would manage central hospitals more effectively than the provincial authorities. There is no evidence to suggest that this will be the case. The WCG is of the view that there are compelling reasons for provinces to continue managing central hospitals and that if provinces retain control over central hospitals, it would not interfere or detract from the policy objective and design of the Bill which is to establish the NHI Fund as a single purchaser and payer of health services to ensure the delivery of quality health care services free at the point of care. It is not the core policy goal of NHI to break up an existing provincial health service, yet that will be the result if the management and control of central hospitals is shifted to national government. The reasons for this view are the following:

- 8.5.2.1. The two central hospitals in the Western Cape, do not only provide tertiary services. Both hospitals also provide general specialist services to the Western Cape. Together, the two hospitals account for 44% of the general specialist services in the Western Cape. These general specialist services are critical to the functioning of the provincial health service and significant disruption would lead to the fragmentation of the provincial health system.
- 8.5.2.2. The central hospitals in the Western Cape also provide general specialist, tertiary and quaternary services to residents from other provinces, particularly the Northern Cape and the Eastern Cape and additionally render regional and district hospital services.
- 8.5.2.3. The central hospitals in the Western Cape are fully integrated into the provincial health system. The staff is employed by the WCG. Resources, staff, knowledge, and even consumables are shared across the service platform. There is an overriding philosophy that these health facilities function as part of a service platform, not as individual entities. The image is that of a crisscrossing network of interactions that more closely resemble a spiderweb than a linear referral relationship. The chief executive officers of the central hospitals, in addition to managing their institutions, form part of the executive management of the WCPDoH and serve a critical role in the development of provincial health strategy.
- 8.5.2.4. Medical staff and resources are shared across institutions. Notable examples include:
- (a) Central hospitals perform outreach and support functions to other levels of the service platform. Should the governance arrangements in respect of central hospitals change as envisaged in the Bill, there is a risk that commitment to performing this function could be withdrawn under service pressure. This would be detrimental to the overall service platform.
 - (b) Theatre time is shared, and it is not uncommon for specialists from central hospitals to carry out surgical lists at district and regional hospitals e.g. orthopaedic surgery and breast cancer surgery.
 - (c) Training also happens across facilities with specialists from central hospitals training junior consultants through collegial agreements.
 - (d) The critical concern regarding the change in the governance of central hospitals is the resulting fragmentation of the health system. The first casualty of this fragmentation will be that the chief executive officers of central hospitals will no longer be part of the executive management of the WCPDoH. Health system decisions will be made without the input of central hospitals. Similarly, strategic decisions at central hospitals will be made without the input of provincial officials. The health system will effectively be divided. This will diminish the cohesiveness and coherence of the health system as it currently exists. The next

casualty of fragmentation is the movement of patients across the health system. Presently, patients are referred across the health system with relative ease. On the occasion when there are impediments to this, governance arrangements resolve issues rapidly. We are concerned that changing the governance of central hospitals will negatively influence the existing governance arrangements and lead to a fragmented referral system. Finally, and most significantly, the experience of the WCPDoH with the City of Cape Town and the military hospitals is that there are always barriers and impediments to relationships between health institutions with different reporting lines. These barriers and impediments affect functioning on almost every level. The result is a breakdown of a health system into individual health entities. This is antithetical to the principle of a cohesive health system and will lead to poorer service delivery.

- (e) Accountability is a further area of concern. If central hospitals report to the NDoH but provide services at a local level, then the question arises whether the hospital should be accountable to the NDoH or to the community it serves. The WCG is of the view that accountability is to the patients we serve and therefore central hospitals should report to the relevant provincial authority.
- (f) Training in the Western Cape is not limited to central hospitals. Undergraduate and post-graduate training occurs across the service platform. These arrangements are made relatively easily with a single agreement between the province and each of the training institutions. Altering the governance arrangements will lead to a more complicated training arrangement with multiple additional agreements and permissions.
- (g) The right to health care services is provided for in section 27(1)(a) of the Constitution, 1996. It is therefore government's constitutional obligation to ensure the best possible healthcare for the public. There are numerous reasons why shifting the governance of central hospitals to the NDoH will weaken the health system, leading to poorer health care service delivery. Additionally, as set out in paragraph 8.4, the Bill can be fully implemented without changing the governance of central hospitals. For the reasons set out above, clauses 7(2)(f)(i) and (ii) that transform central hospitals into national government components is not supported. It will lead to fragmentation of the service delivery system as well as the disruption of clear accountability lines and will have significant negative consequences.

