The following matters occurred in the period from April 2019 and merit consideration by all practitioners.

1. NHI Bill, 2019

The NHI Bill has been introduced in Parliament, and will now follow parliamentary processes, namely a call for comments by the Portfolio Committee on Health, followed by verbal presentations. There will also be provincial processes, whereby provincial parliaments will obtain input from the public to inform their mandates sent to the National Council of Provinces, which will also deal with the Bill.

It is important that practitioners look at the implications of the Bill for themselves, and their patients. These are, from our point of view, largely practical, i.e. relating to what is indeed possible, and what is feasible in the short, medium- and longer term.

The Bill envisages a re-organisation of the public and private healthcare sectors:

- In the public sector, all regional, tertiary and central hospitals will no longer fall under provinces, but under the National Department of Health (NDoH). This would include academia, and will be complex from constitutional- and labour law perspectives, as health science facilities and medical schools, which are in part governed by the specific university's Act, and in part by labour law with the specific province as the employer, but also the entity that sets availability of types of care, etc. Hospitals are described as “semi-autonomous” for central hospitals (with cost-centres) and “autonomous legal entities” for regional and tertiary hospitals. Hospitals will get budgets from the NHI Fund (“NHIF”) based on diagnosis-related groups (DRG) for the population it serves.

- “Primary healthcare will be organized in so-called “Contracting Units for Primary Health Care” (“CUPs”), being subject to oversight by District Health Management Offices (“DHMOs”), which will also not be part of the provinces, but form a “component” of the NDoH. The DHMOs will also be responsible, through an amendment to the National Health Act, for the District Specialist Support Teams, although the relationship with, or in the NHI, is not clear (e.g. will the capitated fee paid to the CUPs include the work of the District Specialist Teams?).

- There is very little in the Bill on the details around private sector specialist care, and how its re-organisation is expected to take shape. The Bill states that the NHIF will contract CUPs, emergency
services and “hospitals”. Under the payment clause, it merely states that payment for specialist and hospital services must be “all-inclusive and based on the performance of the health care service provider, health establishment or supplier of health goods”. Although providers will not claim from the NHIF in the way one does from a medical scheme, the Compensation Fund or RAF, providers are expected to stick to the “national pricing regimen” for services. It is not clear when this will, in fact, apply.

- There will be an Office of Health Products Procurement (“OHPP”), which will facilitate the procurement of “high cost devices and equipment”. All procurement must be done in line with the OHPP’s Formulary, which will be based on the Essential Medicines List (EML) and the Essential Equipment List (EEL). It is unclear how existing equipment in practices, that may not be included in the EEL, will be handled. As a condition of contracting, practitioners will be expected to adhere to the Formulary. Mention is made of a “complementary list”, which will have to be approved by the Minister of Health. Unlike the Medical Schemes Regulations, which requires of formularies and protocols to be set on the basis of evidence-based medicine, and for exceptions to be made for deviations from those in cases of ineffectiveness in treatment, harm or potential harm, and adverse effects, no such principles appear in the NHI Bill.

The most controversial aspects of the NHI, and not addressed in the Bill, relates to the funding of the system (“money in”), and the payment of providers (“money out”). The National Treasury paper on the funding of the NHI is still awaited.

Although the shifting of funds from medical scheme contributions through a special payroll tax will lead to an increase in the pool of money available to the NHIF, and increase the amount available per patient per annum in the public sector, the annual amount available for a patient who were, but no longer can afford, medical scheme cover will be significantly less. This assumes that there is a possibility to, through increased volume, lower pricing of all services and goods in the private sector. It is unclear whether the willingness, and feasibility, of industry-wide price reductions have been modelled, in particular as basic practice costs (salaries, rental, already-procured goods and equipment, etc.) will not change, unless there is a large-scale physical and structural re-organisation in practices.

The Davis Tax Committee in March 2017 found as follows in relation to the feasibility of the NHI:

*Given the current costing parameters outlined in the White Paper, the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth.*

There are also aspects on which the NHI Bill is silent, such as the role of the NHLS and private pathology, the provision of blood and blood products by SANBS, research & development (and post-
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trial access), etc. It is also not clear how provincial departments of health debts and liabilities, e.g. for
malpractice lawsuits and unpaid suppliers, will be handled in the transition into an NHI system.

2. The PMB Review

In spite of uncertainty as to the exact nature of the “complementary cover” medical schemes would be able to
provide under the NHI, and the certainty that the NHI will provide primary care (PHC), the CMS is pressing ahead
of the inclusion of a PHC portion to the PMBs. The process is currently with a priority-setting committee, to engage
on the draft PHC package that was issued earlier this year.

Dr Kabana, Registrar of the CMS said in an interview on Business Day TV, that as benefits are included in the NHI,
it will be removed from medical scheme cover. Practically, it would be difficult for a patient to enter the NHI system,
receive professional services and to then exist again to access, for example, innovative technologies not available
in the NHI.

3. Section 59 Inquiry

The CMS has initiated an inquiry into allegations of racial discrimination during the conduct of medical scheme
forensic inquiries (section 59’s). Although there has been mixed reaction as to whether there is indeed racial
profiling, there was remarkable commonality in the testimonies of provider groups and advisors on how forensic
investigations are undertaken. One of the key matters raised, was the lack of common understanding on the coding
system, and that it creates room for claw-backs to occur. Such coding issues do not necessarily mean that fraud
had been committed.

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