

SECTION27 AND TREATMENT ACTION CAMPAIGN SUBMISSION

DRAFT NATIONAL HEALTH INSURANCE BILL, 2018

DRAFT MEDICAL SCHEMES AMENDMENT BILL, 2018

DRAFT NATIONAL QUALITY IMPROVEMENT PLAN, 2018

21 September 2018

Introduction

1. SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights. Our name is drawn from section 27 of the Constitution which enshrines everyone's right to health care services, food, water and social security.
2. The Treatment Action Campaign ("TAC") is a membership-based organisation with over 8000 members in 182 branches across the country. It is the premier HIV and health activist organisation in the country and works for its members who are the people who most need the public health system to work.
3. SECTION27 and TAC work to ensure the realisation of the right of access to healthcare services. We therefore support wholeheartedly any efforts to achieve universal health coverage. It is in this context that we make these submissions.

4. Between June and August 2018, there has been significant development in health policy and the release of important evidence on the problems in the system. In particular,
 - a. on 5 June 2018, the Office of Health Standards Compliance released its Annual Inspection Report for 2016/17;
 - b. on 21 June 2018, two Bills were gazetted – the National Health Insurance Bill, 2018 (“NHI Bill”) and the Medical Schemes Amendment Bill, 2018 (“MSA Bill”);
 - c. on 5 July 2018, the Preliminary Report of the Health Market Inquiry was released for public comment; and
 - d. at a Stakeholder Consultation on NHI on 24 August 2018, the Draft National Quality Improvement Plan, 2018 (“NQIP”) was presented to delegates.

5. It would be remiss of us not to consider these documents collectively. The above documents were also published in the context of now widely recognised dysfunction in one important aspect of the health care system – mental health. The findings and award in the Life Esidimeni Arbitration, handed down on 19 March 2018; the findings of the Health Ombud in respect of Tower Hospital in the Eastern Cape, released on 23 August 2018; and the preliminary report of the South African Human Rights Commission on the mental health system across the country all demonstrate deep seated issues in mental health care services.

6. Together the various reports and proposals provide a good indication of the evidence for the problems in the private sector, an assessment of the problems in health facilities in the public sector, and the steps being proposed or recommended to remedy these problems.

7. In this submission we provide comment on three of the policy documents recently released: the NHI Bill, the Medical Schemes Amendment Bill, and the Draft National Quality Improvement Plan. While we provide specific comment on each of

these documents in turn, we must forefront our comments with our overall concern.

8. We are in agreement that the current two tiered health system is inequitable and that there is a need to change health funding. We are further in agreement that the right of everyone to access to health care services means that everyone should be able to access quality services on the basis of need, rather than on the basis of ability to pay. This agreement is unequivocal. However, this agreement does not require agreement with the way in which the change to the health system and the establishment of the NHI Fund has been laid out in the NHI Bill and associated documents (“NHI proposals”). Disagreement with the NHI proposals does not, in our case, equate to anti-poor sentiment or satisfaction with the status quo. Instead, the purpose behind our criticism is that we are concerned to ensure the health system reforms that are required are in fact implementable and sustainable.
9. As it stands we have two overarching practical concerns with the NHI proposals. First, the proposals are likely further to weaken the health care system by creating undue complexity, and deepening governance and financial management problems. They do not establish a coherent health system structure and risk exacerbating current dysfunctionality. Second, the proposals do not take into account the parlous state of the health care system currently and therefore, even if the proposals were to set up a coherent structure, they lack specificity on how they will overcome the serious defects in the health system and, thus, would not be capable of implementation. Both concerns mean that we run the risk of not achieving the goal of NHI: universal health coverage.
10. While the process of developing policy on NHI has been long, it has not been transparent. We are aware of research being commissioned, workstreams submitting reports, and the Treasury issuing a discussion document, none of which has been released into the public domain. Rather than encouraging a careful analysis of evidence and policy options, the weighing of evidence from other

countries, and fostering real critical engagement on how to make NHI work, the National Department of Health's discussion of NHI has been based largely on rhetoric. In adopting this approach, the Department has failed to capitalise on the knowledge, experience and expertise of the many people who work in, use and study the public health system and indeed the private health system. It has failed to allow the public to participate meaningfully in the policy making process by withholding the information and research that it has obtained, no doubt at some expense. The result is an NHI proposal that neither speaks to the health system problems that we are experiencing, nor proposes a viable alternative. And it certainly does not show how the Department proposes that we get from the health system we have now to that envisaged under NHI.

11. Under the NHI proposals, a complex and large fund will be set up that will be complicated to manage and tempting to loot from. Many contracts will be created that will require skilled HR capacity to manage – skills we do not presently have in the public service. New structures will be created with overlapping functions and unclear relations to each other, further complicating the political tensions already present in the health system. Excess capacity will be leveraged from the private sector to serve all health service users, but how this will be done in practice remains opaque. And maybe most importantly, little will be done to address the underlying political and governance challenges that are the sand in the gears of our public service.
12. Legally, section 27 of the Constitution requires that government takes reasonable measures progressively to realise the right of access to health care services. Reasonableness has been interpreted in this context to require that the measures must be comprehensive, coherent and coordinated¹ and must be reasonably conceived and implemented.² The NHI proposals are neither coherent nor are they reasonably conceived. Implementation of the NHI proposals also risks regression in access to health care services, a violation of section 27 of the Constitution. Finally,

¹ *Government of RSA and Others v Grootboom and Others* 2001 (1) SA 46, para 39 and 40.

