SADA Professional Advisory Bulletin

- Scheme updates
- DENIS Benefit Changes in 2024
- Discovery
- Understanding National Health Insurance ("NHI Bill"), 2019

- **Circulation date: 30 November 2023**

Dear SADA Member

CLINICAL

As the year draws to a close, the SADA clinical department trusts that many of our members are inundated with patients who wish to perform their pre-holiday treatments. We hope that this edition of the clinical bulletin focusing on medical scheme updates will serve as a valuable resource to optimize your practice's financial efficiency while ensuring the best possible outcomes for your patients.

Scheme Updates:

Denis have issued communications to providers advising of the following:

- An increase of 5.9% will apply to providers part of the Medshield Dental Network, all Polmed providers and all remaining schemes administered by Denis.
- All DENIS tariffs, including those for Polmed, will be available for download from 07 December 2023 for download at https://www.denis.co.za/providers/denis-dental-tariffs/
- DENIS Dental Network Providers will be paid for code 8163 (Fissure Sealants) at an increased rate of 25% from the 2023 tariff. This increase forms part of the initiative by DENIS to advocate preventative dentistry. The benefit for fissure sealants on these options is limited to beneficiaries younger than 16 years of age.
- Polmed tariffs for code 8163 will be increased by 50% from the current tariff and includes four dental fissure sealants per beneficiary per year; limited to beneficiaries between the ages of 5 and 25.
- Tariffs for Infection Control (code 8109) will reduce slightly as of 1 January 2024 as practices resume their pre-Covid processes. The new tariff will be available in the 2024 Dental Tariff Schedule, published on the DENIS website from 7 December 2023.

DENIS Benefit Changes in 2024:

1. Bonitas:

- In 2024, an admission co-payment is applicable to hospital as well as day clinic admissions for the following options: BonClassic, BonComplete, BonEssential, BonEssential Select, BonSave, Hospital Standard, Primary, Primary Select, Standard & Standard Select.
- In 2024 preventative dental benefits for BonSave and BonFit Select are paid from the risk benefit. Where claimed, code 8145 (local anaesthetic) is payable from the member’s available savings, and not from the risk benefit.

- One Membership Number for Life - Bonitas members retain their current membership numbers for as long as they are members on Bonitas, irrespective of future option changes.

2. Enablemed:

- From 2024 the Sizwe Hosmed Essential Copper plan is no longer managed by Enablemed and thus not included in the DENIS service offering.

3. KeyHealth:

- From 2024 the dental benefits for the KeyHealth Essence option will be managed by DENIS.

4. Medshield:

- A 20% penalty applies if authorisation is required and the authorisation is approved after the treatment has been done.
- A 25% co-payment on the hospital account is applicable for an elective procedure authorised for admission in a non-network hospital.

5. Thebemed:

- From 2024 a benefit is available for full root canal therapy treatment, subject to managed care protocols on Universal, Universal EDO and the Fantasy Plan.

6. Polmed:

• From 2024, non-network co-payments will not be applied in the following scenarios:

- Involuntary use of a non-network practitioner or facility in a medical emergency (PMB or clinically indicated), i.e., the patient does not have the option to choose the practitioner or network facility.
- When a network provider is not available within a 50 km radius from the member's residence.
- For conservative dental treatment, members are advised to verify the funds or limits for scheme members before administering treatment. Following telephonic benefit confirmation, DENIS can connect service providers with Medscheme in the same call to assess the financial limits for a patient before treatment is initiated. It is important to note that benefit confirmation letters do not assure payment, as funds are not specifically earmarked for any particular treatment discipline or practice type. DENIS is responsible for approving and validating dental treatment and claims, while Medscheme handles the payment process and distributes remittance advice for POLMED members.
- **Last claim payment run in December 2023: Friday 22 December 2023**
- **First claim payment run in January 2024: Friday 12 January 2024**

Discovery:

- The annual tariff increase will amount to 5.2%.

