| B4SA SUBMISSION TO NCOP SEPTEMBER 2023: TABLE OF PROPOSED AMENDMENTS | | | | |
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| **NHI Bill section(s)** | **Legal comment (to NCOP)** | **Drafting proposal (to NCOP)** | **Explanation of concern** | **Explanation of solution** |
| **SUSTAINABILITY OF NHI FUNDING INCLUDING ROLE OF MEDICAL SCHEMES** | | | | |
| **Role of private healthcare funders:**<br><br>Section 33 | • The phrase "fully implemented" is not defined and no parameters are provided to guide the exercise of the ministerial discretion.<br><br>• Section 57(2)(b) provides that "Phase 2 must be for a period of three years from 2026 to 2028" which suggests that "fully implemented" actually means 31 December 2028, regardless of the extent of implementation. | Replace section 33 with the following:<br><br>"Once National Health Insurance has been fully implemented as determined by the Minister in consultation with the Benefits Advisory Committee and the Stakeholder Advisory Committee, the Minister shall publish notice of such determination in the Gazette, and may make regulations regarding the role of medical schemes consistent with the objective of the progressive realization of access to sustainable, quality healthcare services by users of the Fund." | The Bill proposes to eventually allow medical schemes only to fund services that are not offered by the NHI Fund. But there is no indication of what the NHI's service offering will be, or will become over time, so it is not clear what the limitations on medical schemes will be, or when they will take effect. The Minister has full discretion to decide that offering, and to decide when that happens. The timing for the exercise of that power is vague, which makes it unconstitutional.<br><br>This means citizens will not be able to insure themselves (using their own money after paying their NHI contributions) against | The proposed amendment gives a framework to the Minister's power, as well as a requirement to consult relevant structures. It empowers the Minister to find a reasonable and sustainable mix of health care funding options suitable to the circumstances that apply at the time of his/her decision making. |

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| | • The Bill envisages a purely complementary role for private health funding at an indeterminate point in future, with no reference to the potential health requirements of the country at that indeterminate time. That is irrational and unlawful. | | the risk of the NHI Fund refusing or failing to provide services it has undertaken to cover. This is unconstitutional.<br><br>This impacts medical schemes' and insurers' ability to plan and price benefits. It also affects doctors' and hospitals' ability to plan for service delivery as well. It will negatively and unnecessarily impact healthcare investment and service delivery.<br><br>Government's proposal to delay the implementation of section 33 does not solve the problem, as s33 already has a 'built in' (but unclear) time frame. Delaying an unconstitutional provision does not make it constitutional. | |
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| **Pricing of health care services** :<br><br>Sections 11(2)(e) and 26(3) | The Bill prescribes that the NHI Fund must negotiate the lowest possible price when procuring health care services and that the Health Care Benefits Pricing | Amend section 11(2)(e) by replacing 'lowest possible price' with 'competitive prices' and including 'the consideration of the ability of providers to realise a reasonable return', as follows: | The Bill places too much emphasis on the Fund getting the 'lowest possible price' when buying goods and services. This is not necessarily a sustainable basis. Since the Competition Act and | It is better to focus the Benefits Advisory Committee and the Fund on ensuring that the prices in the healthcare sector are sustainable, as this better serves the long-term |

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| | Committee of the Board must recommend the prices of health service benefits. These provisions do not adequately incorporate general economic principles.<br><br>The pricing methodology should mimic a competitive market and recognise that a full regulatory cost system will be required for the Health Care Benefits Pricing Committee to make any meaningful recommendations on pricing. | '11 (2) The Fund may enter into a contract for the procurement and supply of specific health care services, medicines, health goods and health related products with an accredited health care service provider, health establishment or supplier, and must—<br><br>(e) negotiate ~~the lowest possible price~~ <u>competitive prices</u> for goods and health care services without compromising the interests of users, <u>the sustainability of providers</u>, or violating the provisions of this Act or any other applicable law.'<br><br>AND<br><br>Amend section 26(3) by including wording to subject the Health Care Benefits Pricing Committee's recommendations on pricing to general economic principles, as follows:<br><br>'26(3) The Committee must recommend the prices of health service benefits to the Fund. <u>The prices recommended by the Committee must comply with</u> | Competition Commission may have a very limited role in regulating sustainable pricing in the future healthcare sector, the Bill should recognise the need for sustainable pricing. | interest of the sector including the NHI Fund. |