² *Grootboom* para 40-43.

the NHI proposals have been developed contrary to section 195 of the Constitution which requires responsive, transparent, and people-centred public administration. We are therefore of the view that the proposals in the NHI Bill and associated documents should not be forwarded to Parliament in their current form. There is a need for a dramatic rethink and the development of an immediately implementable outcomes-based plan aimed at improving quality of and access to health care services.

13. Below we provide our more specific comments on the NHI Bill, the Draft National Quality Improvement Plan and the Medical Schemes Amendment Bill. We conclude with a proposal on the way forward.

Comment on the NHI proposals

NHI Bill

14. While we are concerned about many aspects of the NHI Bill, we highlight our foremost concerns below.

15. The NHI proposal relies primarily on the establishment of the NHI Fund. The role of the Fund is many layered and includes purchasing services, designing the health services that it will purchase, accrediting providers, entering into contracts with providers, establishing mechanisms for payment of providers, determining prices, collating data and doing research with that data, and conducting various forms of analysis.³ This variety of roles will require significant administrative infrastructure and capacity that is not currently present in the public sector. Indeed even in many of the existing regulatory bodies in the health system there is a skills, budgeting and capacity crisis that must be analysed and addressed.

16. There is also little separation between the Fund and the Minister. The Minister recommends people for appointment to the Board of the Fund,⁴ has the ability to dissolve the Board,⁵ appoints the CEO⁶ and is responsible for stewardship of the Fund.⁷ The Fund must, moreover, account to the Minister for the performance of its functions and the exercise of its powers⁸ and support the Minister in fulfilling his or her obligations under section 3 of the National Health Act.⁹ A significant contributor to the failures in the public health system at present is the blurring of lines between the political and the administrative, particularly at provincial level. Accordingly, there is a need to establish structures and systems of governance that insulate a reformed health system from this risk. Having all health funding and most decisions on health largely in the hands of one politician is dangerous.

17. There is little detail on how the Fund will be isolated from corruption and fraud. The Fund must “take all reasonable steps to prevent and discourage” corruption

³ NHI Bill, section 5(1)

⁴ NHI Bill, section 14(1)

⁵ NHI Bill, section 14(9)

⁶ NHI Bill, section 21(2)

⁷ NHI Bill, section 32(b)

⁸ NHI Bill, section 5(1)(m)

⁹ NHI Bill, section 5(3)

and fraud,¹⁰ must identify, develop, promote and facilitate the implementation of best practices in respect of fraud prevention¹¹ and the CEO must appoint an investigating unit to, inter alia, investigate corruption.¹² This is the extent of the detail on protecting the entire pool of money for health in the country. In the light of large scale corruption and mismanagement of funds in the health system, this lack of detail is startling.

18. Finally, a public distrust in large funds and state owned entities, stemming from national experience with SASSA, the RAF, Eskom, SAA and others, necessitates careful consideration of the need for centralisation of funds and the mechanisms that will be adopted to protect such funds and assure decision-making in the interests of the people of South Africa.

Roles of departments and new structures under NHI

19. The role of provincial departments of health under NHI has been in question for some time. The NHI Bill now provides that provincial departments of health remain responsible for the provision of health care services for the Fund to purchase. They are responsible for providing and maintaining equipment, vehicles and facilities in the public sector (it is not clear whether this includes paying human resources but we assume that it does).
20. However, a major change comes in the way in which the provincial departments of health receive funding. In our understanding of the Bill, funding for primary health care services will be channelled to provinces for services provided in the facilities owned by the province, via the Contracting Unit for Primary Care (“CUP”). The CUP contracts with facilities and pays facilities with which it has contracted using money provided by the Fund.¹³ To put it simply, the national structure (the Fund) pays a sub-district level structure (the CUP) which then pays contracted providers

¹⁰ NHI Bill, section 6(1)(l)

¹¹ NHI Bill, section 6(2)(i)(vi)

¹² NHI Bill, section 22(2)(g)

¹³ NHI Bill, section 35(4) and 37(1)

(owned privately, by the province, or by the municipality). The political implications of money flowing from national to a sub-district body and then to the province are likely to be complicated and open to abuse, making its practical implementation very difficult. This is one concrete area in which the implementation of the NHI proposals might well result in greater mismanagement and poorer health outcomes than the current system.

21. Apart from its politically complicated existence, the CUPs will need to be sophisticated and multi-skilled structures, capable of performing an extensive role including identifying health care service needs of the sub-district, identifying providers, monitoring contacts, monitoring disbursement of funds, accessing information on disease profile of the district, ensuring functionality of the referral system, issuing certificates of accreditation, facilitating integration of public and private services, and resolving complaints.¹⁴ The decentralised and complex nature of this structure necessitates the presence of considerable capacity at sub-district level – a level of leadership that has until now been neglected. Implementing the NHI proposals in the absence of this capacity is extremely risky and may be setting NHI up for failure.

22. At district level, another new structure is envisaged. The District Health Management Office (“DHMO”) appears to have contradictory functions in the body of the NHI Bill and the section of the Bill displaying amendments to other legislation – in this case the National Health Act 61 of 2003 (“NHA”). The DHMO must either facilitate, coordinate and manage the provision of non-personal public health care programmes at district level,¹⁵ or must facilitate, coordinate and manage (under the supervision of the MEC) the provision of primary health care services at district level.¹⁶ This contradiction in the Bill makes it difficult to determine the role of the DHMO. Amendments to the NHA suggest that the DHMO

¹⁴ NHI Bill, section 37(2)

¹⁵ NHI Bill, section 36(1)

¹⁶ NHI Bill, Amendment to the National Health Act through insertion of section 31A(1)

will share some functions with the provincial department of health¹⁷ and others with the CUP,¹⁸ while being established as a public entity under the supervision of the provincial department of health.¹⁹ The overlap of roles with sub-district and provincial level structures, contradictions in the roles of the DHMO within the Bill, and the funding of the DHMO through the provincial department of health makes the need for the establishment of the DHMO unclear.

