REPORT OF THE COMMITTEE ON HEALTH, COMMUNITY DEVELOPMENT AND SOCIAL SERVICES ON THE NATIONAL HEALTH INSURANCE BILL, N.A.B NO. 22 OF 2017, FOR THE SECOND SESSION OF THE TWELFTH NATIONAL ASSEMBLY, APPOINTED ON 20TH SEPTEMBER 2017

Consisting of:

Dr C Kalila, MP (Chairperson); Ms P Kasune, MP (Vice Chairperson); Dr C Kambwili, MP ; Dr J K Chanda, MP; Mr L N Tembo, MP; Mr J Kabamba, MP; Ms A M Chisangano, MP; Mr L Kintu, MP; Mr M Ndalamei, MP; and Mr A Mandumbwa, MP.

The Honourable Mr Speaker
National Assembly
Parliament Buildings
LUSAKA

Sir
Your Committee has the honour to present its Report on the National Health Insurance Bill, N.A.B. No. 22 of 2017, referred to it by the House on Friday 8th December, 2017.

Functions of the Committee
2.0 In addition to duties conferred upon it by the Standing Orders or any other Order of the House, your Committee is mandated to consider any Bill that may be referred to it by the House.

Meetings of the Committee
3.0 Your Committee, in considering the proposed legislation, held seven meetings and interacted with various stakeholders and examined in detail, all the submissions presented before it.

Procedure Adopted by the Committee
4.0 In order to gain insights into the ramifications of the Bill, your Committee sought both written and oral submissions from various stakeholders. The list of the witnesses who gave oral and written evidence to your committee is at Appendix II of the Report.

5.0 Objects of the National Health Insurance Bill

The objects of the Bill are to:

i. provide for sound financing for the national health system;

ii. provide for a universal access to quality insured health care services;

iii. establish the National Health Insurance Management Authority and provide for its functions and powers;

iv. establish the National Health Insurance Scheme and provide for its systems, procedures and operations;
v. establish the National Health Insurance Fund and provide for contributions to and payments from the Fund;

vi. provide for accreditation criteria and conditions in respect of insured health care services;

vii. provide for complaints and appeals processes;

viii. provide for the progressive establishment of provincial and district health offices of the Authority; and

ix. provide for matters connected with, or incidental to, the foregoing.

Background

6.0 Universal health coverage is currently top of the global health policy agenda and has now been globally adopted as part of Sustainable Development Goal (SDG) Number 3. The goal of universal coverage is defined as "Ensuring people have access to needed promotive, preventive, curative and rehabilitative health services of sufficient quality to be effective, without suffering financial hardship when paying for them."

Since 1992, the Zambian Government has been implementing significant health sector reforms aimed at strengthening health service delivery in order to improve the health status of Zambians. In this regard, in 2017, the Minister of Health launched the National Health Strategic Plan 2017-2021. The Strategic plan includes nine Legacy Goals, namely:

i. Reduction in maternal and child mortality;
ii. Elimination of malaria;
iii. Recruitment of 30,000 care health workers;
iv. Introduction of health care insurance to increase coverage from 4% to 100%;
v. Introduction of Alcohol and Drug Abuse Policy and Programme;
vi. Achieve HIV epidemic control, reduce new HIV infections from 48,000 to less than 5,000;
vii. Construct six new specialised hospitals and 500 health facilities in the next five years;
viii. Train 500 specialists by 2021; and
ix. Halt and reduce non communicable diseases.

Therefore, in line with SDG 3 and Legacy Goal 4 of the Strategic Plan 2017-2021, the Government has introduced the National Health Insurance Bill, No. 22 of 2017 to strengthen health care service delivery in order to improve the health status of Zambians.

Summary of the Salient Provisions of the Bill

7.0 The salient provisions of the National Health Insurance Bill, N.A.B. No. 22 of 2017, are set out hereunder.

Part 1 - Preliminary Provisions

Clause 1: **Short Title and Commencement**
This clause provides for the short title of the Act and that the Act shall come into operation on a date that the Minister may appoint by Statutory Instrument.

Clause 2: **Interpretation**
This clause defines various technical and non-technical terms used in the Bill. Some of the terms used are "accreditation", "actuarial assessment", "emergency medical condition" and "established resident".

Clause 3: **Application and Power of Exemption**
This clause provides that the provisions of the Act shall bind the Republic and that the Minister may prescribe health care services that are not covered by the Scheme. The clause also provides that the Minister may, by Statutory Instrument, extend the categories of individuals to whom the Act applies.