8.5.3. The WCG proposes that central hospitals continue to function under the governance of the provincial departments of health. This will result in a more integrated and cohesive health system and therefore improved patient care.

We submit that the proposal will not impact on the policy objective of the Bill, which is the realisation of UHC. It is acknowledged that capacities, resources and capabilities differ between provinces and in situations where central hospitals have proven to be unable to fulfil their service mandate, and when their continued non-performance places the health system at risk, the WCG proposes that the Minister adopts an approach that permits differential treatment of provinces to ensure service provision where a province has demonstrated that it is unable to do so.

8.6. Governance of the NHI Fund as provided for in the Bill

8.6.1. The Bill empowers the Minister to:

- appoint ad-hoc committees that must conduct interviews for the board of the NHI Fund
- appoint the board⁶
- remove a board member under the specific circumstances set out in clause 3(8)
- dissolve the board under the specific circumstances set out in clause 13(9)
- add a discretionary complementary list to the Formulary

8.6.2. The Chief Executive Officer (CEO) of the NHI Fund will be appointed by Cabinet⁷ and will report directly to the NHI Fund board. The CEO will be the administrative head of the NHI Fund.⁸

8.6.3. On a reading of the above clauses of the Bill there will be considerable consolidation of power in the positions of the CEO and the Minister. The Minister will have full control of every aspect of health apart from that which relates to the military, the defence force and the State Security Agency. The Minister will have control of 8.3%⁹ of the gross domestic product of South Africa and will be able to influence the lives of every single member of the public. The most critical observation is that the board members, and the chairperson of the board, are to be appointed by the Minister. In the draft Bill, Cabinet would appoint the board members and they would elect a chairperson. All the power will then be vested in one individual, which poses great risk to accountable governance.

8.6.4. Whilst one of the functions of the Board is to develop the comprehensive health care services that are to be funded, representation on the board excludes representatives of civil society and public health management. Knowledge of health as a human right, the understanding and experience related to inter-sectoral actions required to address the social determinants of health, and

⁶ Clause 13(1) of the Bill

⁷ Clause 19(2)(b) of the Bill

⁸ Clause 20(a) of the Bill

⁹ This assumes that total health spending remains unchanged.

knowledge in respect of multi-level governance are specific skill sets that would be crucial for board members to possess.

8.6.5. The CEO will be the administrative head of health services and will have the authority to influence the health of every member of the public. The Bill envisages that the CEO is recruited and interviewed by the board and that the Minister will make a recommendation to Cabinet on the appointment of the CEO. The risk of undue influence by the Minister is evident.

8.6.6. The CEO has to establish sound fund administration and establish 9 units.

With regard to decision-making, the 9 units that would support the CEO, the NHI Fund, and the board, all advise the Minister. All decisions concerning health, healthcare and the purchasing for 60 million people will be vested in one person. This organisational arrangement has inconceivable governance risks.

The governance burden of the NDoH will increase exponentially with the establishment of the NHI Fund.

8.6.7. Currently the NDoH is responsible for the governance of a range of public entities that include the Office of Health Standards Compliance, Medical Research Council as well as a range of councils for health professionals.

8.6.8. Apart from newly added functions to the NDoH under the Bill, the Bill proposes that 10 central hospitals and at least 52 districts also report directly to the NDoH.

8.6.9. The WCG is of the view that such consolidation of authority is unhealthy for democracy in South Africa. The findings of the Nugent Commission¹⁰ should serve as warning of the impact that a single powerful individual can have on the functioning of a state institution and the impact this could have on the country. An ideology, a political view or even a personal bias could lead to health policy that could have devastating effects on the health of our population. What would the consequences be if a future Minister developed a view opposing vaccination? Put simply, the Bill does not have appropriate checks and balances with regard to the power of the Minister and the CEO.