23. In addition to political and structural implications, creating new structures and changing funding streams has legal implications. As a concurrent legislative competence under Schedule 4 of the Constitution, “health services” is a matter on which both national and provincial legislatures may legislate. While national legislation on NHI is likely to prevail under section 146(2)(b) of the Constitution, if the health system were redesigned to so that provincial legislatures would never be able to legislate on health because of the standardisation of the system, health would become in practice a national competency, contrary to Schedule 4. It is not clear from the NHI Bill whether there would still be space for provincial legislation on health services.

24. The proposal fundamentally changes the role of provinces and introduces structures at various political levels. Some structures take over or share current provincial department of health competencies. While there is some amendment to the NHA to reflect this, the amendments do not seem sufficient to embed the changes envisaged elsewhere in the NHI Bill. There will also be a need to change the formula for calculation of the equitable share and the budgets allocated to provinces so the administrative costs of the provincial departments of health and of DHMOs are covered, while the services provided by province-run health facilities are excluded.

¹⁷ Such as ensuring that each health district and sub-district is managed effectively (s31(6))

¹⁸ Such as the identification of certified and accredited health care providers (s31A(2)(c))

¹⁹ Insertion of section 31A(1) into the NHA

25. While we recognise the shortcomings of the current funding system in public health, we advise against the implementation of an equally problematic system. Rather than working around provincial departments, consideration must be given to use of public planning and accountability mechanisms to enforce performance and to the reasons for current poor performance. Not only is the current proposal very likely to be subject to legal challenge by provinces (and to push back in the National Council of Provinces) on cooperative governance grounds,²⁰ but it risks creating new legal, political and health system problems in an attempt to avoid the current political and health system problems.
26. If we are to proceed down this road (and we caution against it) the new structures would benefit from a piloting programme to determine the extent to which they are likely to succeed. Unlike in the case of the NHI pilot districts, a transparent process for piloting and assessing the piloting of the envisaged structures must be established.

Contract management

27. The premise of NHI is to harness the benefits of monopsony (or single-purchaser) power by using a single public purchaser (the Fund) to buy services from accredited health facilities rather than using global budgets for the funding of health facilities. While this allows the purchaser to determine prices, it essentially turns the health system into a supply-chain and contract management system. The Fund will need to manage contracts with hospitals (there were 480 hospitals – public and private – in the country in 2016)²¹ and CUPs (of which there will be at least 208 if there is one CUP per sub-district).²² CUPs will need to manage contracts with facilities, public and private, and other suppliers.²³

²⁰ See Chapter 3 of the Constitution, *Minister of Police and others v Premier of the Western Cape and others* [2013] ZACC 33 at [64] and *National Gambling Board v Premier of KwaZulu-Natal* 2002 (2) SA 715.

²¹ South African Health Review 2017, p 300

²² NHI Bill, section 5(1)(d)

²³ NHI Bill, section 37(2)(d)

28. The Bill is silent on the capacitation of the various role players to manage such contracts. According to health professionals, supply chain management is at the centre of much of the corruption and vast wasted expenditure in the health system and elsewhere. An urgent review of this system together with capacity-building and functional systems to prevent, detect, and prosecute corruption are required.

Lack of detail

29. While the Green and White Papers provided some information on, for example, human resources for health, the development of infrastructure, and the funding streams and funding mechanisms, the NHI Bill is largely denuded of this detail. Instead, responsibility for determining the comprehensive health service benefits package, the means of reimbursement and other key details are left to committees²⁴ and to the Minister by regulation.²⁵ There were advertisements for committees in July 2017 but to our knowledge, no committees have yet been appointed. The composition of the committees and their terms of reference also bring into question whether they will be able to fulfil the important functions assigned to them.

30. The lack of detail about the salient features of the health system under NHI is of great concern. We have repeatedly submitted that government cannot be expected to know, for example, exactly how much the system will cost. Nevertheless, either not knowing the details or hiding all details from the public is not the way to implement massive health system change.

31. The Bill pays little attention to the important health governance structures including hospital boards and health committees. While these structures require enhanced capacity to ensure the effective governance of health facilities under NHI, they have been ignored.

²⁴ NHI Bill, Part 5

²⁵ NHI Bill, section 52

32. It is concerning that no motivation or supporting evidence has been given for various specifics in the design of the NHI proposals, particularly regarding the roles of DHMOs and CUPs. The public has not been told why DHMOs and CUPs specifically are required, as opposed to any number of other potential structures. Ideally, the public would have been apprised of various structural options together with the evidence and arguments in support of using these structures during the White or Green Paper phase. This would allow the public to understand the ultimate decision to elect this structure and roles ahead of possible alternatives. As it is, there has been no real public discussion of the structural options open to us in implementing NHI.

Regression in access to health care services by migrants

33. The NHI Bill provides for access to services for refugees and asylum seekers only for emergency medical treatment; for maternal and child health and primary health care level; and for treatment and screening for notifiable conditions.²⁶ No mention is made of undocumented migrants.

34. Currently, refugees, asylum seekers and undocumented migrants from SADC states are entitled to be treated the same as South Africans, including being means tested to determine the level of state subsidisation of the cost of their health care services.

35. While the Constitution requires the progressive realisation of the right of access to health care services, the NHI Bill envisages a dramatic regression in access to such services. Such regression is likely to be the subject of legal challenge.