LEGAL

UNDERSTANDING NATIONAL HEALTH INSURANCE BILL ('NHI Bill'), 2019

Legislative Process

After 12 years of public discussion and parliamentary procedures, the National Health Insurance Bill (the Bill) was passed by the National Assembly on 13 June 2023. The passing of the Bill by the National Assembly falls within the larger context of bringing the Bill into law.

Background

The National Health Policy, introduced by the ANC, dates back to 1994. In 2011, the Department of Health (DoH) released a green paper on NHI, for the public to discuss and provide comments on the NHI policy. A more detailed policy document, a white paper on NHI, was published by the DoH for public comment in 2015. Well over 300,000 written submissions were received from the public providing comments on the NHI policy. The Bill is currently with the National Council of Provinces (NCOP) for consideration. The NHI Bill is currently before the National Council of Provinces for concurrence.

In the NCOP, the Bill must be sent to a select parliamentary committee (the select committee) for initial consideration. The select committee, or other NCOP committee to which the Bill is referred:
• must enquire into the subject of the Bill;
• may make changes to it; and
• may find it unconstitutional.

If at least five of the nine provinces approve the Bill, it will be referred to the president for signature. If the NCOP amends the Bill, it will be referred back to the National Assembly for consideration. If the National Assembly votes to pass the Bill with a two-thirds majority, it will not need to be passed by the NCOP. If the NCOP rejects the Bill, it will be referred to the Mediation Committee. If a compromise is reached, the Bill will be passed by Parliament. Once passed by Parliament, the Bill will be sent to the president to sign it into law.

Section 79 of the constitution states that, once a Bill has been passed by Parliament, the president must either assent to or sign a bill passed by Parliament or, if the president has reservations about the constitutionality of the Bill, must refer it back to the National Assembly and NCOP for reconsideration. Once referred back to the president by Parliament, the president may either sign it or refer it to the Constitutional Court.

Universal health care

The NHI is promoted by the Health Department as the ‘universal’ health system for the country. However, the NHI is nothing more than a ‘health financing system’ in which the NHI Fund which will buy all health services for South Africans free at the point of service. Although universal access to healthcare and the NHI is related, they are not the same thing.

Technically, the current combination of public and private sector provision meets the internationally accepted criteria for universal health coverage (UHC). The whole population has access to pre-funded services that are free at the point of service. Even where access is not free, there is minimal exposure to financial distress.

What is NHI?

NHI is a health financing system that is designed to pool funds together to provide access to quality and affordable personal health services to all South Africans based on their health needs, irrespective of their socio-economic status. I

The fund will pay for health care for all South Africans, there will be no fees charged at the health facility because the NHI fund will cover the costs of your care. It is exactly what medical aids schemes are doing but with two notable differences:

Difference 1: This health insurance will cover every South African, employed or unemployed, earning low income or high income.
Difference 2: The socio-economic status of members of the public will not influence the type of healthcare you receive but it will be influenced by the condition of your health. There will be no limited benefits because of the salary you earn or because you are unemployed.

National Health Insurance will be run as a non-profit public entity. The National Health Insurance Fund will pay public and private healthcare providers on exactly the same basis – and expect the same standard of care from both.

Nationalisation

The goal of the NHI is the nationalisation of all medicine including dentistry in the country.

NHI Bill if signed will effectively lead to the nationalisation of health services of dentists and other providers who will be forced to contract to the NHI. It seeks to create a completely new system out of two potentially functional public and private systems. There will not be distinct public and private sectors anymore.

It will create a single-payer of health services to both the public and private healthcare service providers: general practitioners, clinics, hospitals, specialists and pharmacies. Simply put, citizens in a single-payer system do not pay premiums to a private insurance company but pay taxes or separate health care premiums to the government, which then runs an insurance programme for all citizens.

When a citizen visits the health service provider, the government which is the insurer who pays the bill.

Hospitals, doctors, and dentists will then be reimbursed at tariffs set by the NHI.