Part II: The National Health Insurance Management Authority

Clause 4 and 5: **Establishment of National Health Insurance Authority and its Functions**
These clauses provide for the establishment of the National Health Insurance Management Authority and its functions.

Clause 6 and 7: **Board of Authority and Functions of the Board**
These clauses provide for the appointment and functions of the Board of the Authority. Despite the clauses conferring the Minister with discretionary power to appoint the Board, the Bill provides guidelines for the composition of the Board and further provides that the members shall be nominated by their respective institutions.

Clause 8: **Committees**
This clause provides that the Board may constitute committees that it considers necessary and delegate any of its functions to these committees.

Clause 9 and 10: **Delegation of Functions and Director General and Other Staff of Authority**
These clauses provide for the delegation of functions of the Board to the Director-General and the appointment of the Director-General who shall be the chief executive officer.

Clause 11: **Provincial and District Offices of Authority**
This clause provides that the Authority shall, with the approval of the Board, progressively establish and maintain provincial and district offices of the Authority.

Part III: National Health Insurance Scheme, Coverage and Benefits

Clauses 12 to 15 deal with the establishment of the National Health Insurance Scheme, membership and registration. This Part further provides for possession of travel health insurance by foreigners, persons eligible for exemptions and procedure upon death of member.

Part IV: Accreditation of Health Care Providers

Clauses 26 to 36 provide for the prohibition of provision of insured health care services without accreditation, application for accreditation to provide insured health care services, suspension or revocation of accreditation, among others.

Part V: Quality Assurance

Clauses 37 to 40 deal with the compliance with quality standards, quality assurance, contracts and monitoring mechanisms and inspections.

Part VI: National Health Insurance Fund

Clauses 41 to 44 provide for the establishment of the National Health Insurance Fund for the purpose of the Scheme, administration and management of the Fund, Fund accounts and disbursement, and annual reports.

Part VII: Financial Provisions

Clauses 45 to 48 deal with funds of the Authority, its financial year, accounts, audit and annual report.

Part VIII: General Provisions

Clauses 49 to 57 deal with general unrelated provisions such as the Health Complaints Committee and appeals, immunity of the Authority from execution of judgments, registers, general offences, and general penalty, among others.

Concerns Raised by Stakeholders

8.0 Most of the stakeholders who appeared before your Committee were in support of the establishment of a National Health Insurance Scheme but were not in favour of the National Health Insurance Bill in its current form. They were of the view that the National Health Insurance Scheme was a progressive and long overdue innovation which would promote access to health care through pooling of resources and risks.

Most stakeholders expressed concern about lack of wide consultation in the process of development of the Bill. They contended that they had initially been consulted regarding a proposed Social Protection Bill, which also proposed to incorporate health insurance, but which was radically different from the National Health Insurance Bill, which had now been presented to the National Assembly. They emphasized that they were seeing this Bill for the first time. There were two schools of thought on whether or not the Bill should be separated from the general social protection legislation. On one hand were those who held the view that the Bill should be returned to the Social Protection platform, while on the other, were those who felt that

the Bill could stand alone provided that the concerns they raised were addressed. Those who held the latter view were by far in the majority.

Specific Concerns Raised by Stakeholders
The specific concerns of the stakeholders who interacted with your Committee are set out below.

Part 1 - Preliminary Provisions
Stakeholders were of the view that it would be very costly to run all the structures proposed to be established under the Act. They feared that the resources meant to improve health care delivery would be swallowed up in administration costs. They further contended that this was a recipe for increased bureaucracy and reduced efficiency. The stakeholders, therefore, recommended that the functions of the Authority be integrated into those of the National Health Insurance Fund to avoid duplication of functions.

Clause 2 – Interpretations
The stakeholders were concerned that the term "*Emoluments Commission"* referred to numerous times in the Bill has not been defined under Clause 2. They proposed that the term *"Emoluments Commission"* be clearly defined with a cross-reference to the Republican Constitution.

Clause 3 – Application and Power Exemption

(i) Some stakeholders were concerned that the provisions in Clause 3(1) of the Bill were binding on the Republic. They were of the view that these provisions should only bind the insured members.
(ii) Stakeholders were also concerned that neither Clause 3 (1) nor its partner Clause 57 (1) provide for consultation on application and exemption to enact these provisions. The stakeholders were of the view that the Bill should provide for consultation with employers and employees or at the very least, with the Board.

Part II – The National Health Insurance Management Authority

Clause 4 – Establishment of the National Health Insurance Management Authority
Some stakeholders wondered whether there was need to establish the National Health Insurance Management Authority. They were of the view that the Board was sufficient to govern the Health Insurance Fund. They were concerned that sustaining the National Health Insurance Management Authority would be a financial challenge.