²⁶ NHI Bill, section 7(2)

Access to information

36. The NHI Bill provides for access by health care service users to their own health records in line with the provisions of the Promotion of Access to Information Act 2 of 2000 (“PAIA”).²⁷ While it ought not to be used in this way, PAIA is in fact used as a block to access to information. It requires that a request is made in writing to the public body, which then has a lengthy period to comply with the request. There appears to be no justification for requiring a health care service user to go through such a process to obtain their own health records. Instead, users should be provided with instant and easy access to their healthcare information through secure online services and on request at healthcare facilities.

Timing of implementation and law reform

37. We have repeatedly warned against government setting itself (and the health system) up for failure by pushing through legislative reforms and aiming for implementation within an unrealistically short period of time.
38. Phase one of NHI concluded in 2017 and phase two was meant to start the same year. There has been no publically-available assessment of phase one and yet we are now in the midst of phase two. Rushed implementation, in the absence of almost all salient details and plans, could be fatal for the health system and the people who rely on it.
39. There is no indication in the NHI timeline that law reform and implementation are contingent upon reaching various predetermined benchmarks, particularly in terms of human resource capacity and infrastructure. This creates the obvious risk that new systems will be implemented absent the required infrastructure and capacity. As it is, it appears that the NHI Fund will be set up in the absence of the health system from which it will buy services.

²⁷ NHI Bill, section 9(c)

40. A particular concern arises in relation to the repeal of section 4 of the NHA which provides for the right of everyone to free health care services at PHC level, of pregnant women and children under 6 to free health care services at state facilities, and of women to free abortions. The immediate repeal of this provision would have potentially disastrous consequences, particularly for vulnerable groups. While some provisions of the NHI Bill, due to their lack of specificity, will likely have no impact on users of the health care system (in itself a problem), others have a profound impact. This needs to be taken into account in the timing of promulgation of different sections.

Draft National Quality Improvement Plan

41. The Draft National Quality Improvement Plan (“NQIP”) represents an acknowledgement by the Department of Health that there are deficiencies in the current health system which require developing a detailed and adequately funded quality improvement plan and guideline.²⁸ We welcome this recognition. However, we are concerned that the NQIP does not suggest a clear or realistically realizable plan to attain its intended objectives for health establishments’ ability to meet NHI requirements.
42. The NQIP appears to be a plan for another plan in order to “bring all these initiatives together, identify those that are working well and review the implementation of those with poor results.”
43. The Access to Quality Health Care in South Africa Report identified the lack of publicly available, comprehensive, and accurate data (in particular in relation to health outcomes) on both the public and private health sectors, as a key constraint to detailed evaluation of the efficiency, equity and quality of the South African

²⁸ Draft National Quality Improvement Plan for Consultation 24 August 2018, at p 3

health system.²⁹ Indeed as the NQIP itself acknowledges, “systems and processes can be improved and streamlined through the application of evidence based healthcare.”³⁰ Prior to the introduction of an improvement plan, there must be a detailed evaluation of the existing data and an examination of the state of health care facilities in the country. This will map a plan to improve the quality of health establishments. This is one of the recommendations of the HMI for the private sector and it is equally applicable to the public sector.

44. Having not conducted (or published) assessments of the various initiatives or plans before development of the NQIP, the NQIP itself is somewhat hollow. We are left with another plan to create a plan without knowing how the previous plans have worked. Similar to the NHI pilot districts, we fail to assess and therefore fail to learn the lessons from past investment in initiatives.
45. With that, we support the principles of the NQIP (as we see them), being to develop a standards- and systems-based quality improvement process, focussing on health outcomes, including by building management and team work capacity and health facility readiness at district and facility level and testing initiatives within a set roadmap and timeframes. Our concern is that a plan in line with these principles is not reflected in the NQIP.
46. We also stress that yet another quality improvement programme will not work unless it is built into employees’ ways of working. The Lancet High Quality Health Systems Report advises that all policies affecting front-line workers be reviewed so that there is a coherent policy set,³¹ and that quality improvement initiatives are not seen as a burden and extra work.³²

²⁹ D McIntyre and J Ataguba “Access to Quality Health Care in South Africa: is the health sector contributing to addressing the inequality challenge?”, Health Economics Unit, University of Cape Town. https://www.parliament.gov.za/storage/app/media/Pages/2017/october/High_Level_Panel/Commissioned_reports_for_triple_challenges_of_poverty_unemployment_and_inequality/Diagnostic_Report_on_Access_to_Quality_Healthcare.pdf Accessed 21 September 2018.

³⁰ NQIP, at g 16

³¹ Lancet Global Health Commission, High Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution, at p 53

³² NQIP, at p 11

47. We comment below on some specific themes of the NQIP.

Immediate Practical Interventions

48. The immediate, practical interventions identified in the NQIP include:

- a. Lifting the moratorium on the filling of critical and essential clinical and administrative posts as there is a critical shortage of staff in many facilities.
- b. Dealing with basic maintenance and repairs to make facilities operational.³³

49. The above two recommendations are the most sensible proposals of the NQIP, and detailed plans and proposals on steps to achieve these objectives should be provided. An important component of such proposals would be the allocation of additional budget for the filling of critical and essential posts and dealing with basic maintenance and repairs. We welcome President Ramaphosa's announcement today of the immediate filling of 2200 critical health posts and note that additional budget will be required to fill posts and deal with maintenance and repairs as the budgets for the 2018/19 and 2019/20 financial years showed no additional budget to fulfil this mandate.