8.6.10. Health system planning and the information system required for it is a function of the NDoH in the Bill. Clarity is needed on how this will work practically to ensure no duplication.

8.6.11. Whilst it is noted that the NHI Fund will be a section 3A public entity in terms of the Public Finance Management Act, 1999, the fact that it has a single purchaser-payer function, exposes it to extensive risk.

¹⁰ The Nugent Commission of Inquiry into Tax Administration and Governance by SARS

- 8.6.12. The NDoH is required in terms of the NHA to set national norms and standards, conduct monitoring and evaluation and oversee the running of districts. The NDoH will now under the Bill also have to manage the delivery of services through the NHI Fund. It is submitted that the management of the delivery of services is a function that should be separated from a policy development function.
- 8.6.13. The history of capacity challenges of the NDoH should be noted. See the comments regarding the management of national tenders for medicines in this regard. It is submitted that it is unlikely that the NDoH will be capable of dealing with the increased governance burden allocated to it in terms of the Bill.
- 8.6.14. It is proposed that the appointment process of the board as envisaged in the Bill is revised and redrafted to allow for a more inclusive process and that appropriate checks and balances for the appointment of the board members and the CEO are developed which should include but not be limited to the appointment process being subjected to a parliamentary oversight committee. Finally, we reiterate our recommendation that the NHI Fund, the NDoH, the Minister and the provinces collaborate to deliver health services to the public.

8.7. The impact of the Bill on the current provincial mandate

- 8.7.1. In the 2019-20 financial year health was the largest component of the Western Cape provincial budget. Health was allocated R 24.757 billion, or 36.87% of the total provincial budget.
- 8.7.2. The Bill proposes that a major portion of this allocation be centralised to the NHI Fund. In the scheme of NHI envisaged in the Bill the role of provinces will be reduced to the management of disasters, the management of ambulance services and the management of emergency medical services. It may include a role to act as a management agent of the NHI Fund, but this latter role is subject to the transitional arrangements of the Bill and if the Minister initiates certain amendments to the NHA successfully. In constraining the role of provinces to provide full health care services, the role of the head of the WCPDoH to deliver services to the residents of the Western Cape would be impacted. It is submitted that this will lead to poorer governance and ultimately, poorer service delivery.
- 8.7.3. Currently the accountability for health system performance rests with the head of the WCPDoH in terms of the Public Finance Management Act, 1999, and the NHA. The Bill is unclear with whom accountability for health system performance will rest.

8.7.4. The WCG is strongly of the view that the existing mandate of the provinces be maintained. The NHI Fund must work in partnership with provincial authorities to be co-stewards of health.

8.8. **The strategic purchaser role of the NHI Fund**

8.8.1. Clause 2(a) of the Bill provides for the role of the NHI Fund as the single purchaser and single payer of health services. The Bill combines the role of the funder and the strategic purchaser into a single structure. There is a lack of clarity on how this would work in practice. There is also a lack of clarity on the funding flows between the DHMOs, the CUPs, the NHI Fund, the NDoH and the provinces. Clause 57 of the Bill indicates that the purchasing of services will begin in phase 1 of implementation. In the absence of complete clarity and a shared understanding amongst all the provinces as to how this will work in practice, this proposal is not supported. Clarity will only emerge when the relevant literature and the global experience is studied, and these learnings are customised to suit the local context.

8.8.2. The strategic purchaser function is critical to improve access, equity, and efficiency to meet service needs. The WCG supports the principle of strategic purchasing. However, the dangers of vesting the total strategic purchasing power in one entity are as follows:

- Poor performance will have a multiplied effect across the country.
- Failure to conclude contracts timeously would lead to national stock outs. See the earlier comment on the shortage of certain medicines.
- Contracts will be more complicated thereby increasing the audit risk.
- The NHI Fund may struggle to find sufficient suitably qualified and skilled staff to carry out its functions.
- The large financial exchanges will make the NHI Fund a target for poor financial management, impropriety, fraud and corruption.
- The strategic purchasing of services requires a nuanced understanding of local context, population needs and provider dynamics of both the public and private sectors. This is difficult to achieve solely within a highly centralised national structure.