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| | | general economic principles of regulated prices, in that the Committee must determine the cost of capital employed and a reasonable return on such investment.' | | |
| **Transitional arrangements and other laws: Sections 57 and 58** | The definition of two time-based phases is peremptory but arbitrary, as it serves no valid purpose (there are no consequences for breaching timeframes) and creates potentially inaccurate targets for the affected public to plan against.<br><br>57(2)(a)(v) includes "prepare for the establishment of the Fund" as a first phase priority, whereas 57(4) includes among the first phase objectives "establishment of the Fund" and the "purchasing of hospital services…funded by the Fund", yet 57(5) includes the establishment of the Fund as a second phase priority. | The following amendments are necessary:<br><br>S57(1)(a) '…must be implemented over ~~two~~ phases.'<br><br>S57(2) 'The initial two phases contemplated…are as follows "S57(2)(a) "Phase 1, ~~for a period of three years from 2023 to 2026~~ which must include –<br><br>(i) continuing with the concentrated implementation of health system strengthening initiatives, including alignment of human resources with that which will be required users of the Fund;<br><br>(ii) ~~include~~ the development of National Health Insurance legislation and amendments to other legislation;<br><br>(iii) ~~include the undertaking of~~ initiatives which are aimed at | The Bill is vague and contradictory about the roll out and timing of the UHC program. It refers to timeframes that government already acknowledges cannot be achieved, and gives no consequences for not meeting those timeframes. | The Bill amendments give substance and guidance for a sustainable, phased implementation, and give guidance to the Minister for purposes of declaring phases as implemented (see section 33). |

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| | Section 57(4) requires that amendments to various statutes be "initiated" during the first phase, but section 58(1) provides that those same statutes are "hereby" amended or repealed. This suggests either that the public participation process already undertaken by the National Assembly was the public's last opportunity to engage on the detailed specific amendments to other pieces of legislation; or it means that any proposed future engagement will be meaningless as the relevant statutes are already amended (*fait accompli*).<br><br>This arrangement of sections conflicts with sections 31(2) and 32(2). | establishing institutions that will be the foundation for a fully functional Fund ; and<br><br>(iv) ~~include~~ <u>establishment of systems that ensure</u> the purchasing of personal healthcare services for vulnerable groups such as children, women, people with disability and the elderly; and'<br><br>S57(2)(b) 'Phase 2 ~~must be for a period of three years from 2026 to 2028 and~~ must include'<br><br>S57(4)(a) 'the ~~migration~~ <u>realignment</u> of Central Hospitals <u>so</u> that <u>they</u> are funded, governed and managed nationally as <u>national</u> semi-autonomous entities;<br><br>(b) the structuring of the Contracting Units for Primary Healthcare Services at district level in a cooperative management arrangement with the district hospitals linked to a number of <u>P</u>rimary <u>H</u>ealth <u>C</u>are facilities | | |

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| | | establishment and individual providers;<br><br>(c) the establishment of the Fund, including the establishment of the necessary governance and administrative structures such as the Board, its statutory Committees, the Fund office, District Health Management Offices and Contracting Units for Primary Health Care;<br><br>(d) the development of a Health Patient Registration System referred to in section 5 and the integration of the digital platform required to support portable health care and strategic purchasing of services;<br><br>(e) the process for the accreditation of public health care service providers, which will require that health establishments are inspected and certified by the Office of Health Standards Compliance, health professionals are licensed by their respective statutory bodies and health care service providers comply | | |

