national treasury
Department:
National Treasury
REPUBLIC OF SOUTH AFRICA

Private Bag X115, Pretoria, 0001,

Enquiries : Mampho Modise
Tel : (012) 315 5931
Fax : (012) 395 6553
Email : Mampho.Modise@gtreasury.gov.za

Dr O Shisana
Advisor to Presidency on NHI
Private Bag X1000
PRETORIA
0001

Dear Dr Shisana

REVISED NATIONAL HEALTH INSURANCE BILL

I am writing to you to alert you to Treasury's concerns on the draft NHI Bill.

In May 2018 after several discussions between the previous Minister of Finance (MoF) and Minister of Health and with the State Law Advisor, several amendments were made to the NHI Bill, which allowed the MoF to support the publication of the Bill for public comment (Cab memo 2B of 2018).

However, the Bill has now, without any consultation with the Treasury or Minister of Finance, been very substantively amended in October 2018 and the previous amendments effected to satisfy the Treasury's concerns around the intergovernmental financing system have been unilaterally removed. There is also a great risk of constitutional challenges related to the functions and funding of provincial health departments as well as other interest groups.

After supporting the previous version, the new version of the Bill now has reintroduced several major problems, in the areas of:

- Functioning of Intergovernmental financing system
- Location of health functions
- The Bill attempts to supersede all other legislation including PFMA and DORA
- Prescribing functions on behalf of and which have not been agreed with MoF eg NHI Fund to be a direct charge and not go through any vote
- Making the role of medical schemes complementary, which is in our view premature and will be perceived as a threat to the private sector and current medical aid users and taxpayers and open the Bill to legal challenges

- Financial implications are not costed e.g. of creation of 300 contracting units for primary care (CUPS), all services free of charge. The fiscal situation has also changed significantly since the original costing and financing was presented in the White Paper.

- Major implications across Departments and funds which have not been discussed e.g. NHI Fund paying for health services in prisons

These issues are discussed in more detail in Annexure A.

I am aware that over the past few days, two meetings have been held with Treasury officials and that they have provided you with our draft comments and also proposed track and trace changes on the Bill. I am informed that you have in principle agreed to certain changes to the Bill and not to others. However, as we have not seen these agreed changes in writing and the Bill serving in Cabinet next week is the unchanged version, I am also including our original comments formally here.

In particular, I am concerned that more than half of the functions of provinces pertaining to health are unilaterally removed, as shown in Table 1, without:

- In most cases no clear allocation of where the function will be relocated

- No consultation in Budget Council as required by Intergovernmental Fiscal Relations Act

- No accompanying explanation to Cabinet of the function shift will be effected, whether powers and functions are coherent, how the new system of delivery of the health functions will work, implications for personnel, facilities, how the National Department of Health will deal with expanded functions

- The proposal to split funding of personnel and capex (via provinces) and goods (via NHI fund) funding streams is in our view unworkable and undermines the coherence of functions

- Overlap, inconsistencies and lack of clarity in roles of District Management Organizations and Contracting Units for Primary Care

Table 1. Powers and functions removed from provinces

	S25	Function remains with province	Function removed
a	Specialised hospitals		Specialised hospitals
b	Provincial health information system		Provincial health information system
c	Intersectoral collab	Intersectoral collab	
d	Cordinate funding of District Councils	Cordinate funding of District Councils	
e	Technical logistic support to DC	Technical logistic support to DC	
f	Plan, monitor and evaluate HS		Plan, monitor and evaluate HS
g	Coordinate health services in provincial disasters	Coordinate health services in provincial disasters	
h	Research		Research
i	Plan, mx and develop HR		Plan, mx and develop HR
j	Plan development of hospitals		Plan development of hospitals
k	Control mx cost and financing of HS		Control mx cost and financing of HS
l	Comprehensive primary health and comm hosp		Comprehensive primary health and comm hosp
m	Emerg med forensic, mort	Emerg med forensic, mort	
?n ?r	Control quality		Control quality
?o	Health programmes	?	?
?p	Equip, vehicles	?	?
?r	Occupational health services	?	?
	Strategic, medium term and HR plans		Strategic, medium term and HR plans

It is important that a legal opinion be secured on the shifting of provincial functions to reduce the risk of delay through further constitutional challenges.