The Bill takes away powers of provinces to finance, plan and run health services and redirects it to the national level. All revenue that would have been allocated via the provincial equitable share (PES) and conditional grants will now be re-directed to the NHI Fund. The centralisation of the provincial equitable share (PES) is effectively an intrusion by national government into the legitimate tax revenue of provinces to carry out their constitutionally mandated functions, which includes health services and ambulance services.

Provincial governments will therefore not receive transfers from national government to carry out their Constitutional obligations with respect to healthcare. In effect, provincial departments will become agents of the NHI Fund.

It would appear, that provincial health services would receive revenue in the form of health service reimbursements – much the way private health services receive them. Technically this means that national government appropriates the funds for the NHI Fund, which then buys either provincial or private health services.

Lack of Detail

Although the Bill consists of 11 chapters, the Bill is simply a skeleton with the majority of provisions left to be determined in regulations, to be promulgated by Government (without the accountability involved in the process of passing bills). The Minister will decide on a timeline of his/her own choosing for publication of regulations and finalise it as he/she thinks appropriate.

Chapter 1 also provides that the act will not apply to the National Defence Force and State Security Agency.

Chapter 2 of the Bill covers "Access to Health Care Services". This chapter outlines the people for whom the NHI fund will purchase health care services. These people include South African citizens, refugees and prisoners, while asylum seekers and illegal foreigners will only be entitled to emergency services and services for notifiable conditions of public health concern. All children in South Africa, including children of asylum seekers and illegal foreigners, will be entitled to basic healthcare services. It also provides for the rights of users and their registration.

Chapter 3 of the Bill, titled "National Health Insurance Fund", establishes the NHI fund, its functions and powers. Chapter 4, titled "Board of Fund", deals with the board of directors to govern the NHI fund, while Chapter 5, titled "Chief Executive Officer" deals with the appointment and responsibilities of the chief executive officer of the NHI fund.

Chapters 6 and 7 of the Bill, titled "Committees to be Established by Board" and "Advisory Committees Established by Minister" respectively provide for various committees to help achieve the purposes of the act.

Chapter 8 of the Bill is titled "General Provisions Applicable to Operation of the Fund". Of particular importance, section 33 deals with the "role of medical schemes" and states that once NHI has been fully implemented (at such time as decided by the Minister of Health), medical schemes may only offer complementary cover for services not covered by NHI.

Chapter 9 of the Bill, titled "Complaints and Appeals" provides that people may submit a complaint to the NHI fund. The complainant must be informed of the outcome of the complaint within a reasonable period of time. This chapter also provides for appeals of decisions made by the NHI fund.

Chapter 10 is titled "Financial Matters". This chapter regulates the sources of income of the NHI fund, of which the primary source is provided as money appropriated annually by Parliament to achieve the purposes of the act. Aside from investments, donations and erroneous payments to the NHI fund, the Bill provides that funding will be primarily generated from:
• general tax revenue;
• reallocation of funding for medical scheme tax credits;
• payroll tax; and
• surcharge on personal income tax.

Chapter 11, titled "Miscellaneous", provides for other matters including offences and penalties. Importantly, section 54 of the Bill provides that any person who misuses NHI fund money or obtains money from the NHI fund under false pretences is guilty of an offence and liable on conviction to a fine of up to 100,000 rand and/or imprisonment for a period of up to five years.

Chapter 11 also includes section 57, titled "Transitional arrangements". This section provides that the Bill (once passed) will be implemented in two phases. Phase one is provided as three years from 2023 to 2026. During phase one, the health system is to be strengthened, while NHI is to be implemented to purchase health care services for:
• women;
• children;
• the elderly; and
• people with disabilities.

Phase two is planned to occur for a period of three years between 2026 and 2028. Phase two will include the selective contracting of health care services from private providers, while further strengthening the health system.

Nothing is known about the potential cost of the NHI as costing has been done to date, how it will be phased in, what additional institutions will be required, and what services will be provided.

There is no information on:
• What the exact costs of NHI will be cost as no costing or scenario planning has been done. It is not clear what will happen when the NHI Fund runs out of money.