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| | | with criteria for accreditation by the Fund;<br><br>(f) the design and costing of the benefits package, and implementation of the requisite systems, including training of health providers, quantifying the case mix to estimate and manage the budget shifts, and implementing training sites required for:<br><br>(i) the purchasing of health care service benefits through capitation contracts which include personal health services such as primary health care services, maternity and child healthcare services including school health services, healthcare services for the aged, people with disabilities and rural communities from contracted public and private providers including general practitioners, audiologists, oral health practitioners, optometrists, speech therapists and other designated providers at a Primary Health Care level focusing on disease prevention, health promotion, provision of | | |

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| | | primary health care services and addressing critical backlogs;<br><br>~~(g)~~ (ii) the purchasing of hospital services and other clinical support services which must be—<br><br>(i) funded by Fund;<br><br>(ii) an expansion of the personal health services purchased; and<br><br>(iii) from higher levels of care from public hospitals (central, tertiary, regional and district hospitals) including emergency medical services and pathology services provided by National Health Laboratory Services; ~~and~~<br><br>(g) the initiation of the process for legislative ~~reforms~~ amendments in order to enable the introduction of the National Health Insurance, including changes to the—<br><br>(i) Medicines and Related Substances Act, 1965 (Act N0. 101 of 1965);<br><br>(ii) Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973); | | |

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| | | (iii) Health Professions Act, 1974 (Act No.56 of 1974);<br><br>(iv) Dental Technicians Act, 1979 (Act No. 19 of 1979);<br><br>(v) Allied Health Professions Act, 1982 (Act No. 63 of 1982);<br><br>(vi) Medical Schemes Act, 1998 (Act No. 131 of 1998);<br><br>(vii) Mental Health Care Act, 2002 (Act No. 17 of 2002);<br><br>(viii) National Health Act, 2003 (Act No.61 of 2003);<br><br>(ix) Nursing Act, 2005 (Act No. 33 of 2005);<br><br>(x) Traditional Health Practitioners Act, 2007 (Act No. 22 of 2007); and<br><br>(xi) other relevant Acts~~;~~ and<br><br>(h) draft regulations required for implementation of the Fund. '<br><br>S57(5) 'Objectives that must be achieved in Phase 2 include –<br><br>(a) the establishment and operationalisation of the Fund as a | | |

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| | | purchaser of health care services through; a system of mandatory prepayment;<br><br>(b) commencement of active strategic purchasing of primary health care service benefits, which include personal health services such as, maternity and child healthcare services, school health services, healthcare services for the aged, people with disabilities and rural communities, from contracted public and private providers including family practitioners, audiologists, oral health practitioners, optometrists, speech therapists and other accredited providers in the Contracting Units for Primary Health Care, focusing on disease prevention, health promotion, provision of primary health care services and addressing critical backlogs; and<br><br>(c) commencement of active strategic purchasing of hospital services and other clinical support services from accredited establishment and individual health care providers.' | | |

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| | | NEW s57(6) 'Phase 3, and any subsequent phases, must include achievement of: [TO BE AGREED] (a) levels of population coverage; (b) expansion of priority services; (c) reduction in average out of pocket expenditure; and (d) specific public health outcomes, in each case as prescribed by the Minister [ALTERNATIVELY by the Director-General] in the Gazette in consultation with the Fund, the Benefits Advisory Committee, the Benefits Pricing Committee, the Stakeholder Advisory Committee, the Contracting Unit for Primary Healthcare, the Office for Health Standards Compliance and the medical schemes industry.'<br><br>Section 58(1) should be renumbered 57(7) and amended as follows:<br>'[~~Subject to this section and section 57 dealing with transitional arrangements, the~~]The laws [~~mentioned~~] named in paragraph (g) | | |