Clause 5 – Functions of Authority
Under Clause 5 (c), some stakeholders raised concern that the Bill was confusing as it appeared to suggest that the regulatory role of the Health Professions Council of Zambia (HPCZ) would now be taken up by the Board of Authority. They submitted that currently, the health providers were regulated by the HPCZ.

Clause 6 – Board of Authority

(i) Regarding Clause 6(a), some stakeholders expressed concern that the proposed composition of the Board had an unacceptably low representation of the proposed principal contributors to the National Health Insurance Scheme who were the employers and employees. They added that the critical role of Clause 6 (1) (a) (vii) and (viii) was properly recognised under the *National Pension Scheme Act No. 40 of 1996* where employers and employees each had two seats on the Board. This was the case also under the Workers' Compensation Fund Control Board where umbrella bodies of employers and workers had three seats each.

(ii) Other stakeholders expressed concern that although the Pensions and Insurance Authority (PIA) were the regulators of medical insurance, they were not represented on the Board. They therefore, proposed that a representative of the insurance profession be included on the list of members to constitute the Board of Authority.

Clause 9- Delegation of Functions

Stakeholders expressed concern that the clause provided that the Board could delegate its oversight function at the governance level to the Director General whom it was supposed to oversee. They submitted that the Board's functions, which were truly about governance, were stated in Clause 7 and in contrast, those of the Director General, who is responsible for the day-to-day management, were provided for in Clause 10. Stakeholders further submitted that mixing the Director General's functions under Clause 10 and the Board's functions under Clause 7 could amount to abdication of the Board's responsibilities and result in bad corporate governance. They, therefore, proposed that the two roles be independent of each other.

Clause 10 – Director General and Other Staff Authority

Stakeholders were of the view that in Clause 10(3), the person to be appointed as Director General should also be a fully paid up member of a body of insurance professionals as this would make such an appointment professional and not political and eventually improve confidence in the Fund.

Clause 11- Provincial and District Offices of the Authority

The Bill proposes the establishment of the National Health Insurance Management Authority, the National Health Insurance Scheme, the National Health Insurance Fund, and the Board of Authority. Stakeholders were of the view that the additional creation of provincial and district offices of the Authority, as proposed by the Bill in Clause 11, would further increase operational costs thereby reducing the funds available for the core business of the Authority. They, therefore, proposed that the Authority be run through already established authorities such as Pensions and Insurance Authority (PIA) and the Workers' Compensation Fund Control Board (WCFCB) in order to reduce costs.

Part III – National Health Insurance, Coverage and Benefits

Clause 13 – Membership and Registration

(i) Stakeholders were concerned that Clause 13 made a provision for compulsory membership but did not provide for penalties for employers who would not register their

employees with the Authority. They, therefore, proposed that the provisions relating to penalties be included in Clause 13 of the Bill.

(ii) In Clause 13 (1), the stakeholders were also concerned that the limitation of registration of a citizen or a resident above eighteen years defeated the purpose of universal coverage as it excluded family members of the employees who were under the age of eighteen. They proposed that the provision be rephrased to read "*every citizen or established resident shall be registered as a member of the Scheme within thirty days of the commencement of this Act in the prescribed manner or form"*

Other stakeholders were of the view that this provision on age did not take into account the fact that at eighteen years of age, most of the Zambian youths would have just completed their secondary education and were preparing to go for higher education. Therefore, they may not have the capacity to pay for medical services. They proposed that there must be a proviso to enable those below the prescribed age to access medical care as dependants of registered citizens.

They further proposed that the age requirement be raised to twenty five years with a proviso that those who will get economically active in income generation activities at any age *between 18 and 25 must register with the Scheme.*

(iii) In Clause 13(2) the stakeholders were of the view that the Fund, and not the Minister, should determine the criteria for enrolling beneficiaries under this Bill. Further, stakeholders wondered how Clause 13 and 15 would be reconciled. They noted that whereas Clause 13 dealt with membership and stipulated that a citizen who was above eighteen years shall be registered as a member of the Scheme, Clause 15 presupposed that a member was in employment and the contributions were made by the employee and the employer. Further, by making health insurance compulsory under Clause 13 (1), the following would arise:

(i) insurance was a levy which was a cost to the citizens and residents of the country;
(ii) the total cost to an employer in relation to an employee would increase. They contended that this was counterproductive as it might lead to increased unemployment in the country; and
(iii) this policy position was inconsistent with liberalised economic orientation given that there were other health insurance companies who provided similar services.