• What health service will be provided under NHI, so we do not know if dental services are included, and if they are to what extent. It is left up to the Benefits Advisory Committee to determine this and will be regulated later
• What remuneration will be payable to dentists – capitation which is a fixed fee per month for each patient seen or fixed tariffs. This will also be regulated later.
• Coding systems to be employed.
• Role and future of medical schemes.

As a result, nobody in the health sector has an idea of what the final product will look like and how it will impact our members who are providers of healthcare services.

NHI Fund

The Bill establishes a Schedule 3A autonomous public entity accountable to the Minister of Health. The NHI Fund is established which will purchase all healthcare services from public and private providers and pay for them. The boards of Schedule 3A entities (there are 147) all report to line ministers.

With the NHI in place, all health revenue will be deposited into a single fund and nationalised. The fund will be a massive state-run medical scheme, and all South Africans will be members. Citizens will not have a choice and will compulsorily belong to the Fund.

The Minister of Health is given all the power and is responsible for the overall governance and stewardship of the National Health Insurance Fund. The Fund is accountable to the Minister for its functions and powers. The Minister has the power to appoint and dissolve the entire board of the Fund. The Minister also plays a significant role in the appointment and removal of the CEO.

The Minister can veto the Fund's purchasing decisions, its design of "healthcare service benefits" decisions, "and best practices etc. in terms of referral networks". In other words, the Fund is totally tied down. It cannot operate under normal corporate governance because the Minister is basically a political appointee, not an expert, not an employee of a national executive, but a politician.

The Minister, in cooperation with the Board, shall appoint three advisory committees:
a) Benefits Advisory Committee;
b) Health Care Benefits Pricing Committee; and
c) Stakeholder Advisory Committee.

How will NHI raise funds or who will pay for NHI?

The NHI Fund will get a large amount from general taxes. The Fund will be financed by the government which will levy an extra tax on personal income, and use the money it will save by not giving tax credits for being a member of a medical scheme Therefore, every person in South Africa will make a contribution to the fund because we will all pay some kind of tax. There may also be a tax levied on employers. There have been some discussions about the possibility of increasing VAT for additional income. It was speculated that an "NHI tax" of between 3.5% and 5% could be levied on salary.

People with low income will not make any direct payment to the NHI Fund. Every person earning above a set amount will be required by law to contribute. Monthly contributions made by the employees to the fund, in almost all cases will be lower than medical aid tariffs and the direct NHI payment will be larger for higher-income earners.

Employers will assist the NHI Fund by ensuring that their workers NHI contributions are collected and submitted, in a manner similar to UIF contributions. Employers will match their employees` contributions to NHI.

LIKELY IMPACT OF NHI ON PRIVATE PRACTITIONERS

What dental services will be covered by the NHI?

At this stage, such information is not available.

The bill does envisage a formulary and a Benefits Advisory Committee, who in consultation with the Minister and the board of the Fund, will determine the benefits provided by the Fund.

Section 8 of the bill states that a user will be personally liable for (a) treatment not included in the formulary, (b) services that are not medically necessary and (c) services due to noncompliance with the referral pathways.

Treatment will not be funded if the provider shows no medical necessity for the service, no cost-effective intervention exists and product or treatment is not in the formulary.

Registration of users

All those covered by NHI will need to register with the Fund and everyone that is registered will be expected to access the health system via an accredited care provider or establishment.

If persons are not registered then they are not covered by NHI. The intention is that people registered with the Fund will access care via a primary care provider or establishment in the area covered. The primary care provider then acts as the gatekeeper to the rest of the system and patients will be required to adhere to the referral pathways.

Even if people retain additional medical insurance, you will still be expected to register for NHI. Registered users will be entitled to healthcare services that are free at the point of care. Private general practices would therefore be able to retain their patients if the practice is accredited by the fund and their patients choose to utilise them.

The Bill does not define a minimum number of registered patients per provider. The Contracting Unit for Primary healthcare (CUP) will contract services for the catchment area of a district hospital and its finances will be primarily based on the size of the population in that area. The fund will not divide patients between public and private facilities. Patients will be able to utilise any accredited primary care provider or health establishment of their choice.