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| | | of sub-section (4) [~~the second column of the Schedule are hereby~~] shall be proposed to be repealed or amended to the extent set out in the third column of the Schedule.' | | |
| **Definitions** | Section 33 can only take effect once NHI is "fully implemented". This requires a definition to guide the Ministerial power. | The following definition of "fully implemented" is proposed:<br>(a) The Minister has prescribed a comprehensive package of health care services with associated treatment protocols and referral pathways based on targeted utilisation levels for the population that the NHI Fund will reimburse;<br>(b) the Minister, after consultation with the Office of Health Standards Compliance, by notice in the Gazette has published the requisite quality of care standard that must be adhered to in the course of rendering a service specified in prescribed comprehensive package of health services;<br>(c) the Minister by notice in the Gazette certifies that, after consultation with the Minister of Public Administration, he/she is satisfied that the Fund has the | The Bill does not guide the Minister's discretion. It is vague and gives the Minister undue power. This makes it unconstitutional. | The definition is not unreasonable. It addresses citizens' most basic expectations of a fair decision and so it guides the Minister in citizens' best interests rather than possible competing interests. |

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| | | requisite operational infrastructure to carry out its functions of the Fund and that adequate accredited providers in the public and private sectors have been contracted to ensure that the population has reasonable access to the prescribed comprehensive package of health services; and<br>(d) the National Treasury has issued a notice in the Government Gazette certifying that a sustainable framework is in place for the Fund to finance the prescribed comprehensive package of health services. | | |
| **OTHER NECESSARY AMENDMENTS** | | | | |
| Competition Act exclusion: 3(5) | • Section 3(5) of the previous draft Bill was amended by the National Assembly following public input, but the change is material, and has not | Delete section 3(5) of the Bill; or<br>Invite further public comment on the revised formulation | The Bill exempts the NHI Fund from the Competition Act. This is unnecessary. If there are valid reasons for the Competition Act not to apply to NHI Fund activities that is a matter for our competition laws to determine. The attempted exemption is overly broad and therefore | By deleting the section that limits the Competition Act's influence, the operations of the NHI Fund reman subject to the ordinary competition laws of the country. |

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| | been presented to the public for further input;<br>• S3(5) amounts to an inadvisable, disproportionate measure: it is not necessary in order for the NHI Fund to operate; whereas a sophisticated framework has developed around the Competition Act to curtail inadvertent risks/unforeseen consequences of monopolistic power. | | unlawful. It invites litigation unnecessarily and will hamper and delay implementation and generate legal costs. | |
| 6(m)(i), (ii): Relaxation of data privacy | The proposed relaxation of the POPI Act standards of data protection are excessive and unnecessary, and fail to meet the standard for limitation of rights in section 36 of the Constitution. | Delete the following words:<br>'unless the information – (i) is shared among health care service providers for the lawful purpose of serving the interests of users; or (ii) is utilised by the Fund for any other lawful purpose related to or incidental to the functions of the Fund;' | The Bill proposes to change (relax) existing data privacy laws to suit the NHI Fund. There is no legitimate reason for this as the Protection of Personal Information Act, 2013 (**POPI Act**) caters for this adequately. It also seems that the amendments are derived from European regulations (General Data Protection Regulation), not from South Africa's POPI Act. The | The proposed solutions keeps the NHI Fund subject to the same POPIA laws and regulations that apply to all South Africans, and does not create exemptions or different rules for the NHI Fund that deviate from those protections. |

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| | | | amendments are intrusive, unnecessary, and unconstitutional. | |
| Refusal to fund health care services:<br>7(5),(6) | The Fund's unqualified right to refuse to fund a health care service will in some cases have the effect of denying health care access altogether, where the user cannot afford to procure it directly or through insurance; and/or such denial may exacerbate the health care need. That would entail a regressive impact on the fundamental right of progressive realisation of access to health care services (S27 Constitution), which the appeal right does not adequately address. | Introduce a new section 7(7) to address the user right in the case of semi-urgent, or time-sensitive conditions, and to confirm that the Fund will reimburse at the private contracted rate if an appeal is successful. | If the NHI Fund mistakenly refuses to authorise health services, the user must go through an elaborate appeal process, but this will not address the immediate health care need. Even if the need is not urgent, the user needs to pay out-of-pocket to be treated, there is no guarantee that the Fund will reimburse those costs at the out-of-pocket cost if the user's appeal succeeds. This is unconstitutional. | The proposed solution is to protect consumers who are incorrectly refused treatment. They will be reimbursed for the expenses they have to incur at a private (non-NHI) facility, and will not have to choose between unaffordable treatment or no treatment at all. |
| Information platform:<br>40(3), 40(4)(b) | Section 40(3) empowers the Fund to use personal data for 6 listed functions, using the word "may". This creates a conflict with POPI Act, which | Change the word 'may' to either 'may only' or to 'must'.<br>AND<br>Amend section to address cyber-risk. | Firstly, the Bill changes the existing laws (POPI Act) regarding personal health data. This is not necessary; therefore it is unlawful. | The proposed amendment restores the primacy of the POPI Act.<br>BUSA has requested NCOP to address the gap around cyber security in respect of personal health data. |