Clause 15 – Contributions and Payment Mechanisms

Clause 15 (3) provided that the manager of a pension scheme shall pay to the scheme, a retiree's contribution as prescribed. Stakeholders were of the view that this provision was contrary to pension laws, international conventions and principles which provided that pension benefits shall not be:

(a) capable of being assigned or charged;
(b) attached by the order of any court; or
(c) set off against any debt by the person entitled.

i. They noted further, that this provision was in conflict with Article 187 (2) of the *Constitution of Zambia (Amendment) Act No. 2 of 2016*, which stated that:

> *"A person's benefit shall not be withheld or altered to that employee's disadvantage."*

Stakeholders, therefore, recommended that Clause 15(3) be deleted.

ii. In Clause 15(5), some stakeholders wondered why the Bill had a provision for the Minister to prescribe rates of contribution and not the National Health Insurance Board. They proposed that the rates should be based on current actuarial assessments, especially those conducted within three years.

(iii) Stakeholders submitted that Clause 15 was inconsistent with Clause 41. Particularly, Clause 15 which provided that contributions should be paid to National Health Insurance (NHI) Scheme, yet Clause 41 (3) (a) provided that contributions will be paid into the NHI Fund.

Clause 17 – Standard Unit Cost

Stakeholders submitted that the National Health Insurance Authority (NHIA), like any other insurance scheme, were purchasers of the service and thus it was not right for them to unilaterally determine the Standard Unit Cost. They proposed that negotiations should be encouraged.

Clause 18 – Negotiated Fees Charges and Payment mechanisms

(i) In Clause 18 (2) (a), some stakeholders contended that the provision was not practical. They proposed that a system of differential cost of services should be in place for facilities located in a similar geographical area as the cost of providing a service varied depending on where the service was being provided.

Other stakeholders were of the view that only market forces should influence the pricing, especially as it related to the poor and vulnerable communities. Further, that market segmentation and supply should create its own demand to influence pricing but with reasonable regulation from impartial and appropriate regulatory bodies.

(ii) Further, some stakeholders noted that Clauses 18 (2) (c) and (d) of the Bill made provisions to establish a drug formulary system as well as the need to use generic medications. Stakeholders submitted that these were already contained in the Essential Medicines List and the development of this List was the mandate of the already existing Zambia Medicines Regulatory Authority (ZAMRA). They, therefore, recommended that the Authority should work in conjunction with and use the Medicines List provided by ZAMRA.

Clause 21- Death of a Member

Clause 21 provided that upon the death of a member, a family member was entitled to continued benefits for a period of four months. Some stakeholders contended that this provision was unfair as it did not adequately take care of the interests of a beneficiary after the four months of the death of a member. They proposed that a longer period, such as until a beneficiary turned eighteen or was in gainful employment be considered.

Part IV-Accreditation of Health Facilities

Clause 26 – Prohibition of Provision of Insured Health Care Services Without Accreditation

Stakeholders observed that this provision would bring conflict, as currently, the Health Professions Council of Zambia (HPCZ) was responsible for accreditation of health providers under the *Health Professions Act, No. 24 of 2009*. They proposed that the clause be deleted.

Part VI- National Health Insurance Fund

Clause 42 – Administration and Management of the Fund

(i) Stakeholders submitted that Clause 42 (1) of the Bill placed the responsibility of prudent management of the Fund on the Board. Best practice suggested that there should be a minimum external regulatory framework to guide financial institutions regarding fund or asset management. The objectives of such investment regulations included the need to assure financial soundness and stability of the institution or the need to manage systemic risk in the wider financial system. Such external regulations would also provide a measure of protection to the Fund and the internal Board from unsafe or unsound pressure from appointing authorities. In Zambia, insurance and pension funds (as established by licensed insurers or pension schemes) are subject to solvency and investment regulations as provided in the Insurance Act and the Pension Scheme Regulation Act, respectively. Stakeholders proposed that a provision be added in Clause 42 immediately after to Clause 42 and should read as follows:

> "*In the management of the Fund, the Board shall comply with investment regulations and standards as may be made under the Insurance Act.*"

(ii) Under Clause 42 (1), some stakeholders submitted that the Bill did not provide clear separation between the Authority and the Fund and also if the Authority would provide checks and balances. They proposed that if the Authority would run the Fund, then it should be subordinate to the Pensions and Insurance Authority, which was the regulator of insurance and pension providers. In this regard, some stakeholders felt that Clause 42 should include a monitoring and enforcement provision which should read as follows:

> *"For purposes of Parts VI and VII of this Act, the Registrar of the Pensions and Insurance Authority may inspect the management of the National Health Insurance Fund and Scheme and direct or take supervisory action against the*

Board, any member of the Board or a senior manager of the National Health Insurance Management Authority for continued breach of any accounting, valuation or investment regulation or standard."

