FINANCIAL AND FISCAL COMMISSION

For an Equitable Sharing of National Revenue

POLICY BRIEF

Health Care Financing Reform and NHI Implementation in South Africa

The Financial and Fiscal Commission

The Commission is a body that makes recommendations and gives advice to Organs of State on financial and fiscal matters. As an institution created in the Constitution, it is an independent, juristic person subject only to the Constitution itself, the Financial and Fiscal Commission Act, 1997 (Act No 99 of 1997) (as amended) and relevant legislative prescripts and may perform its functions on its own initiative or on request of an Organ of State.

The vision of the Commission is to provide influential advice for equitable, efficient and sustainable intergovernmental fiscal relations between the national, provincial and local spheres of government. This relates to the equitable division of government revenue among the three spheres of government and to the related service delivery of public services to South Africans.

Through focused research, the Commission aims to provide proactive, expert and independent advice on promoting the intergovernmental fiscal relations system, using evidence-based policy analysis to ensure the realisation of constitutional values. The Commission reports directly both to Parliament and the Provincial Legislatures, who hold government institutions to account. Government must respond to the Commission's recommendations and the extent to which they will be implemented at the tabling of the annual national budget in February.

The Commission consists of women and men appointed by the President: the Chairperson and Deputy Chairperson; three representatives of provinces; two representatives of organised local government: and two other persons. The Commission pledges its commitment to the betterment of South Africa and South African's in the execution of its duties.

FINANCIAL AND FISCAL COMMISSION

Policy Brief

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31 January 2021

Executive Summary

Prior to the advent of democracy, South Africa's health care system was divided along racial lines, with a highly resourced health care system for the white minority and under-resourced health care services for the non-white majority. Although the 1996 Constitution guarantees socio-economic rights, including the right to health care for all, the lack of a unifying system of financing for universal health care has entrenched a two-tiered health care financing system, comprising public health financed by government and private health care financed through medical care schemes and patient's own pockets. As a result, access to health care services is determined by socio-economic status and remains similarly divided as pre-1994. The need for a health care system for all is not debatable. However, key aspects within the NHI Bill require strengthening in order to ensure a strong foundation for establishing a National Health Insurance (NHI). The Commission's research identified four critical success factors for achieving the unification of health care access through the NHI: an aligned policy and legislative framework, capacitated and consistent intergovernmental arrangements, clarity on the funding requirements and sources for NHI, and defined comprehensive benefits of NHI.

Background

Under apartheid, South Africa's health care system was divided along racial lines: the white minority benefited from a highly resourced health system, while the non-white majority received under-resourced care and services. With the advent of democracy, the 1996 Constitution outlawed racial discrimination and guaranteed socio-economic rights, including the right to health care for all (section 27). However, the lack of a unifying system of financing for universal health care has entrenched a two-tiered health care system, comprising public health care financed by the government through the tax system, and private health care financed through medical care schemes and patient's own pockets (i.e. out-of-pocket). As a result, socio-economic status determines access to health care services, which remains similarly divided as in the pre-1994 era. The gap between public and private health care in South Africa must be bridged, to arrive at a just health care system for all. To ensure a strong foundation for establishing a National Health Insurance (NHI), key aspects within the NHI Bill require strengthening.

Research Findings

The Commission's research identified four critical success factors for achieving the unification of health care access through the NHI.

1. Aligned policy and legislative framework

The 2018 NHI Bill creates a broad enabling framework for the introduction of NHI, but before an NHI Act can be implemented, other laws need to passed or amended.[1] While the objective of aligning the legislative framework to support the NHI is clear, the practical application is problematic. Although the Bill's Transitional Arrangements include a list of the legislative reforms that must be initiated in Phase 1 (2017–2022)[2], the Bill is unclear about other legislation.

- The Medical Schemes Act was not amended by the NHI Bill but by a separate amendment Bill published on the day that the NHI Bill was gazetted.
- Several Acts are listed as legislation requiring changes but are not amended by the NHI Bill.[3]
- Other Acts are amended in section 58 but are not included in the list in section 57.[4]

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[1] Section 3(4) states: "The Act does not in any way amend, change or affect the funding and functions of any organs of state in respect of health care services until legislation contemplated in sections 77 and 214, read with section 227, of the Constitution and any other relevant legislations have been enacted or amended".

[2] In section 57(4)(h)

[3] Section 57 includes the Mental Health Care Act (No. 17 of 2002), the Traditional Health Practitioners Act (No. 22 of 2007), the Dental Technicians Act (No. 19 of 1979), the Medicines and Related Substances Act (No. 101 of 1965) and the Nursing Act (No. 33 of 2005).

[4] The Compensation for Occupational Injuries and Diseases Act (No. 130 of 1993), the Competition Act (No. 89 of 1998), the Correctional Services Act (No. 111 of 1998) and the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008).

- Section 57 refers to "other relevant Acts" (previously "various Provincial Health Acts") that require changes but does not specify which Acts.