This means that if the catchment area is over serviced, with too many accredited providers, there will be less funding available per provider. This also implies that people will need to utilise a primary care provider within the area covered by their CUP as the money for their benefits is allocated to the CUP where they live.

Some kind of capitation fee is presented without details for primary healthcare services.

Role of Medical Schemes

Section 33 of the NHI Bill says that once NHI is fully implemented, medical schemes may provide only complementary cover for services not covered by the fund.

So if any citizen decides not to register as a user with the Fund, he or she cannot obtain a private medical scheme to cover all health care services. The Bill thus prevents those who can afford it from using their medical scheme cover, and forcing them into the NHI system.

The Bill and the accompanying memorandum offer no explanation at all as to why an attempt is being made to exclude private medical schemes from continuing to provide cover.

Once fully implemented, practitioners will no longer be able to provide services already covered by NHI and claim these costs from the patient's medical scheme.

Private practitioners who do not register with the Fund will only have patients who pay cash for dental services and those with scheme cover for non-NHI covered services.

Accreditation of Providers

All dentists will have to obtain accreditation from the Fund. To do so the dentist must be in possession of certification by the Office of Health Standards Compliance as well as proof of registration with the relevant statutory council.

A further requirement that must be met for accreditation is the allocation of the appropriate number and mix of healthcare professionals to deliver the specified healthcare services.

In addition, the provisions of the National Health Act (ss 36 to 40) will be proclaimed into law which will require practitioners to obtain a Certificate of Need from the Director-General's office. Dentists will have 24 months to obtain the certificate after proclamation or sooner if want to be accredited and contract with the Fund.

This will severely impact practitioners relocating and opening a practice in a different locality or province, in the case of sale of the practice or opening multiple practices in different locations.

Accreditation will compel practitioners to adhere to treatment protocols and guidelines, health care referral networks, submission of information, and adherence to the national pricing regimen to retain accreditation.

Effectively it could mean that without accreditation, a practitioner may not practice his or her chosen occupation. This could also mean that healthcare providers who are not accredited by, and do not contract with the fund, cannot be paid for their services by anyone.

Dental practitioners will be subject to the decision-making powers of the minister, and would see their freedom to practice their profession limited or redefined to a point where their only remaining choice is whether to practice as healthcare practitioners or not.

This will have significant consequences for all dentists in that they will have no alternative but to obtain accreditation with the Fund in order to obtain a certificate of need, without which such practitioners cannot operate their practices.

Payment of healthcare service providers

The Bill is silent on the nature of payment of service provider payment mechanisms It is left to be determined by the Fund in consultation with the Minister. It is stated they will negotiate the lowest possible price for goods and health care services.

The payment method and determined will only be known when regulations is published. The speculation is that private general practitioners who contract into NHI will be paid on a capitation basis for service to a particular population. The burden and severity of disease in the community will be taken into consideration, calculating this capitation rate. Promotive and preventive practices will likely be incentivised.

In the case of specialist and hospital services will be all-inclusive and based on performance as part of the hospital bill. Quite how this performance will be assessed is unclear. The work of at least some types of

medical specialists is likely to fall entirely, or almost entirely within the scope of conditions and treatments covered by NHI.

This will mean that specialists can only charge NHI rates – which is likely to be substantially lower than their current private sector rates. The NHI Fund will reimburse according to prices set for each published benefit. It will take some time to get to a point of price negotiations.

The gatekeeping principle of patients entering the health system at PHC level (mostly GPs for patients presently using the private sector) is likely to impact on dental. The aim is to reduce the use of specialists in the care of uncomplicated conditions.

Only the really ill patient will be referred for specialist services will (at least partly) offset those “lost” to gate-keeping. How the NHI Fund engages with providers and how prices are set is going to be subject to engagement and discussion.

As it is likely that NHI will introduce price controls that will make it harder for private hospitals to be as profitable as they are now. Again it is most likely that NHI will introduce price controls that will make it harder for private hospitals to be as profitable as they are now.