Part VIII-General Provisions

Clause 49 – General Provisions

Under Clause (2), some stakeholders submitted that the Bill should clearly state that members of the Complaints Committee should not be serving members of the Board for purposes of oversight. Others were of the view that the clause should provide for a minimum of seven years experience for the members of the Health Complaints Committee, which is standard in many statutory adjudicatory bodies.

Other Concerns

Some stakeholders were of the view that in line with the Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144) ratified by the Government of Zambia, it was critical that employers' and workers' organisations, as well as civil society organisations, were provided adequate opportunities to raise concerns and make concrete contributions towards the finalisation of the Bill. They argued that as the matter stood:

a. the National Health Insurance Bill had not been submitted to tripartite consultations through the Tripartite Consultative Labour Committee (TCLC);
b. general national and provincial consultations dated back to 2014. There had since been substantial revisions to the National Health Insurance Bill but no adequate consultations on the version submitted to the National Assembly; and
c. the submission to Parliament of a stand-alone Bill was not consistent with the tripartite agreement and recommendation at the Tripartite Consultative Committee Council meeting held in July, 2017, which recommended that if NHI was introduced, it should be integrated under the Social Security Agencies.

Some stakeholders also contended that whereas, some objects of the Bill were to provide for "*universal access to quality insured health care services"* and for a "*sound financing for the national health system",* the actual provisions of the Bill were not consistent with these objectives. They contended that, despite the reduction in the poverty levels, more than half of the Zambian population still lived in poverty and would not be in a position to contribute to the National Health Insurance Scheme. In addition, a significant percentage of the total labour force was in the informal sector. Moreover, most of them were self-employed, which implied that they did not have an employer to co-share the cost of the NHI contributions with. In this regard, some stakeholders were of the view that the law must ensure that primary health care continued to be funded from general tax revenue and provided at minimal or no cost to all citizens. Therefore, additional resources should not be expected from the collection of user fees at primary health care level.

As regards *"universal access to quality insured health care services,*" stakeholders contended that the definition of universal coverage referred to the extension of social health protection with respect to the size of the population that could access health services and the extent to which

costs of the defined services were covered, so that the amount of health-care cost borne out of pocket did not pose a barrier to access or result in service of limited quality. They further argued that this multi-dimensional objective was ambitious and required additional efforts and strengthened health systems which were beyond the reach of the NHI Scheme alone. This was because, to be effective, universal coverage needed to ensure access to care for all residents in the country. Further, providing adequate financial health protection implied that out-of-pocket payments were kept at a minimum level by limiting exclusion of services from the benefit package and keeping co- payments low.

Some stakeholders submitted that despite major efforts from the Government to bring services "as close to the community as possible", through, among other measures, the deployment of rural health workers and the building of additional health posts, geographical barriers (more particularly distance, travel cost, unavailability of transport means) had remained. This was compounded by the perceived low quality of care, which acted as a major deterrent for people to seek care from public health institutions. Therefore, the success of the NHI Scheme in providing effective access to services would require that the Government succeeds in addressing geographical barriers and the human resource constraints through sustained investment in infrastructure and human resources.

Some stakeholders argued that through the Social Protection Bill, the Government expressed its commendable intention to establish a comprehensive legal framework for the social protection sector in Zambia and synergies between different components of the social protection system, including social assistance as well as social insurance. The establishment of a unified legislative framework for the overall social protection system could enhance coordination between different schemes and interventions, including contributory and non-contributory schemes, and provide the foundation to progressively implement a comprehensive social protection system which included a national social protection floor established by law, as recommended by the ILO Social Protection Floors Recommendation, 2012 (No. 202). This could improve the efficiency and effectiveness of the system by realising economies of scale; as well as raise the visibility and the relevance of the social protection sector. They contended that the establishment of clear coordination mechanisms and full integration of social security systems and processes across different schemes and institutions should be given priority, in order to foster systems efficiency, reduce the burden on workers and employers and contribute to extending coverage to the largest possible share of the population.

Stakeholders were of the view that despite the excision of the National Health Insurance Scheme from the Social Protection Bill, adequate coordination should be ensured across all components of the social security system, to make the most of the expertise already in place, foster efficiency gains, reduce transactional costs and achieve economies of scale. Effective coordination across institutions and ministries was also the foundation for the necessary multi-sectoral action to address key social determinants of health.