The magnitude and complexity of aligning the policy and legislative framework should not be underestimated. Health services are a concurrent national and provincial function, which means that both national and provincial legislation will need to be aligned in order to revise the distribution of powers and functions between the spheres of government. In the event of conflicting provincial and national legislation, determining which laws prevail will require following intergovernmental dispute resolution or judicial processes. The only, and arduous, option is to follow the necessary intergovernmental processes and align the legislation in order to create an appropriate legislative framework to enable the NHI's implementation.

2. Capacitated and consistent intergovernmental arrangements

The NHI Bill contains two significant changes that affect the intergovernmental functions and powers (and associated fiscal flows):

Decentralised management and control of hospitals. Provincial health departments will no longer control and manage the cost and financing of the health facilities, as funding for providing services will be paid directly to the hospitals.

- The Bill removes the function to "control and manage the cost and financing of public health establishments and public health agencies" from provincial health departments.[5]
- The Bill allows direct contracting between the NHI Fund and all hospitals (district, specialised, regional, provincial and central), and direct payment from the NHI Fund to the contracted hospitals, [6] including accredited private health care service providers.[7]

Strengthened management and control of district health services. The Bill amends the National Health Act, making district health management offices (DHMOs) the primary management authorities, with extensive responsibilities and "considerable powers to manage, facilitate, support and coordinate the provision[8] of primary health care services for personal health care services and non-personal health services[9] at the district level in compliance with national policy guidelines and relevant law".[10]

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[5] Section 25(2)(k) of the National Health Act (No. 61 of 2003), deleted by section 59 read with Schedule to the NHI Bill.

[6] Sections 35 and 38 of the NHI Bill.

[7] Section 37(2)(b), (g) and (h).

[8] Importantly, the DHMO will be responsible for controlling the quality of all health services and facilities with assistance from the provincial departments in managing the contracted health care providers.

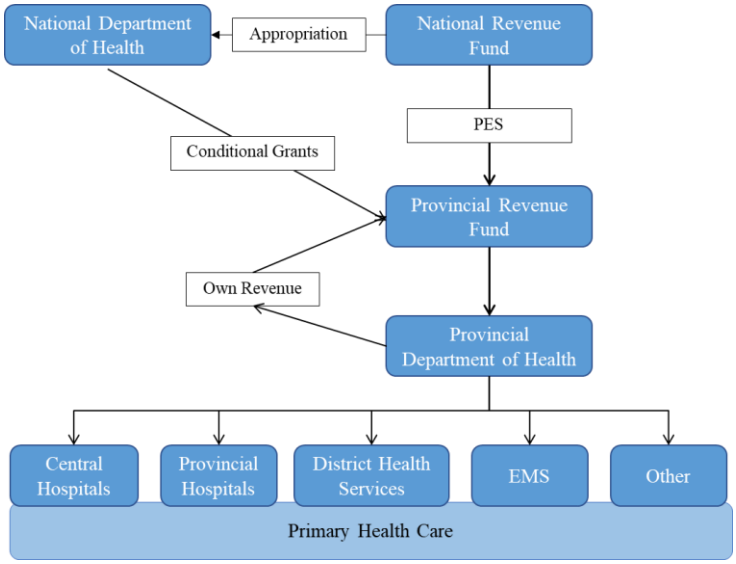
[9] Personal health services , which are of a therapeutic or rehabilitative nature, are delivered individually. Non-personal health services include mass health education and basic sanitation.

[10] Section 36 of the NHI Bill: 31A of the National Health Act, to be inserted by section 58 read with the Schedule to the NHI Bill. In the 2018 version of the NHI Bill, the DHMOs engaged mainly with the NHI Fund.

- It provides for the establishment of contracting units for primary health care (CUPs), with which the NHI Fund contracts for the provision of primary health care services within a specified geographical area.[11]
- It amends the powers and functions of district health councils and provincial health departments, with associated changes to the funding flow.

The shift in functions means a significant shift in funding flows. Provincial government currently receives the majority of its funding from the national fiscus, mainly through the provincial equitable share (PES) and conditional grants,[12] with a miniscule of funding from provincial own revenue (Figure 1).[13]

Figure 1: Current funding flows for health services



Note: Excludes municipal health services
Source: Commission's own compilation

The NHI Bill explicitly states that hospitals (central, provincial, regional, specialised and district) will be paid directly from the NHI Fund. It is assumed that funds transferred to CUPs will also come from the NHI Fund.[14] Emergency medical services will be "reimbursed on the basis of a capped case-based fee with adjustments made for case severity, where necessary", whereas public ambulance services will be reimbursed from the PES.[15] DHMOs fall within the remit of, and so are assumed to be funded via, the Department of Health.[16]