50. The current effective post freezing in many provinces has serious negative effects. In Gauteng, for example, on 12 April 2018 the Gauteng Department of Health issued a circular³⁴ indicating that only 50% of critical positions will be considered for filling. Another circular on 4 May 2018 requested institutional and district managers not to appoint any statutory posts from now onwards. The 50% required attrition rate is arbitrary, unsafe and has already contributed to adverse events such as the Klebsiella outbreak at Thelle Mogoerane hospital.

³³ NQIP, at p 17

³⁴ GDoH Personnel Circular 3 of 2018

51. Not only do staff shortages frustrate the staff that remain in facilities but the evidence is clear on the health impact of such shortages. The Saving Babies Report³⁵ revealed that there was no decrease in the percentage of babies dying from intra-partum asphyxia, which is a preventable cause of death. Rather, it showed that 53.4% of avoidable factors were medical personnel related.
52. The parlous state of many health care facilities furthermore results in ever decreasing faith in the health care system. Millions of rand over many years have been dedicated to infrastructural improvements and maintenance. Despite this financial allocation, insufficient progress has been made.
53. Some recommendations of the Operation Phakisa Ideal Clinic Laboratory were to develop a standard blueprint for the construction of new facilities or existing facilities needing refurbishment; and to develop maintenance hubs in districts to ensure that planned maintenance is carried out promptly. The 2017 Health Review indicated that the National Department of Health in collaboration with the provinces was in the process of completing schedules for PHC facilities which need refurbishment.³⁶ It is unclear what the status of these schedules are and whether the recommendations of Operation Phakisa were ever implemented.
54. Concrete plans and reprioritization of the budget will be required to address the moratorium on critical posts and the issues of basic maintenance and repairs of facilities. There is also need for an independent audit and a costed comprehensive plan in relation to both. The unimplemented Human Resources for Health Strategy 2012/13 – 2016/17 should serve as a warning of the risks of creating unfunded human resources and other strategies.

³⁵ Saving Babies Triennial Report on Perinatal Mortality in South Africa 2014-16

³⁶ 2017 South African Health Review, at p 117

Certification by the OHSC

55. The NQIP provides “It is a requirement that all health facilities designated for NHI meet the quality standards set by the Office of Health Standards Compliance. Thereafter, 25% of facilities will need to achieve accreditation as set out in the draft NHI Bill within a year.”³⁷
56. OHSC certification before accreditation for contracting with the NHI Fund first requires an OHSC that is adequately capacitated to inspect and certify all health facilities designated for NHI.
57. The OHSC’s 2016/2017 Annual Inspection Report reflects that in that financial year, 18% (696 of 3816) health establishments were inspected. Of those establishments which scored 50% or less, 35% were targeted for re-inspection. During re-inspections, there was minimal improvement. The OHSC identified the following as contributing factors:
- a. Infrastructure changes are dependent on budget availability and could take time to be implemented in health establishments;
 - b. Policy development is a lengthy process involving several consultations, could therefore take time to implement;
 - c. Quality Improvement Plans need adequate time to be implemented and with constant monitoring. Due to these facts approach to re-inspections will be reviewed; and
 - d. Lengthy time-lapse between inspection and re-inspection.³⁸

³⁷ NQIP at p 2

³⁸ OHSC Annual Inspection Report 2016/17, at p 178

58. Where there is non-compliance with any of the norms and standards, the Procedural Regulations of the OHSC requires that the person in charge must provide the inspector with the health establishment's quality improvement plan detailing the actions which will be taken to achieve compliance with the norms and standards.³⁹
59. The OHSC is also required to develop a Policy to enforce compliance.⁴⁰ While the 2016/17 Annual Inspections were completed based on pre-regulation Norms and Standards and may not represent the ordinary functioning of the OHSC, as the OHSC is the baseline qualifying criteria for the accreditation for NHI, it is imperative that the OHSC be strengthened and sufficiently resourced to effectively measure and enforce compliance with the Norms and Standards, which are themselves intended to be "enhanced" over time.⁴¹
60. The OHSC total budget allocation for the 2018/19 year is R129.7 million with 61% geared towards the core business activities. This will increase to R144.5 million in the 2020/21 financial year. Due to budgetary constraints, the total staff complement is expected to remain at 121. Overall, the budget allocation for the OHSC increases by 5.5% whereas the compensation for employees increases by 8%. This has led to a gradual decrease in expenditure allocated for goods and services, including the OHSC's ability to deliver on its core mandate of inspections.⁴²
61. Based on its existing capacity and budgetary constraints, unless there are serious adjustments in budgetary allocations, the OHSC is highly unlikely to be able to inspect all the public health establishments to assess compliance with the Norms and Standards Regulations Applicable to Different Categories of Health Establishments.

³⁹ Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Health Ombud, Section 21

⁴⁰ Ibid, Section 22

⁴¹ NQIP, at p 6

⁴² Office of Health Standards Compliance Annual Performance Plan Fiscal Year 2018/19

62. Urgent capacitation of the OHSC is therefore required to enable it to fulfil its foundational function under NHI and the NQIP.

Accreditation for the purposes of contracting with the NHI Fund

63. The NHI Bill and NQIP set out two processes in assessing a provider's suitability: firstly certification by the OHSC; and secondly accreditation by the NHI Fund. We have already stressed the need for urgent capacitation of the OHSC to assess and issue certification to meet the first level of accreditation.

64. Section 38(2)(b) of the NHI Bill sets out the additional criteria for accreditation by the Fund as follows:

- (i) Provision of the minimum required range of personal health care services;
- (ii) Allocation of the appropriate number and mix of health care professionals to deliver the health care services specified;
- (iii) Adherence to treatment protocols and guidelines, including prescribing medicines;
- (iv) Adherence to health care referral networks;
- (v) Submission of information to the National Health Information Repository and Data System; and
- (vi) Adherence to the national pricing regimen for services delivered.