Response by the Minister of Health

The Minister of Health appeared before your Committee and submitted on several aspects of the Bill. The Minister stated that, contrary to the contention that the Bill was not subjected to wide consultation, the Ministry of Health had conducted several workshops in different parts of the

country where stakeholders from relevant institutions, including the labour movement, were represented. He assured your Committee that the Ministry operated an open-door policy and was still open to further consultations to deal with any issues and concerns raised by the stakeholders. The Minister further explained that even though the last Actuarial Assessment Report was done in 2012, it had a projection of thirty years and could, therefore, still be relied upon.

Committee's Observations and Recommendations

Following interactions with various stakeholders, your Committee's observations and recommendations are as outlined below.

i. the Bill, if enacted, will have a far reaching impact on the employers and employees and expresses concern that there was not sufficient consultation in line with the Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144) ratified by the Government of Zambia. Your Committee is of the view that mother bodies of employers and employees, who are the main financiers of the Fund, should have been involved in the development of the final version of the Bill which was presented to the National Assembly;

   Your Committee, therefore, strongly recommends that the Bill be subjected to wider consultations before it can be enacted into law.

ii. Your Committee expresses concern that the age limit placed on the eligibility for membership and registration to the Scheme under Clause 13(1) is unrealistic as it does not take into account that most Zambian citizens or residents at eighteen years are still learners and dependants and may not have the capacity to contribute to the Scheme.

   Therefore, your Committee recommends that the Bill provides that those under the eligibility age of eighteen years, should access medical care as dependants of their registered parents or guardians.

iii. In Clause 13, the Bill does not provide mechanisms for registration as scheme members for citizens and established residents, who are not employed, are self employed or retired and those in the remotest of rural areas.

   Your Committee therefore recommends that the Bill be amended to clearly state how these categories of citizens will be captured.

iv. The Bill in Clause 4 makes provision for the establishment of the National Health Insurance Management Authority ((NHIMA) and at the same time proposes under Clause 6(1) (a), to constitute the Board of the Authority. Your Committee finds this structure top heavy, ambiguous and a source of unnecessary bureaucracy, which will also escalate operational costs at the expense of service delivery.

   Your Committee, therefore, strongly recommends that instead of the four bodies, only the Board and the Fund should be established; with the Board responsible for management of the Fund to ensure sustainability.

v. In Clause 6(a), the proposed composition of the Board has an unacceptably low representation from employers' and the employees' representatives, yet these are initially the principal contributors to the proposed National Health Insurance Fund. Your Committee is concerned that this is unlike the provisions of the *National Pension Scheme Act, No. 40 of 1996,* where employers and employees each have two seats on the Board as is the case also under the *Workers' Compensation Act, No. 10 of 1999* where employers and workers have three seats each.

Your Committee therefore, strongly recommends that the representation on the National Health Insurance Scheme be revised to take into account representation of all relevant stakeholders, particularly the representative bodies of employers and employees.

vi. Clause 5 and clauses 26 to 36 of the Bill, provides for accreditation of health care providers, licensing and inspection of the health facilities which is the mandate of the Health Professions Council of Zambia (HPCZ), as provided under the *Health Professions Act, No. 24 of 2009.*

Your Committee, therefore, strongly recommends that in order to avoid duplication of efforts and conflict of interest, the accreditation and inspection of health facilities by the Authority should be done through already existing institutions in accordance with existing legislation.

vii. The provision in Clause 11, to establish and maintain provincial and district offices of the Authority will significantly raise administration costs, which is undesirable.

Your Committee, therefore, recommends that the Authority should take advantage of the synergies of other existing institutions such as the Local Authorities Superannuation Fund (LASF), Pensions and Insurance Authority (PIA) and other related agencies to reduce overhead costs.

viii. Clause 13(2) empowers the Minister to prescribe conditions and procedures under which a person who is not eligible to become a member of the Scheme under the Act, may access insured heath care services.

Your Committee is of the view that the Fund and not the Minister should determine the criteria for accessing insured heath care services by ineligible beneficiaries.

ix Giving too much power to the Minister, as the Bill does, in Clause 15 (5), to prescribe rates; in Clause 6(1), to appoint the board; and in Clause 6(e), to prescribe persons exempt from contributions, is bad corporate governance practice, and could be a recipe for abuse.

Your Committee, therefore, recommends that these functions be left to the Board.

x. Clause 17 stipulates that the determination of the standard unit cost has been left to the Authority which may result in citizens being exploited.

