OSSA

The Ophthalmological Society of South Africa

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For Attention

Chairperson: Portfolio Committee on Health

Dr Sibongiseni Dhlomo,

Per address

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Dr Dhlomo

OSSA SUBMISSION ON NATIONAL HEALTH INSURANCE BILL

1. The Ophthalmological Society of South Africa (OSSA), is the umbrella body that represents the majority of ophthalmologists practicing in South Africa. We believe we play the role of a national custodian of eye care. The society, which was established in 1930, has an established history of inclusive representation and is led by an Executive Committee composed of 12 elected volunteer members. The constitution of the society guides the composition of the board, which is geographically represented and has elected members from private practice, public service and academia. The length of term of the president, honorary secretary and honorary treasurer are stipulated in the constitution. OSSA would like to embrace this opportunity to respond to the contents of the National Health Insurance Bill, which was published on 9 August 2019.

2. OSSA will focus its response on issues that could impact on clinical provision of Ophthalmological services, the benefits afforded to these and the availability of such services in the proposed NHI Model. Other, broader issues will be addressed in responses by other industry bodies with which OSSA has relationships.

3. Primary and preventative care forms a vital part of the NHI proposal. The lack of clarity on the setting in the NHI structures where primary eye care services will be rendered, and indeed which healthcare providers will be responsible for primary eye care in the NHI environment, is of concern to OSSA. Certain eye disease and conditions may rapidly lead to blindness, so it

is vitally important that suitably qualified carers are used in the diagnosis of eye related conditions. To repeat, a delay in diagnosis and referral of certain diseases will lead to avoidable blindness in certain patients. The Bill remains vague on aspects of service delivery and it is vitally important that any NHI Act should provide absolute clarity as to services covered by the NHI Fund and the level at which services are rendered and the referral paths to be followed. Failure of the Act to specify such details, means that the Regulations dealing with such issues should have accompanied the NHI Bill for comments, so that the proposed model could be reviewed in totality. There is a concern that the Minister of Health may publish Regulations on such details at a later stage without any need for public engagement, or engagement with OSSA on matters related to Eye care.

4. Section 41 (3) b of the NHI Bill states that "In the case of specialist and hospital services, payments must be all-inclusive and based on the performance of the health care service provider, health establishment or supplier of health goods, as the case may be." Other than this reference, there is no information on reimbursement of private practice ophthalmologists in the NHI environment. This description is also concerningly vague on how services will be funded in the private sector.

5. The contracting design of the NHI, as interpreted from information contained in the NHI Bill, states that the NHI Fund will contract with Facilities, making no provision in the current draft for reimbursement of individual Ophthalmologists for services rendered outside of Hospital facilities. While it is indicated that treatment in Hospital facilities will be reimbursed based on Diagnostic Related groupers, there is no indication how ongoing care will be funded in the private service delivery environment once a patient is discharged and requires ongoing management, or requires non hospital based management. Most Ophthalmic conditions, such as Glaucoma and Age Related Macular Degeneration, require continuous ongoing specialist management outside of Hospital facilities. There is no indication of how funding for these services will flow between the NHI Fund and the providers involved with rendering these services.

6. One of the underlying implications of a Diagnostic Related Grouper funding model is that the Hospital will received the fee for the admitted patient and reimburse all those involved with the care of the patient. The only way this can happen is if Ophthalmologists are employed by facilities. Employment of doctors by facilities is something which is not currently allowed by HPCSA regulations and we are therefore curious to know how such payment mechanisms will

be implementable if the HPCSA Ethical rules are not amended. OSSA is concerned that if the HPCSA rules on doctor employment are amended prior to the full implementation of NHI, it could lead to an exodus of medical personnel who are currently working in the state sector to fill such posts in the private sector. Perceptions of private sector working conditions being much better than those in the state, could lead to this shift of resources if a salaried environment is created in Private Hospitals. The majority of Private sector specialists are unlikely to take up such posts, and government should therefore carefully consider any such changes to the HPCSA rules.