65. Whilst section 37(2)(b) of the NHI Bill indicates that the Contracting Unit for Primary Health Care must assist the Fund to identify certified and accredited public and private health care providers at primary care facilities, it is unclear which institution would be responsible for determining whether service providers meet the requirements for accreditation in terms of section 38 of the NHI Bill.

66. The NQIP states that “there is already an internationally recognised healthcare facility accreditation organisation in SA that could offer the NHI and accreditation system.”⁴³ Further information relating to this organisation should be provided. Specifically, clarity as to whether this will be the organisation tasked with accreditation for the NHI process. In addition, while the NQIP provides that the accreditation process will be tested,⁴⁴ there is no detail on testing or piloting of accreditation.

Four Levels of Achievement

67. The NQIP identifies four levels of achievement within the NHI accreditation process, with delivery of specific services at each level of compliance. Facilities with full compliance will be permitted to provide the complete range of services offered in the NHI.⁴⁵

68. Whilst some private and possibly some public facilities may easily meet the full compliance criteria, it is unclear to us how communities currently served only by public facilities (which may not meet the full compliance criteria) would be served should such facilities not be contracted by the NHI Fund, and how this will affect their rights of access to health care services. Potentially it could mean that people with current access to poor quality services end up without access to services completely as facilities are not accredited and therefore not funded. The process for bringing non-compliant facilities to a state of compliance is not provided. This risks a reduction in access to services and a regression in the realisation of the right to access health care services.

⁴³ NQIP, at p 11

⁴⁴ NQIP, at p 11

⁴⁵ NQIP, at p 22

Governance, Management and Leadership

69. The NQIP supports the NHI Bill's call for the decentralisation of decision-making to facility level in the case of hospitals, providing "[t]here needs to be a wholesale transformation of the management system with decentralization...[p]rovincial departments will need to delegate decision-making to hospital managers, giving them greater control and flexibility to manage daily operations, including the authority to make decisions relating to personnel, procurement and financial management."⁴⁶
70. We agree with this approach where there has been proper capacitation and standardisation of the functions of hospital management and hospital boards (which are intended to play a role in governance). This level of leadership has been long neglected and disempowered and may not currently have the capacity to fulfil the required responsibilities. The NQIP does not contain provisions detailing how such capacitation will be executed.

Ideal Clinic Realisation and Maintenance Programme and Integrated Clinical Services Management Programme

71. The NQIP provides that "[t]he Ideal Clinic Realisation and Maintenance (ICRM) programme is designed to address current deficiencies in the quality of PHC services. The first two phases have been completed, the focus is now on implementation... since the annual district budgets are meant for current cost of employment and operations, additional funding has had to be obtained to address the backlog in infrastructure and for staffing shortfalls."⁴⁷

⁴⁶ NQIP, at p 15

⁴⁷ NQIP, at p 8

72. The Integrated Clinical Services Management Manual requires that “clinical audits be conducted quarterly to evaluate the quality of clinical care. Lot quality assurance sampling could be employed as the methodology”.⁴⁸
73. If the clinical audits are undertaken, they should be published on the Department of Health website. There should also be publicly available progress reports on the implementation of the ICRM model and an assessment of whether it should be pursued as an effective method of improving quality care. Operation Phakisa was launched in 2014 to scale up ICRM, however, four years later clinics assessed by the OHSC averaged only 47%, and only 43% of clinics had reportedly met the Ideal Clinic status at the end of March 2018.⁴⁹ There is a failure to demonstrate what the plan is urgently to improve the status of clinics to a level at which they could be certified by the OHSC, and thus accredited to provide services for the Fund.

Web-Based Information System

74. The NQIP states “[w]e recommend that the implementation of the standards and their monitoring at facility, local, provincial and national levels be supported by a suitable, integrated and interoperable web-based information system.”⁵⁰
75. We note also the reference to the Health Market Inquiry recommendation on reporting and measuring key health outcomes⁵¹ as well as standards compliance. We therefore welcome the recognition of the need to harmonise such data collection across the public and private sectors.
76. Clarity is needed as to whether this web-based information system is reference to the National Health Information Repository and Data system referred to in section 34 of the NHI Bill.

⁴⁸ Integrated Clinical Services Manual, section 2.3

⁴⁹ NQIP, at p 10

⁵⁰ NQIP, at p 14

⁵¹ NQIP, at p 18

77. The Access to Quality Healthcare Report states that although it is necessary to improve facility information systems to capture data such as ICD diagnostic and procedure codes for all services provided in public sector facilities to enable effective strategic purchasing of these services, the National Health Information Repository and Data Warehouse (NHIRD) could already provide a relatively comprehensive set of data on resources and services in the public health sector. Linking data to the NHI registration number may finally meet the long overdue need for unique patient identifiers. However, there is neither publicly available information on the status of the NHIRD nor does it seem likely that the data will be made publicly available; access to data is tightly controlled by the National Department of Health.⁵²
78. The Department of Health should publicise the status of the NHIRD and its relation to other information collection systems, and duplication of systems should be avoided. It should also bear in mind that the monitoring system cannot be purely web-based, and alternative systems should be available considering rural contexts, which often do not have access to functional web-based systems.