I am therefore unable to support the Bill in the current form submitted to Cabinet which has been submitted to Cabinet and would like to make the following proposals for a way forward:

- A more measured, gradual and practical approach is required to the shifting of major functions between spheres

- If the changes being proposed by Treasury are being taken seriously as stated, then the Bill should be revised and resubmitted to Cabinet with a copy sent to the Treasury urgently so we do not repeat issues that have already been addressed

- There needs to be a series of technical and political discussions between Health, Treasury, Presidency and State Law Advisor teams to resolve problematic areas or to revert to previous agreements

- Potentially NHI war room should be reconfigured as a NHI IMC and Technical Committee as a forum to take NHI forward, noting that multiple departments are involved

- A thorough discussion needs to take place in extended Cabinet and PCC (including Provincial Premiers) on the future location of the health function – noting that constitutionally the large bulk of funds currently funding health services in provinces, especially the Provincial Equitable Share (PES), cannot be shifted unless the function is shifted. The NHI Fund Bill and Memo is concealing a much deeper issue of the statutory location of functions for the health service delivery and that the intergovernmental financing arrangements being

proposed here cannot be effected in the absence of these changes being dealt with in a satisfactory way.

A copy of proposed track changes to the Bill, as previously sent to you by our officials is again attached.

Yours sincerely

ISMAIL MOMONIAT
ACTING DIRECTOR-GENERAL
DATE: 9/11/2018

cc Mr Busani Ngcaweni

ANNEXURE A: Note on revised National Health Insurance Bill
Oct 2018

Introduction

In May 2018 after several discussions between the previous Minister of Finance and Minister of Health and with the State Law Advisor, several amendments were made to the NHI Bill in which allowed the Minister of Finance to support the publication of the Bill for public comment (Cab memo 2B of 2018).

However, the Bill has now, without any consultation with the National Treasury or Minister of Finance now been very substantively amended in October 2018 and the previous amendments agreed and made to satisfy the Treasury's concerns around the intergovernmental financing system have been unilaterally removed.

After supporting the previous version, the new version of the Bill now has reintroduced several major problems, in the areas of:

Intergovernmental financing system

- Location of health functions
- The Bill attempts to supersede all other legislation including PFMA and DORA
- A highly premature reform to make the role of medical schemes complementary, which will be perceived as a threat to the private sector and current medical aid users and taxpayers
- Financial implications not costed e.g. of creation of 350 CUPS, all services free of charge
- Major implications across Departments and funds which have not been discussed e.g. NHI Fund paying for health services in prisons
- Prescribing functions for and which have not been agreed with MoF e.g. NHI Fund to be a direct charge and not go through any vote

These are outlined below:

Functions of provinces and inter-governmental financing system

The NHI Bill is a major Bill that potentially completely changes not just the financing but also functional arrangements for delivery of health care services. The new Bill has massive implications for provinces, which have not been properly or openly discussed with Budget Council, PCC or any provincial structures. Health services is the 2nd largest function of provinces and this Bill massively effects whether the health function stays with provinces or moves to national level.

In several previous versions of the Bill, there has been a major inconsistency between the National Health Act, which allocates the major service delivery responsibility for Health to provinces, this Bill (which seeks to centralise all health financing in a central Fund) and S214 and S227 of the Constitution which entitles provinces to a provincial equitable share (PES) for

the functions they perform. The core problem from the Treasury perspective is that, in terms of constitutional provisions, the bulk of the funds cannot be shifted from provinces (provincial equitable share, PES is a direct charge against the National Revenue Fund in terms of section 213 of the Constitution) to the national sphere and NHI Fund, unless the functions are shifted. It is also likely that there would be legal restrictions in transferring direct provincial conditional grants through a central NHI Fund instead of directly to provinces as is the current practice.

The compromise clause previously inserted by the State Law Advisor is S2(2) stated that this Act does not in any way amend the funding and functions of organs of state until legislation contemplated in S77 and S214 read with S227 of the Constitution has been enacted....", i.e. until the Health Act is amended to amend provincial health functions. This clause seemed to solve the problem of lack of alignment of this Bill and the Health Act. This clause allowed us to support the previous gazetting of the Bill.