Your Committee recommends that a provision for negotiations for the standard unit cost should be made in the Bill because citizens risk paying more if the Authority is left to unilaterally set the standard unit cost.

The provision in Clause 18 2 (a), on a uniform national standard of fees and charges, is inappropriate because the cost of providing health services and care vary, depending on, among other things, where the provider gets their equipment, the patient-staff ratios and the medicines used. Your Committee, further, wonders whether the Government will be subsidising private health institutions which may be offering the service at a higher overhead cost.

In this regard, your Committee strongly recommends that a system of differential cost of services be put in place to cater for facilities located in similar geographical areas, as the cost of providing a service tends to vary depending on where the service is being provided.

xi. Your Committee observes that the Bill does not provide an option for private service providers who may incur losses due to the standard schedule of fees and charges to opt out of the Scheme.

Your Committee, therefore, recommends that this option be provided, considering that private service providers are in this sector for business.

xii. The provisions in Clauses 18 (2) (c) and (d) to establish a drug formulary system, as well as the need to use generic medications are already provided for in the Essential Medicines List under the Zambia Medicines Regulatory Authority (ZAMRA).

Your Committee, therefore, recommends that the Authority works in conjunction with and uses the Medicines List provided by ZAMRA.

xiii. Your Committee observes that the phrase "areas of work" in Clause 24 is unclear and has not been defined in the Bill.

Your Committee, therefore, recommends that the phrase "areas of work" be clearly defined in the Bill.

xiv. Your Committee observes that Clause 48(1), makes provisions for funds of the Authority, its financial year, accounts, audit and annual report but does not provide the time frame for submission of the annual reports to the National Assembly by the Minister while Clause 48(1) directs the Authority to submit an annual report to the Minister not later that ninety days after the end of the financial year.

Your committee, therefore, recommends that the time within which the Minister should lay the annual report before the House should be provided for.

xv. The Bill is also silent on whether or not HIV/AIDS related matters will be funded by the NHIF because currently National HIV/AIDS/STI/ Council (NAC) is mandated under the *National Aids Council Act, No.10 of 2002* to establish a Fund, which has not been actualised to date.

Your Committee, therefore, strongly recommends that in spite of the establishment of the National Health Insurance Fund, National HIV/AIDS/STI Council should establish its own Fund under the *National Aids Council Act, No.10 of 2002.*

xvi. The Bill makes membership to the Scheme compulsory but does not provide for penalties for failure to contribute to the Scheme.

Your Committee therefore, recommends that penalties for failure to contribute to the Scheme be provided for in the Bill.

xvii. Clause 13 (1) provides that a citizen or established resident who is above eighteen years shall be registered as a member of the Scheme within thirty days of the commencement of the Act in the prescribed manner and form. Your Committee is of the view that the period of thirty days for first registration on commencement of the Act is too ambitious considering that people in remote areas are far removed from facilities that would make this provision tenable.

Your Committee, therefore, strongly recommends that this provision be amended to read, "*every citizens or established resident shall be registered as a member of the Scheme within ninety days of the commencement of this Act in the prescribed manner or form",* to allow enough time for registration.

xviii. Clause 15 (1) provides that an employer shall pay to the scheme an employee's contribution consisting of the employer's contribution and the employee's contribution at a prescribed percentage. This implies the Bill is targeting the formal sector as it does not provide for how the informal sector will be registered and the modalities for contributing to the Fund.
Your Committee, therefore, recommends that this be addressed and appropriate provisions be made in the Bill.

xix. Your Committee is of the view that the provisions of Clause 15 (3), which provide that a manager of a pension Scheme shall pay to the Scheme, a retiree's contribution as prescribed, are inconsistent with the pension laws, international conventions and principles, as well as Article 187 (2) of the *Constitution of Zambia (Amendment) Act, No. 2 of 2016,* which state that pension benefits shall not be:

(d) capable of being assigned or charged;
(e) attached by the order of any court;
(f) set off against any debt by the person entitled; or
(g) withheld or altered to that employee's disadvantage.

Your Committee agrees with concerns by stakeholders that a pension would be altered, if the pension managers were compelled by law to remit part of the pension as subscription to the Fund.

Your Committee, therefore, recommends that this clause be deleted.

xx. Your Committee notes that the Bill does not provide for the establishment of a reserve fund, which is, money earmarked to meet future obligations of an entity. Your Committee, therefore, recommends that this be provided for.

xxi. Your Committee notes that whereas the Bill intends to provide for sound financing for the national health system and for universal access to quality insured heath care services, it does not provide for what services will be provided to members of the Scheme who will be located in areas where health facilities are not in existence.