7. It is important to note that certain conditions which need to be managed on an ongoing basis, cannot be managed at a primary care level. By way of example, non-Ophthalmologists are not suitably qualified to administer Intravitreal Injections for the ongoing management of common retinal diseases and specialised equipment is needed for ongoing management of many eye conditions, which quite appropriately, will not be available in primary care settings. The establishment of Care Pathways for ongoing management and emergency management of eye diseases is of paramount importance and these need to be clarified before the bill can be supported.

8. The nature of Ophthalmology is such that inadequate or inappropriate patient care could lead to irreversible blindness amongst patients. Especially in Retinopathy of Prematurity, such debilitating blindness could last for the lifetime of the infant patient. In the light iof such high levels of medicolegal risk in the profession, we are concerned with the limited reference to medicolegal liability in the NHI Bill. While provinces currently accepts liability on behalf of all employees, the NHI model removes specialised-, regional-, central- and tertiary hospitals from the provincial sphere. The assumption has to be that every facility would have to accept medicolegal liability for cases managed in the facility. There is no indication whether the NHI fund will accept any such liability or will include medicolegal insurance as a cost-component in both state and private facility fees. It is vitally important that this aspect be considered, especially if limitations imposed by drug lists or protocols could create delays in treating patient, or leave patients without funded treatment options for certain conditions. The treating ophthalmologist could be called upon to accept medicolegal liability for failing to provide sight-saving treatment which may not form part of an NHI funding protocol. Clarification of acceptance of medicolegal risk is therefore imperative in the NHI environment.

9. OSSA wishes to commend the Department of Health for taking initiatives to address the current Cataract Backlog in state facilities, by including a costing for Cataract Surgery in the section on Financial Implications for the state. Despite a tender for delivery of Cataract services being announced last year, no further progress has been made in purchasing of Cataract services in the private sector. OSSA is currently running the Second Sight project, which provides free Cataract Surgery for patients on state waiting lists. Ophthalmologists, anaesthetists and facilities all donate their services for free in the project, while consumables are funded out of donated funds. We wish to encourage the government to look at the Cataract service delivery produced by the project and for government to fund the project to assist with the Cataract Backlog in the state. Details of the project can be found at www.righttosight.org

10. For the sake of ensuring continued access to services which can be currently accessed in both the public and private healthcare sectors, OSSA urges the publication of a costing document on NHI. If it is not known what the current basket of services costs to be delivered to patients receiving the services on a "per service" basis (which is how payments will be structured under NHI). It would be impossible to determine whether the state can deliver such services to all South Africans under NHI in the absence of a costing. If there is insufficient National Funding to deliver a similar set of services under NHI as is currently available in the state sector, that would not be the Progressive Realisation of access to healthcare which is a Constitutional requirement under S27(2) of the Constitution, even if the smaller basket is also accessible to state patients in the private sector.

11. OSSA wishes to appeal to the department of Health to consult with OSSA on all eye care related issues of funding, benefit design and service delivery in the NHI. There has been a disappointing lack of consultation with OSSA on the current Cataract backlog, including the tender for cataract services issued, and subsequently withdrawn, by the National Department of Health. The ophthalmology profession should be the first stakeholder to be engaged in any efforts to improve eye care services in South Africa, especially surgical services, which will inevitably be conducted by OSSA members, irrespective of which entity administers the process.

12. While OSSA fully supports the creation of a South African environment where Universal Health Coverage is a reality, one needs to take note of various practical challenges of implementation and funding which can delay the introduction of NHI for many years. OSSA therefore

encourages the government to investigate innovative ways of creating access for state patients to private sector ophthalmic services as an interim measure in the run up to NHI implementation. The Right to Sight Project is an example of an initiative that creates such access and is already up and running.

13. OSSA appreciates the opportunity to contribute to the debate on NHI and trusts that the issues raised will be considered by the Portfolio Committee.

Kind Regards

Dr Linda Visser
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