However, this clause has now been unilaterally deleted (this and many other important changes made are not shown in the track and trace changes presented). This leaves a central problem that the Bill seeks to centralise the funding for health care (e.g. R150 billion in provincial equitable share) while the Constitution (S77, 214, 227) entitles provinces to the funding for these services allocated to them by law. In terms of section 213 of the Constitution, a province's equitable share of revenue raised nationally is a direct charge against the National Revenue Fund and can therefore not be redirected through the NHI Fund.

The health services function is the concurrent legislative competence of national and provincial government. The current scope of responsibility for provinces in respect of health services is given expression to (further defined) in the National Health Act. This version of the Bill may go further than the previous version by deleting some of the health functions of provinces. Besides the shift of central hospitals to the national sphere (S10 2d), the annex appears to repeal parts of the Health Act e.g. some of the key functions of provinces outlined in S25 of the National Health Act (see below extract). However, the Act does not say where these functions will now be located...., but are likely to be national functions (if the current functions assigned to provinces are deleted in the current version of the National Health Act).

> If we are correctly interpreting these as deletions, then these appear to be major amendments to provincial functions that have not been discussed with provinces. Neither has this been discussed with the Treasury. These hardly visible amendments to S25, repealed at the end of Bill, are huge in consequence for the entire location of service delivery functions in the health sector and are probably of greater consequence than the entire rest of the Bill yet no documentation is provided or discussions held on how this huge shift and complete restructuring of functions across the spheres is to be effected. Besides the locations of core functions, this has huge

Section 25

Provincial health services, and general functions of provincial departments

(2) The head of a provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province –

(a) [provide specialised hospital services];
(b) [plan and manage the provincial health information system];
(f) [plan, co-ordinate and monitor health services and must evaluate the render of health services];
(h) [conduct or facilitate research on health and health services];
(i) [plan, manage and develop human resources for the rendering of health services];
(j) [plan the development of public and private hospitals, other health establishments and health agencies];
(k) [control and manage the cost and financing of public health establishments and public health agencies];
(l) [facilitate and promote the provision of port health services, comprehensive primary health services and community hospital services;]

Implications for the intergovernmental financing system.

Ambulance services are listed as a local government function in terms of S32(3) of the Bill whilst it is constitutionally assigned to provinces under Schedule 5A on the Constitution as a functional area of exclusive provincial legislative competence (this error was fixed previously, but is re-introduced in this version of the Bill).

It is important to ensure that a function, such as health, is delimitated and assigned to spheres in such a manner to ensure seamless (and effective) performance of such service. For example, the maintenance of infrastructure (e.g. health facilities) is allocated to the provincial sphere, but the quality of infrastructure is critical to the quality of service delivery in a health facility, where parts of the "overall" function is assigned (in terms of the changes in the NHI Bill) to national government, but where national will have no control over the quality of maintenance in health facilities.

Some of the powers given to the National Department are also confusing e.g.:

- Purchasing medical equipment S32(1) – this should not be separated from the level of government providing the service; and
- Planning the development of public and private hospitals and health establishments

We are don't agree with the unilateral removal of previous Ss2(2) and 55(2) which was key to Treasury compromise around the previous version, and on this basis alone the Bill should not go to Cabinet or be approved. As it stands the Bill introduces massive uncertainty into the intergovernmental financing system and the location of health functions.

The legal interpretation of the Treasury is that the major funds for the sector e.g. R150 billion in the PES cannot shifted to the NHI Fund, unless the health functions are shifted to the national sphere (which appears to be partially the case in this version of the Bill, given the deletions of sections of the National Health Act). A change of this huge magnitude, which changes almost 100 years of location of key health functions, should however be properly consulted, which has not happened in this instance. This could lead to intergovernmental disputes being declared or be constitutionally challenged by one or more provinces. What in fact needs to occur before Cabinet approves the Bill, is for Cabinet and PCC, including the Provincial Premiers, to have a full and proper discussion on the future location of the health functions (noting sections of constitution which require funds to follow function). Once it is clear where the functions for health should be located...then the funds can follow. Proper documentation is also required for

Cabinet on the proposed future location of specific health functions by sphere, the implications of these shifts for service delivery, personnel, facilities etc., which levels of government will manage which services, what will shift, how these function shifts will be effected, whether functions are coherent, arrangements between spheres, capacity of national sphere to take on massive new functions, possible delegation options to provinces etc.