Implementation through Quality and Learning Centres

79. We support the proposal of Quality and Learning Centres based on sites where successful improvement programs have been implemented.⁵³
80. In light of the existing human and fiscal constraints faced by most public health facilities, however, it is difficult to imagine that health facilities would have the capacity to roll out a programme of learning additional to fulfilling their core functions. In private facilities, it is unclear what incentive there would be for such facilities to act as a basis of learning for public facilities which require a high degree of support.

⁵² Above n29 Section 7

⁵³ NQIP, at p 19

81. It is also unclear why the structure of the Quality and Learning Centres do not mirror the CUPs. Alignment with the NHI Bill in this way would be helpful.
82. Provision is made for recognised coaches for leadership and management skills and various technical skills with consultation of the Academy for Leadership and Management. It is unclear what role the Academy for Leadership and Management will play and whether coaches for leadership will be existing personnel at the Quality and Learning Centres or external specialists contracted for the purpose of leadership training.
83. Finally, the 18-month proposed timeframe to establish the Quality and Learning Centres⁵⁴ seems unrealistic in light of the current state of public health facilities. It is also unclear whether the plan relates to the assessment of all health establishments to determine which facilities qualify as Quality and Learning Centres, or whether it applies to those facilities already identified to act as Quality and Learning Centres. The process of self-assessment followed by a baseline evaluation carried out by an external team does not provide any specificity as to who would be responsible for the evaluations or review of progress made.

Medical Schemes Amendment Bill

84. The third policy document on which we comment is the draft Medical Schemes Amendment Bill, 2018 (“MSA Bill”). The MSA Bill must be considered in the context of the NHI Bill and the provisional report of the Health Market Inquiry (HMI). The proposed amendments to the Medical Schemes Act, (“the Act”) are intended to, inter alia, prepare the ground for the roll-out of the NHI. However, the MSA Bill was not accompanied by an explanatory memorandum, which would have been useful to place certain reforms in the proper context. The NHI policy papers provided little detail on the envisaged changes to the private health care sector, in fact the extent of the discussion on the role of the private sector was that the

⁵⁴ NQIP, at p 24

health services must be affordable. The NHI Bill leaves us largely in the dark concerning the role of medical schemes, which as we understand it will be to provide complementary health service benefits. The MSA Bill does not address the issue of affordability of private health services nor does it provide an explanation as to why these proposed amendments are a necessary precursor to NHI.

85. While it is clear that affordability of private health services must be addressed with urgency, not least because it is a constitutional imperative, we believe that this MSA Bill does not do so. It also appears to be premature in light of the soon to be concluded HMI. The HMI provisional report is the outcome of an unprecedented four and a half year investigation into the private health care sector, which was launched partly in the context of numerous failed attempts to regulate the cost of private health care in South Africa.
86. In our view the National Department of Health has a duty to consider the evidence that underpins the findings and recommendations proposed in the provisional report of the HMI. While some of the findings will not come as a surprise because of years of anecdotal evidence, the HMI has developed a basis for evidence-based regulation of the private health sector. It has also proposed pragmatic and evidence based interventions, including the introduction of a supply side regulator to address the gap in regulation on quality and pricing of health services in the private sector.
87. In our view, the extent of changes to aspects of the system, including prescribed minimum benefits, waiting periods, pricing, and expansion of the role of the Council for Medical Schemes and of the Minister require that any draft legislation be preceded by meaningful consultation with all stakeholders and a consideration of all the evidence available, including that uncovered by the HMI. It is our recommendation that the Department await and consider the provisional findings and recommendations as well as the final report of the HMI, which is due to be

released on 30 November 2018, and that thereafter the Department present the policy options to be weighed by stakeholders in a consultative manner.

88. Despite our views set out above, we briefly consider some of the provisions proposed in the MSA Bill.

Pricing of health services

89. The issue of pricing of providers in the private sector is one that has been fraught with debate and discussion over the past 15 years. While it is clear that prices for health care services can no longer be left to the market, there is still serious debate about how to regulate prices. Unfortunately, the MSA Bill does not grapple with these complexities but rather leaves them to the yet to be established Fund and the Council for Medical Schemes. The Health Benefits Pricing Committee, to be established by the Minister in terms of section 26 of the NHI Bill, must 'recommend the prices of health service benefits to the Fund,' however, given that there has been a lacuna in the system for over a decade this requires greater consideration and a weighing of policy options.

90. Without going into details, we note here that the HMI has looked at various options and has proposed multiple methodologies for price setting for public consideration. This is another reason to engage with the findings and recommendations of the HMI as part of the Department's consideration of the role of the private sector.

Prescribed Minimum Benefits and Comprehensive Service Benefits

91. Prescribed Minimum Benefits (PMBs) are an important part of the current medical scheme environment and are a legal entitlement for all scheme members to health care services. The right of everyone to have access to health care services guaranteed in section 27 of the Constitution is directly implicated in these

provisions and it is therefore imperative that the rights of members are not diluted through this amendment and that the amendment does not amount to a retrogressive measure. The PMBs, currently governed by regulation 8 of the regulations to the Act, are defined as ‘a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition’. While one can assume that PMBs will be replaced by Comprehensive Service Benefits (CSBs) proposed in the NHI Bill, this is not specifically stated in the MSA Bill. The bulk of the PMB provisions are found in the regulations, which are untouched by the amendments. The PMBs entitlements therefore remain in place.