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| | is itself constitutionally mandated legislation.<br><br>The proposed centralization of all national health user data creates a material cyber-security risk, and BUSA recommends that wording to permit data sharing, rather than centralization, be considered | | Secondly, the cyber risk of a centralised national health database is not addressed at all. | |
| | Section 40(4)(b) permits the sharing of information about users "for the lawful purpose of serving the interests of users", but the information is not limited to health data; the "lawful purpose" is vague and overbroad; and the provision is disproportionate, creating conflict with POPI Act, in particular section 32(a) and (b) of that Act. No amendment to POPIA is proposed. | Amend section 40(4)(b) as follows:<br><br>"Information concerning a user, including information relating to his or her health status, treatment or stay in a health care establishment is confidential and no [~~third~~] party may disclose information contemplated in section (2) [~~unless … the information is shared among health care service providers for the lawful purpose of serving the interests of users~~] except as permitted by the Protection of Personal Information Act, 2013 (Act No. 4 of 2013)." | As above | As above |

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| Appeal Tribunal: s45 | An appeal to the Appeal Tribunal against a Fund decision must be lodged within 60 days, but the Appeal Tribunal has no power to condone late referral, meaning that a material proportion of appeals will either be time-barred or need to be heard in the High Court. This reduces the right to access health care services, and is inconsistent with the right to administrative justice. | Add section 45(3) to read:<br>'The Appeal Tribunal may condone late filing of an appeal on good cause shown.' | If a user for some reason cannot lodge a challenge in 60 days, he/she must go to the Magistrates or High Court. | The proposed amendment allows the Tribunal to accept late appeals, so that consumers are not forced to approach the Court if they have a good reason for not approaching the Tribunal in time |
| Sources of funding: s48(c) | The sub-section characterizes "money paid erroneously into the Fund which, in the opinion of the Minister, cannot be refunded" as a source of income.<br>This affords the Minister judicial competency which offends the separation of powers. Secondly, the Minister would probably delegate this power to a Fund officer, leading to an | Delete sub-section 48(c). | The Bill gives the Minister the power to lay claim to money paid into the NHI Fund by mistake. This creates a conflict of interest and is unconstitutional because a Minister should not be making judicial decisions (separation of powers). | The proposed amendment removes the offensive power. |

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| | irreconcilable conflict of interest. | | | |
| Chief source of income:<br><br>S49 | • Sub-section 49(1) provides that the "Fund is entitled to money appropriated annually by Parliament", and s49(2) provides that such money must be generated by a combination of new taxes, although those are not detailed or specified. These provisions appear to effectively "authorise direct charges against the National Revenue Fund" in terms of the definition of a money bill in section 77 of the Constitution.<br><br>• The Bill stipulates the basis for the taxation to be "social | Delete Section 49. | The Bill compels Parliament to fund the NHI Fund, and to raise new taxes for that purpose, and also stipulates an approach to tax policy which is not within the Health Department's competency. All of this contradicts the Constitution. | The proposed amendment is to delete the unlawful section, and to leave fiscal and taxing decisions to the National Treasury and Finance Minister |

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| | solidarity" which is defined in the Bill as "providing financial risk pooling to enable cross-subsidisation between the young and the old, the rich and the poor and the healthy and the sick". It is unclear how this definition informs or accords with national taxation policy.<br>• Sub section 49(2)(a)(ii) of the Bill refers to medical scheme tax credits as being "paid to various medical schemes" which is factually incorrect. | | | |