Role of medical schemes S33

This section restricts the role of medical schemes to being complementary to the Fund. This section is in our view highly premature given that it will take years for the Fund to be meaningfully offering services equivalent to those existing 8.8 million current medical scheme users access from the private sector. This section is unnecessary at this point and will be perceived as extremely threatening to existing medical scheme users and tax payers, to the entire private health sector and will undermine investment. This section will almost certainly bog the Bill down in endless legal challenges and should be deleted. This section can be considered in a much later phase once the NHI Fund is established and functioning and users have built up confidence and trust in the Fund and the services it is funding.

33. (1) In order to achieve the objectives of this Act as articulated in section 2 and to eliminate the fragmentation of health care funding, medical schemes registered in terms of the Medical Schemes Act, or any other voluntary private health insurance scheme, shall be restricted to providing complementary cover for health care services that are not purchased by the Fund on behalf users as determined by this Act.

Infringing into functions and responsibilities of Minister of Finance and issue of laws prevailing

After previously removing these sections the Bill now reinserts certain provisions that infringe into powers of the Minister of Finance, but have not been discussed or agreed with him or the Treasury. For example:

- S 48(4) says monies should be paid directly by the Treasury to the Fund ie as a direct charge. This and some other parts of S48 are money Bill issues and the Minister of Finance has neither discussed not agreed to a direct charge. Why should this be a direct charge as opposed to the additional accountability that comes from going through a vote such as for other S3A public entities coordinated by the Department of Health.
- New Section 2(3) says this Act prevails over all other legislation – that means it also prevails over financial legislation such as the PFMA and DORA. It is not clear why this should be so and has not even been discussed with Treasury.

Contracting unit for primary care S31 (S37,1)

S31 has many substantive areas which are unclear. It states that the Minister will establish Contracting Units for Primary care at sub-district level as the main units with which the Fund will contract for Primary Care. However, this new wording makes it unclear under which level of government these institutions will be created, whether they are independent statutory entities, what form of entity they will be, whether they are separately audited etc. If these units are national, it will require that all assets, liabilities and staff need to be shifted from the provincial to national spheres. If these units are provincial, how does the minister establish entities if the

delivery units under it e.g. clinics are provincial? The costs of establishing these – and there will be around 300 given the number of sub-districts is not stated. The functions of these entities is also somewhat unclear as the section both refers to these as them as the entities with which the fund will contract and also states that they will "assist the Fund to monitor contracts ...."

In the assignment of powers and functions, a sphere of government should have the right to exercise any power concerning a matter reasonably necessary for, or incidental to, the effective performance of its function, such as (public) primary health care. These appear to be shared between different entities, and possibly spheres. For example, the delivery units are responsible for serving their designated sub-districts and ensuring sufficient human resources are in place to provide primary health care facilities, whilst provinces more generally (i.e. falling outside the delivery units) will be responsible for purchasing, providing and maintaining vehicles and health care infrastructure (S32(2)); where these are critical elements in ensuring effective primary health care provision (but over which the delivery units will have no control).

Payment of health care service providers

S 41(1) says that the Fund, in consultation with the Ministers of Health and Treasury, will determine the nature of service provider payment mechanisms but: S 41 (2)(a) specifies that accredited public health care PHC health care service providers will be funded on a risk adjusted capitation basis; S 35 (2) specifies that accredited and contracted central, provincial, regional, specialised and district hospitals based on a global budget or Diagnostic Related Groups; and S 35 (4) specifies that Emergency Medical Services provided by accredited and contracted public and private providers will be funded on a capped case-based fee with adjustments made for case severity where necessary.