92. The language of the amendment indicates that CSBs will be paid in full and without co-payments or the use of deductibles, as is currently the case with PMBs, however, the draft does not actually provide a mechanism for ensuring these benefits are paid in full. The amendment does not eliminate co-payments, as announced by the Minister. The evidence shows that under the current system, members continue to have their rights violated by the non-payment or short-payment of their PMBs, leaving them with the liability to pay for the health services. According to the HMI provisional report, there is evidence of large scale over-servicing and supplier induced demand, which is accompanied by an information asymmetry leaving members uninformed and un-empowered and with large bills. The MSA Bill provides no additional protections for these members.
93. Importantly, the reference to emergency medical services in regulation 8 of the current regulations to the Act is not repeated in the definition of CSBs. Again, without any policy documents or explanatory memorandum, it is unclear how the Department intends to protect the right to emergency medical treatment, as guaranteed in section 27(3) of the Constitution in the context of the provision of health care services in the private sector. The state has a positive obligation to ensure no one is denied emergency medical treatment. A decade after the debate about the scope of this right in the context of private sector emergency treatment, the Department has left this issue unaddressed.

Brokers

94. While brokers are not banned by the MSA Bill as announced by the Minister on 21 June 2018, brokers and broker fees are further regulated. According to the HMI report, brokers could provide an important service to members, however the current system incentivises brokers to align with the interests of for-profit scheme administrators rather than members. While greater accountability of brokers is welcomed, we recommend that the Department consider phasing out brokers altogether to reduce non-health costs for members. If brokers are retained, we suggest the Department considers incorporating the recommendations proposed by the HMI, including:

- a. Members should actively opt-in to the use of a broker's services
- b. Members who do not opt-in should achieve the savings directly
- c. Members should be able to choose a broker
- d. Transparency of broker fees and marketing arrangements with specific schemes, to ensure greater independence of brokers.

Waiting periods

95. The Act currently provides for schemes to impose general waiting periods and condition-specific waiting periods. We agree with the prohibition against imposing waiting periods in respect of child beneficiaries introduced in the new Section 32B. The protection of children in this manner is welcomed and is in line with the constitutionally protected rights of children to health care services in terms of section 27 and 28 of the Constitution. Section 28 guarantees children the right to basic health care services, which is not subject to the available resources of the state.

Appeal procedures

96. The MSA Bill proposes significant changes to the appeal procedures for members who have complaints about the conduct of their medical schemes. This is welcomed as the current appeal process, however it is complex, unclear and lengthy. We have represented clients who have had to wait years for the finalisation of appeal.

Governance

97. The MSA Bill introduces minimum qualifications for Trustees of medical schemes. This is a welcome step as it fosters transparency and accountability to members. As stated in the HMI report, Trustees lacking skills and competence may rely heavily on third party administrators and consequently fail to provide adequate oversight or review of their services. The HMI report describes this as a severe failure in governance. Trustees are often inaccessible to members and their interests are aligned with the scheme administrator rather than the members, which is in breach of the Trustees' fiduciary duties to members. The extensive list of duties of both Trustees and the Chief Financial Officer is a welcome addition to the governance of medical schemes, as are the HMI recommendations to regulate the remuneration of Trustees and link remuneration to performance.
98. We also welcome the disclosure of financial interests by Trustees, Chief Executive Officer, Chief Financial Officer, managers, clerks and others as a measure to increase transparency and accountability of medical schemes to its members.

Conclusion

99. It is unclear why, without a clear policy on the future role of the private sector, these amendments are proposed at this time. In our view, it would be rational for the Department to delay the processing of the MSA Bill in order to consider all the

available evidence and develop an approach that effectively meets its duty to progressively realise the right of access to health care services.

Proposal and conclusion

100. We view the proposals (including the NHI Bill, the MSA Bill and the NQIP) as being incapable of achieving the goal of universal health coverage or indeed of NHI itself. As a result, we suggest that the NHI Bill and Medical Schemes Amendment Bill not be sent to Parliament for consideration, and that the following steps are taken instead.

a. Urgent measures must be taken to:

- i. Develop, fund and implement a plan on human resources for health, including the training and placement of health care workers and administrators, as required, in health care facilities and the training, mandating and full integration of community health workers in health facilities and communities.
- ii. Audit and then carry out required maintenance and repairs of health care facilities.
- iii. Strengthen governance and management systems through drawing lessons from provinces and districts in which governance structures are working; develop and implement a plan for the regularisation, appointment (uninfluenced by party political structures and patronage), capacitation and resourcing of clinic committees and hospital boards to begin to exercise governance functions within health facilities.
- iv. Set up an anti-corruption unit within the National Health Department, linked to the Hawks, to root out corruption and fraud, hold people professionally and criminally accountable, and put in place mechanisms to prevent and detect corruption in future.

- v. Mobilise a national campaign to focus on the prevention of perinatal deaths and injuries – stop killing babies through health system failures.
- vi. Properly consider and align the findings and final recommendations of the HMI with NHI.
- vii. Strengthen the capacity and resources of the OHSC to ensure that it is able to fulfil its mandate effectively.

b. A re-think of longer term policy changes must be conducted, including:

- i. Release the workstream reports, research reports, evidence, assessments of piloting and quality improvement programmes and comparative analyses used to settle on the system changes proposed in the NHI documents.
- ii. Facilitate good faith public discussions of the options for possible structures and policy change, including the path towards each option and consideration of models that are working at local level across the country.
- iii. Consider the process of implementation while debating policy change and include those who will be responsible for implementation in the process in order to benefit from good practices and foster buy-in.

c. Develop properly considered system and policy change documents, together with implementation plans that include piloting new structures, phased implementation and changes to the current inequitable health financing model.

101. Progress towards universal health coverage cannot continue to be stalled as we focus on legislative change that is incapable of achieving its stated goals. There are urgent steps that can be taken to start us on the path to universal health

coverage while a transparent consideration of options is undertaken and policy with a view to implementation is developed.

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ENDS