8.8.3. Negotiating prices, using economies of scale for commodities as well as the tariffs to be paid to the providers of services will be an important function of the NHI Fund. However, determining what services are to be reimbursed by the NHI Fund and the actual purchasing of services to meet the population health care needs must be decentralised to local regional settings. The WCG therefore strongly proposes that the provinces play a strategic purchaser role.

8.9. **Duplication of functions between the District Health Management Office and the Contracting Unit for Primary Care**

- 8.9.1. Clause 36 of the Bill establishes the DHMOs as national government components responsible for the management, facilitation, support and provision of primary health care services at district level. Clause 37(a) of the Bill establishes the CUPs as an organisational unit responsible for the provision of primary care services. Clause 37 expands on the role of the CUPs as the preferred organisational unit with which the NHI Fund contracts.
- 8.9.2. The roles and functions described in clauses 36 and 37 of the Bill for DHMOs and CUPs, respectively, overlap and when those clauses are read together, the following questions emerge:
- Who oversees the corporate governance of these two functionaries?
 - Who oversees the clinical governance of these two functionaries?
 - Who oversees quality?
 - What is the role of the NDoH in the scheme?
 - What is the role of provinces in the scheme?
 - What is the role of the municipalities in the scheme?
 - How are the DHMOs and the CUPs funded?
- 8.9.3. There is very little detail in the Bill on how the governance arrangements would work at district level. There appears to be an intentional fractioning of health into three different systems, with the provinces, the DHMOs and the CUPS having different roles. If the proposed plans for the central hospitals are factored in, the provincial health system will be fragmented into at least four components.
- 8.9.4. It is not clear whether DHMOs and CUPs are intended to operate in addition to the existing district and sub-district offices, respectively, or whether they are intended to replace these offices. If the former, then there could be significant overlap in the roles and responsibilities of each functionary which will lead to overlap and duplication of efforts. This will add layers of bureaucracy which will slow down processes, increase costs and reduce efficiency.
- 8.9.5. It has been pointed out that the Bill proposes the establishment of a range of additional units. These further administrative units consist of the decentralised offices of the NHI Fund, DHMOs as well as CUPs (at least 180). These additional administrative units will have to be funded from existing health funds, which have been reducing year on year and left provinces in dire straits. It is important to note the range of the administrative actions that the Bill requires, for example, the administrative actions required to establish new boundaries for districts, the human capital and the infrastructure processes required to shift functions to the NHI Fund. Service delivery in the public sector will deteriorate further during the period of transition envisaged in the Bill. Provincial treasuries will be less inclined to keep on investing in a service that will be drawn up to the NHI Fund, especially given the fact that the equitable share of provinces will be shifted to the NHI Fund.

8.9.6. It is submitted that the result of this will be a fragmented, onerously structured and unaffordable system with no clear leadership. This will lead to a narrow localised approach that focuses on provincial interests to healthcare instead of the preferred systems approach, which may lead to worsening inequity and poorer health outcomes.

8.10. Changes to the conditional grants, equitable share and revenue retention

8.10.1. As stated in paragraph 5.1.3, the Bill is unclear on how the NHI project will be funded and detail may only be provided in future legislation. This staggered approach to providing clarity may lead to fundamental health system reforms being launched in the absence of certainty on funding. The fragility of the health system must be emphasised and an incoherent, staggered approach will result in the destabilisation of the system.

8.10.2. The total budget of the WCPDoH is made up of the province's equitable share, conditional grants and revenue collection. The conditional grants make up 26% of the budget while revenue collection accounts for 2.5% of the total budget. The Memorandum on the Objects of the Bill at paragraph 2.2.4 states that the intention is to shift some of the funds in the conditional grants to provinces to the NHI Fund in phase 1 of the Bill's implementation. In phase 2, paragraph 2.2.5 outlines the plans to shift portions of the equitable share to the NHI Fund.