If payment model for PHC, hospitals, and EMS was specified in different sections it is in conflict with S 41(1) which gives right to the Fund to determine the nature of service provider payment mechanisms. Payment mechanisms should not be prescribed by law because Fund has to have flexibility to change payment mechanisms on the regular basis and to use payment mechanisms to influence performance of the providers and quality of care.

Office of Health Products Procurement

S 38 says that the Board in consultation with the Minister shall establish an Office of Health Products Procurement which sets parameters for procurement, coordinate the supply chain management process and manage the processes of ordering and distribution of health-related products nationally.

The supply chain management process and distribution of health-related products would not usually internationally be a function of the Fund, because of the principle of purchaser provider split.

Organizational structure of the Fund

S 21(3) says that the Chief Executive Officer shall be responsible for establishing the following units; (a) Planning; (b) Benefits Design; (c) Provider payment mechanisms and rates; (d) Accreditation; (e) Purchasing and Contracting; (f) Provider Payment; (g) Procurement; (h) Performance Monitoring; and (i) Risk and Fraud Prevention Investigation.

Organizational structure of the Fund should not be prescribed by law because Fund has to have flexibility to change organizational structure in order to improve efficiency of the Fund.

Implications for other Departments

Although interesting proposals, the implications for other Departments and related finances has not been agreed yet, including:

- *Prisoners*: Fund will purchase services for prisoners S7.1.c – what are financial implications of this…do funds on Correctional Services vote shift to the Fund?
- The implications of the Bill for the *Road Accident Fund and the Compensation Funds* are not entirely clear, noting the sections being amended in this Bill.

Governance arrangements

Some of the proposed governance arrangements are unclear or contradictory e.g:

- If the Board is the accounting authority (agree) then why must it advise the Minister on operational issues (S15(2))
- Why must the Board inform the Minister on any advice it gives the CEO (S15,3d)
- Why does the Minister establish Technical advisory committees of the Board such as the Benefits Committee, Pricing Committee.

Financial implications

The memo does not deal adequately with financial implications, including:

- The costs of 300 new Contracting Units for Primary Care (CUP)
- The cost implications of no user charges even for private providers (S11 1)
- The point and affordability of having 53 District health authorities which now mainly have coordinating functions (S36) in addition to 300 new CUPs
- The cost of NHI itself
- The cost of the Fund
- Fund must cover costs of patient transport (S10 2(b))

Transitional arrangements

The State Law Advisors report is especially critical on the lack of adequate transitional provisions and propose the reinsertion of 2 pages of transitional provisions.

Other matters to consider

- The Fund is entirely excluded from the provisions of the Competition Act (new S2(2))
- No user charges i.e. all services free (S(9a) – this completely disallows fees even in areas where they might play a useful role e.g. contracted private sector services which might be overused
- Fund must cover costs of patient transport (S10 2(b))
- Based on the submissions we have seen, our impression is that the revised Bill largely ignores or does not accept many of the submissions received
- The Bill is unfriendly to refugees, asylum seekers etc. – e.g. even children are not entitled to hospital care unless in an emergency …there may be human rights issues with this

Conclusion and recommendation

The Bill has been very substantively changed since the version approved by the previous MoF, and these new changes have been made without consultation with the MoF. Many of these changes are potentially very problematic and require more work and thorough discussion with MoF. It is therefore recommended that:

- The Bill should not serve before Cabinet before this version is properly consulted with all relevant stakeholders affected by the amendments made
- There needs to be a series of technical and political discussions between Health, Treasury, Presidency and State Law Advisor teams to resolve problematic areas or to revert to previous version of the Bill
- Consideration be given to reconfiguring the NHI war room as a NHI IMC and Technical Committee as a forum to take NHI forward, noting that multiple departments are involved
- A thorough discussion needs to take place in extended Cabinet and PCC (including Provincial Premiers) on the future location of the health function – noting that constitutionally the large bulk of funds in the PES cannot be shifted unless the function is shifted. The NHI Fund Bill and Memo is largely concealing this much deeper issue of the statutory location of functions for the health service delivery and that the intergovernmental financing arrangements being proposed here cannot be effected in the absence of these changes. A proper set of documents on the new proposed functional arrangements for the sector is required.