Dentists will most likely be subject to price control and guidelines if the NHI bill is signed into law.

These prices will be set by a pricing committee. In all instances, the set fees and tariffs to be ‘uniformly’ determined and applied to providers in both the public and private sectors. This is likely to harm private practitioners who have major overhead expenses from which their counterparts in the public service are spared.

There is no indication if the Pricing Committee will take into account the actual costs of providing services by dentists.

Role of District Health Management Office (DHMO)

This office will effectively strip away the powers of provinces to finance, plan and district health services and allocate them to the Minister of Health.

Amendments to the National Health Act further stipulate that the DHMOs must establish contracting units, which will receive funds, determined by a formula, from the NHIF to contract with primary care providers. These contracting units, established as part of DHMOs, will be required to contract with the NHIF to receive funds from the NHIF.

Contracting Unit for Primary Health Care (CUP)

Section 37 of the Bill makes provision for the establishment of contracting units for primary health care. There is also no clarification of what kind of public structure a so-called contracting unit is. Given that they would have substantial delegated powers to procure health services, this is concerning.

The CUP is ostensibly to be comprised of district hospitals, clinics and/or community health and ward based-outreach teams. In addition to these public entities, the CUP is also to include private primary service providers organised in horizontal networks.

There is thus a grouping together of both public and private entities. With regard to the public entities, these form part of the provincial departments of health and are not independent juristic persons that have the capacity to enter into contracts. Similarly, the private networks are themselves not necessarily entities that

have contractual capacity. Assuming that these legal obstacles are overcome, the clause is confusing in respect of the nature of this contractual relationship.

It is unclear how this CUP is to be established and what legal status it enjoys. This is a critical lack of clarity as the Fund, in terms of this clause will, amongst others, contract with the CUP for the provision of primary health care. Inter alia, the role of these units includes identifying accredited public and private health care service providers, and managing contracts entered into with accredited health care service providers. These new structures seem to be the equivalent of the current sub district units, with prescribed levels of care and enhanced health financing competencies.

The CUP appears rather to fulfil a monitoring and enforcement function for the Fund. It will, be responsible to assist the Fund in an array of functions that the Fund (and not the CUP) will perform.

The CUP can therefore be regarded as a functionary of the Fund performing a supportive role, but not an entity with which the Fund contracts for the provision of primary healthcare services. It is submitted that the CUP as described in the Bill does not have contractual capacity to enter into any agreements with the Fund and a revision of the clause is required.

Health Products Procurement Unit (HPPU)

The Bill provides for The Health Products Procurement Unit (HPPU). The Bill provides very little more detail on the HPPU.

It says that the office will be the central body for the public procurement of health-related products as well as medicines, medical devices, and equipment for the accredited facilities.

This will be done by determining the selection of products to be procured; developing a national products list; coordinating the supply-chain management process and negotiating prices; facilitating cost-effective, equitable, and appropriate public procurement of health-related products; supporting the process of ordering and distribution of products nationally; as well as facilitating the procurement of high-cost devices.

According to the Bill accredited healthcare service providers and health establishments must procure according to the Formulary; and suppliers listed in the formulary must deliver directly to the accredited and contracted healthcare service providers and health establishments.

National Health Information System

The Fund will contribute to the development and maintenance of a National Health Information platform. This may mean that dental practitioners will have to install the necessary IT systems in place to access the platform.

Yours in oral health
Dr Tinesha Parbhoo
Head Clinical Support

Punkaj Govan
Head Legal and Corporate

2023 circulated SADArite and Professional Advisory Bulletins
are available in the members only section of www.sada.co.za
Go to the Main Menu Item: Publications and Press
Select Members Newsletters

Go to The SADArite or Professional Advisory Bulletins
to download or read online

Download this and other Professional Advisory Bulletins

08 Mar	**SADA Gauteng South Branch Mini Congress 8-9 March 2024 (GS067)**
30 Aug	**2024 SADA Dental & Oral Health Congress and Exhibition**