8.10.3. It is noted with some concern, that there is no mention of the pooling of private healthcare funds in phase 1 and phase 2, despite this being a critical policy design component of the Bill. We are therefore compelled to conclude that all risks in the early implementation of the Bill will be borne entirely by the public sector. If this assumption is correct, then the WCG objects to this proposal as the public sector is the most fragile part of the health system, servicing the most vulnerable members of society.

8.10.4. Serious concern must also be raised concerning the reallocation of conditional grants in phase 1 when the Bill will not be fully implemented. Health budgets are precariously balanced on a knife edge. In the last 3 years in the Western Cape, the real budget allocation was decreased by R602 million. In the next 3 years it is anticipated that our real budget will reduce significantly even further. Despite this, provinces will continue to provide healthcare to a growing population. After many years of budget cuts, the WCPDoH has no further capacity to absorb any further reduction in financing. Any further reductions, particularly with regards to the conditional grants will have catastrophic consequences for service delivery. The result may be the complete collapse of the health service in the Western Cape, or at the very least a marked reduction in services. We submit that this may also occur in other provinces, many of which are in a more precarious financial position than the Western Cape.

- 8.10.5. Revenue collection accounts for approximately 2.5 % of the total budget, a small but significant amount, enough to run a regional hospital like the New Somerset Hospital. If this revenue is re-allocated to the NHI Fund, the impact on the Western Cape will be a commensurate drop in service output. In a system that is already at capacity the consequences will be borne by our patients who will experience a decrease in service delivery.
- 8.10.6. It may be argued that the services offered by the NHI Fund in phase 1 will make up for the drop in services by provincial departments across all provinces. We strongly disagree. Firstly, it is not possible to argue that the services will be augmented as the service packages in phase 1 have yet to be determined. Secondly, each province is different and the service package to make up for the loss in provincial service output will have to differ from province to province. Finally, we believe that this can only be done if the NHI Fund works through the provincial governance structures, and there is no indication in the Bill that this is the intention.
- 8.10.7. Phase 1 envisages the establishment of the NHI Fund. The funding to establish the NHI Fund will come from conditional grants because it is only in phase 2 that the Bill envisages the shifting of the provincial equitable share. The result is that the current reduced health funding will be reduced even further and will have to fund the establishment of this new administrative entity thereby reducing available funding to provinces even further. Provinces will have to continue to provide services during phase 1.

In summary, the planned re-allocation of conditional grant funds to the NHI Fund in phase 1 unfairly focuses on the public sector. The loss in funding will result in poorer service delivery by provinces.

8.11. The role of regional and specialised hospitals

- 8.11.1. Even though clause 32(2)(a) and (b) alludes to some extent to the roles of regional hospitals, it does so subject to clause 57 of the Bill which deals with transitional arrangements. It is also subject to the Minister initiating certain amendments to the NHA successfully. In sum, clause 32(a) and (b) is not definitive of the role of regional and specialised hospitals in NHI. For lack of clarity, it is assumed that these hospitals, in the absence of the Minister initiating the necessary changes to the NHA in accordance with clause 32, would presumably form part of the CUPs and DHMOs? If so, this would add another layer of uncertainty on an already confusing governance system.
- 8.11.2. Specialised hospitals in the Western Cape include psychiatric hospitals, rehabilitation centres and TB hospitals that are not limited to a sub-district or district footprint. These facilities service multiple districts across the Province. The drainage areas are designed to promote access to care for areas that are not necessarily close to these facilities e.g. George Regional Hospital should be able

to access Valkenberg Psychiatric Hospital located in Cape Town just as easily as New Somerset Hospital, despite the former being 429 km away, and the latter only 11km away. These hospitals will presumably be placed under the governance of DHMOs or CUPs, both of which have a mandate that covers a localised geographic area. This may lead to preferential services based on the location of the institution. This in turn will worsen inequity for patients who live further away from these specialised institutions.