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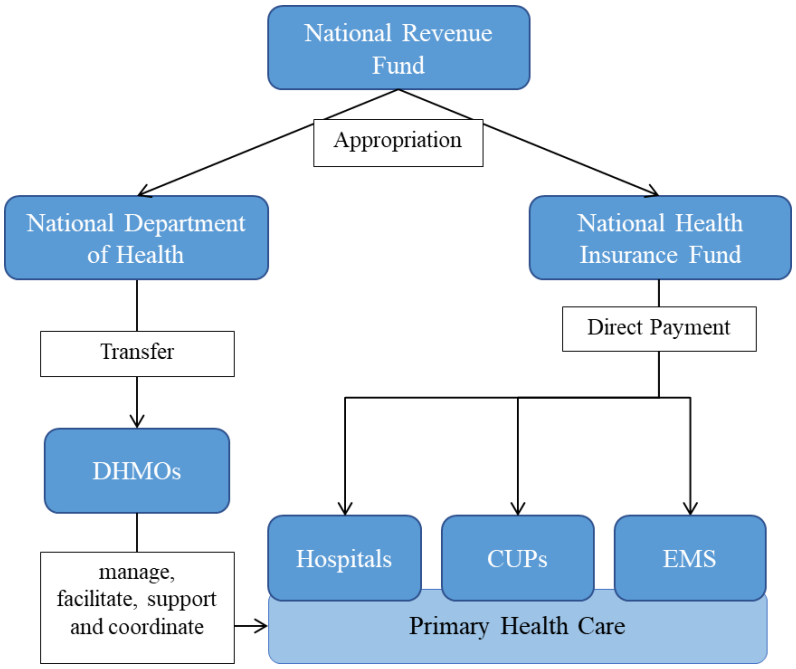
[11] Section 37 of the NHI Bill.
[12] It is worth noting that the PES cannot be allocated on a sectorial basis, as it is a weighted-share, formula-based approach of horizontal division that is calculated as a lump sum.
[13] The provincial own revenue is determined by the Uniform Patient Fee Schedule, published regularly by the National Department of Health. The health patient fees revenue collected is surrendered to the provincial revenue fund unless it is within the department's budget or granted through the revenue retention process.
[14] Section 35(3) states "Funds for primary health care services must be transferred to Contracting Units for Primary Health Care at the sub-district level as outlined in section 37."
[15] Section 35(4). As a specified Schedule 5 Part A service, the Ambulance Service is reimbursed through PES; otherwise, it would have been dealt with like all other health services.
[16] Section 32(2)(c)

Figure 2: Proposed revised funding flows



Source: Commission's own compilation

3. Funding requirements and sources for NHI

Possibly the most contentious issue about the NHI relates to its cost and affordability. The desirability of the intended outcomes of NHI is not debatable, but affordability is a key concern because of its potential risk both to the economy and to achieving a fair and just health system for all.

- The NHI Bill leaves key costing considerations to be made through regulations, including the scope and nature of health service benefits and programmes, and the extent to which they must be funded.[17]
- The cost implications of reconfiguring powers and functions of the various government spheres (such as asset and staff transfers) is not yet understood.
- The NHI Bill provides no clarity on the tax structure reforms needed to support the implementation of NHI, apart from specifying that the NHI Fund's income would include *inter alia* money appropriated by Parliament, and that the minister of health must, in consultation with the minister of finance, annually determine the budget and allocation of revenue of the Fund.[18]

4. Defined comprehensive benefits for NHI beneficiaries

The NHI Bill leaves key costing considerations to be made by the minister of health through regulations. The transitional arrangements provide for a ministerial advisory committee on health care benefits for NHI,[19] as a precursor to a benefits advisory committee that would

[17] In terms of section 25(5)(c), the Benefits Advisory Committee must determine the health service benefits, in consultation with the minister and board.

[18] Section 49 of NHI Bill

[19] Section 57 of the NHI Bill

guide decision-making around benefits.[20] To ensure that the benefits are sufficiently comprehensive, criteria are needed that prescribe the conditions covered by the NHI.

Conclusion and Recommendations

The research identified four critical success factors for enabling the NHI relating to the policy and legislative framework, intergovernmental arrangements, funding requirements and sources, and health benefits covered by the NHI.

The Commission recommends that:

1. The Minister of Health and the Minister of Finance ensure an enabling policy and legislative framework, aligned between spheres of government.
2. The Minister of Health and the Minister of Finance reach a common understanding on how to capacitate institutions with clearly defined responsibilities, supported by a consistent intergovernmental fiscal relations framework detailing the fiscal implications.
3. The Minister of Health and the Minister of Finance reach a common understanding of how to determine the funding requirements and sources for NHI, and to ensure revenue is available to meet those requirements. The funding model should be developed based on real, empirical data with robust modelling of the public's health care needs.
4. The Minister of Health and the Minister of Finance ensure that the benefits to which NHI beneficiaries are entitled, and their limitations, are adequately defined and sufficiently comprehensive, informed by data and actuarial and financial modelling.
5. The Minister of Health examine and eradicate the wastages, corruption and leakages in the procurement system of health care goods and services, by consulting health professionals and workers with the necessary expertise and professional integrity. A portion of the department's budget should be set aside for establishing a technical committee of health professionals to decide on purchasing and procuring of facilities, instruments and drugs.

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[20] In terms of section 25(5)(c), the Benefits Advisory Committee must determine the health service benefits, in consultation with the minister and board.