- 8.11.3. It is therefore recommended that the provisions providing for the DHMOs and CUPs be deleted. Clause 32 proposes, within the circumstances described in that clause, that the NHI Fund contracts with these hospitals through provinces in their capacity as management agents of the NHI Fund. This, we submit, should be the explicit model for NHI in the Bill without qualification in relation to the provision of all health services. The NHI Fund should work through the provincial department which in turn governs provincial health systems. The governance of the specialised hospitals should therefore remain with the provinces. This approach promotes equity and a systems approach to health management.

8.12. The role of intermediate care facilities

- 8.12.1. The Bill does not mention intermediate care facilities and the role they play in the health system. Currently, in the Western Cape Metro, they play a particularly important role in decongesting acute hospitals. Patients are transferred to these facilities to make space for new admissions. In the Western Cape Metro, where bed utilisation rates are an average 95%, these intermediate care facilities form an essential part of the health system by improving access to acute hospital beds and improving the efficiency of bed utilisation. The removal of these facilities from the health system would reduce access to care.

- 8.12.2. The role of intermediate care facilities in the health system must be explicitly provided for in the Bill, particularly its governance structure, funding model and service package.

8.13. The package of care and benefits envisaged by the Bill

- 8.13.1. The Bill does not provide detail and hence clarity on the package of care and benefits that will be provided by the NHI Fund. We are therefore compelled to make assumptions about the eventual package of health services that will be available to people and the impact this may have on health expenditure. Health-user behaviour is driven by the availability of services. Therefore, the greater the availability of services, the greater the utilisation and consequent cost. Four possible scenarios are envisaged for what the service package may include as informed by funding considerations:

- In the first scenario, the service package will be based on available resources. The risk of this model is that the service package may change

from year to year depending on available resources. This is unlikely to be accepted by the public who will have to pay for the deficit in services.

- In the second scenario, the service package will be fixed. The danger of this scenario is that healthcare expenditure could far exceed available resources. This may necessitate additional funding from National Treasury.
- In the third scenario, the service package could be reduced to factor in fluctuations in cost and utilisation. This may lead to a markedly reduced service package, which may be unpalatable to the public.
- In the final scenario, a comprehensive package of care could be developed, based on affordability, and which meets the expectations of the public.

8.13.2. In each of the above scenarios, there is significant risk and uncertainty brought about by the paucity of information on the package of care that the NHI Fund will cover. Urgent consideration needs to be given to the service package for NHI, followed by a costing of that package. It would not be appropriate to consider full implementation of NHI without a clearly defined service package and an informed costing thereof.

8.14. The social determinants of health

8.14.1. The health services sector is the receiver of health problems. Many of these health problems are caused by social determinants such as poverty, unemployment, and social deprivation. If we are to meaningfully address the burden of disease, the social determinants of health need to be addressed, either directly by the NDoH or provincial departments of health or through our partners in government and society. Despite its importance, the Bill does not mention the social determinants, but focuses on direct service delivery. In our view, this is partly driven by the lack of coherence of the governance structures proposed in Bill. It is unclear what role the DHMOs or CUPs will play in addressing the social determinants of health or if they will play any role at all.

8.14.2. To address the social determinants of health, a governance structure is required that is not established only as a health service provider, but as a steward for health. It is submitted that this role could be filled by the provinces and that the social determinants of health could be addressed by working with partners in government, civil society and the private sector.

8.15. The whole-of-society approach

8.15.1. The Whole of Society Approach (WOSA) is an approach to service delivery where government departments in all spheres of government, civil society, the private sector and communities work together to create value for the public. This value is expressed in service delivery and a physically and psychologically healthy society, that is educated, safe, economically secure and spatially

connected. This is an evolution of how we view the role of government. The WCPDoH has started on its WOSA journey.

8.15.2. The Bill does not make any meaningful mention of intersectoral collaboration and instead focuses on linear relationships between the NHI Fund, NDoH, CUPs and DHMOs. The governance arrangements as set out in the Bill appear to be a step back from the important WOSA approach. It is our contention that the current governance system proposed by the Bill lacks the alignment, cohesion and leadership to pursue a WOSA approach. It is therefore proposed that the Bill is reconsidered with a view to considering the role of intersectoral collaboration in improving health service delivery.

8.16. The regulator function of the NHI Fund

While the Bill alludes to the certification of entities by the Office of Health Standards Compliance and the need for accreditation by the NHI Fund, it remains silent on licensing processes and the roles and responsibilities of the functionaries entrusted with the licensing of health establishments and providers. It is proposed that a coherent policy framework is developed that sets out the roles and responsibilities of this function in the Bill. It would be prudent if the Health Market Inquiry report is considered in the development of the policy.

9. Factors to consider in designing a system to achieve UHC

In addition to that set out above, it is submitted that the following should be considered when designing a system to achieve UHC:

9.1. Public Health Service Strengthening (HSS)

The current public health system provides healthcare for 85% of the population. A strong health system is essential for the success of the Bill and the achievement of UHC. Public HSS will require a plan to strengthen the health system at a systemic level to build a capable public health service with optimally functioning systems. Public HSS must ensure:

- Strong, ethical leadership and management with effective accountability.
- Clear design and governance principles.
- Strong external partnerships and relationships across all levels.
- A shared vision, purpose and values.
- Community connectedness.
- Functional systems, policies and processes.
- Optimal health outcomes.
- The principle of subsidiarity (local accountability and decentralised management) must be observed.

- Strong, coherent and inter-connected building blocks (including financing, service delivery, workforce, information, technology, infrastructure)

9.2. Allow space and time to incubate flexible and differentiated models

The Bill represents major and complex health system reforms, in both the public and private sectors. The strengths and weaknesses of health services, and the environments in which they function, differ greatly across the country. Implementation of UHC should not be seen as an event but as a process that will evolve over time and should be flexible enough to result in differentiated models. A phased approach will allow the time and space for HSS interventions within a fragile public health system to take root as well as for the incremental launch of carefully crafted innovative models in line with the goal of UHC. In this regard, the Western Cape, Eastern Cape and Kwa-Zulu Natal have partnered to provide urban and rural learning sites to test tangible options to improve service delivery and private sector contracting. There are many good practices in both the public and private sectors and mechanisms to share and scale up across the country should be explored.

9.3. The system needs an accountable functionary

The health system, due to its complexity and inter-sectoral connections, needs clear lines of accountability. It is contended that a provincial department of health and its accounting officer could fulfil this role. The provincial departments that have capacity and a track record of capable and competent governance could be the functionary through which all funding, including the equitable share, additional NHI funds and conditional grants could flow. Provincial governments will in this proposed model be accountable for all service provision within their provinces, including central hospitals and public and private providers, to ensure a coherent health system providing optimal service delivery. Governance decisions will be made as close as possible to where services are delivered, to ensure optimal responsiveness. The provincial departments will be held accountable for health outcomes, fiscal discipline and good governance. Provincial governments will operate within the norms and standards and policy frameworks developed at the national level. This will ensure a responsible and accountable mechanism for ensuring UHC through mechanisms such as capitation models, strategic purchasing and contracting. However, the Minister must, in this proposed option, strengthen mechanisms to address situations in provinces where there is a lack of service delivery or early signs of system failure.

9.4. Flexibility

Local context, performance, track record and capacity vary significantly across provinces. Therefore, an important principle of achieving UHC is a shared commitment towards the goals of UHC that simultaneously allows for flexibility in organisational arrangements and processes to achieve the same end of UHC, with clear lines of accountability for performance.

10. Conclusion

- 10.1. The WCG would like to thank the committee for the opportunity to provide comments on the Bill. This is the most ambitious proposed health restructuring programme since the start of our democracy and it can only be achieved by drawing on the vast experience of all stakeholders. Such undertakings are not without inherent risk, and we hope that in the implementation of the Bill, due caution is taken in maintaining service levels. Together, we are co-stewards of health, and we look forward to a healthy partnership in our journey towards achieving UHC.
- 10.2. We request an opportunity to present oral submissions to the committee on a mutually convenient date.

Find attached our clause-by clause analysis of the Bill.



Ms. Mbombo

Provincial Minister of Health

Western Cape

Date:

2019/11/28