Your Committee, therefore, recommends that this be provided for in the Bill for the protection of Scheme members who may find themselves in areas where health facilities are not in existence such as in rural communities.

xxiii. Your Committee notes, further, that one of the objectives of this Bill is to provide for sound financing for the national health system. Your Committee is apprehensive that if this objective is misunderstood, there is a possibility of the national treasury withdrawing or reducing funding to the health sector.

Your Committee recommends that care must be taken to treat the Fund as a supplement to the budgetary allocation to the health sector and not as the sole source of financing.

xxiv. Your Committee observes that most of the issues pertaining to the management of the Scheme have been left to regulations, which are in the discretionary power of the Minister to promulgate. Your Committee is of the view that leaving too much to regulations is a recipe for abuse.
Your Committee, in this regard, recommends that the salient features of the operations of the Scheme be spelt out in the Bill.

xxv. Your Committee is aware that an Actuarial Assessment is supposed to be conducted every three years. Your committee, therefore, recommends that the Bill be based on the most recent actuarial report.

While agreeing with stakeholders who contended that the idea of the National Health Insurance Scheme was progressive and long overdue and that it would promote access to health care through pooling of resources, your Committee has strong reservations in supporting the Bill in its current form.

Your Committee observes that in spite of the consultations referred to by the Minister of Health when he appeared before your Committee, the numerous points of disagreement in the proposed

Bill are indicative of the fact that wider and more exhaustive consultations are still required in order to achieve consensus and support by the stakeholders.

Further, your Committee notes that the Tripartite Consultation (International Labour Standards) Convention, 1976 (No. 144), to which Zambia is a State Party, and *the Industrial and Labour Relations Act, cap 269* of the Laws of Zambia, that would have allowed employers' and workers' organisations, as well as civil society organisations, to dialogue and to raise concerns and make concrete contributions towards the finalisation of the Bill was not adhered to.

In view of the foregoing, your Committee recommends that the National Health Insurance Bill, N.A.B. No. 22 of 2017, be deferred to allow for further and more inclusive consultations to achieve consensus on the most essential elements of the proposed law.

Conclusion

9.0 Your Committee wishes to pay tribute to all the stakeholders who appeared before it and tendered both oral and written submissions. It also wishes to thank you, Mr Speaker, for affording it an opportunity to scrutinise the Bill. Your Committee also appreciates the services rendered by the Office of the Clerk of the National Assembly and her staff during its deliberations.

We have the honour to be, Sir, your Committee on Health, Community Development and Social Services mandated to consider the National Health Insurance Bill, N.A.B. No. 22 of 2017.

Dr C Kalila, MP
(**Chairperson)**

Ms P Kasune, MP
(**Vice Chairperson)**

Dr C Kambwili, MP
Member

Dr J K Chanda, MP
Member

Mr L N Tembo, MP
Member

Mr J Kabamba, MP
Member

Ms A M Chisangano, MP
Member

Mr L Kintu, MP
Member

Mr M Ndalamei, MP
Member

Mr A Mandumbwa, MP.
Member

February, 2018
LUSAKA

Dr C K Kalila, MP
CHAIRPERSON

APPENDIX I

List of Officials

National Assembly
Ms C Musonda, Principal Clerk of Committees
Mr F Nabulyato, Deputy Principal Clerk of Committees (SC)
Mr S Chiwota, Acting Senior Committee Clerk (SC)
Mr C Chishimba, Committee Clerk
Mrs E K Zgambo Committee Clerk
Mr C Bulaya, Acting Committee Clerk
Mr E Chilongu, Committee Clerk
Ms B Shula, Typist
Mr M Phiri,Intern
Mr M Chikome, Committee Assistant
Mr D Lupiya, Parliamentary Messenger

APPENDIX II

List of Witnesses

Ministry of Justice – Permanent Witnesses
Ms M K Bwalya, Deputy Chief Parliamentary Counsel
Mr M Kumwenda, Parliamentary Counsel

Zambia Medical Association (ZMA)
Dr A Chansa, President
Dr S Chisele, Vice President
Dr N Sukwe, Chair-Public Health
Dr A Lwando, Member

World Health Organisation (WHO)
Dr N Bakyaita, Country Representative
Dr P Songolo, Disease Control and Prevention Specialist
Dr S Kagulula, National Professional Officer

Insurers' Association of Zambia (IAZ)
Ms A Chikonde, Member
Mr K Chituwo, Member
Mr N Mwashika, Member
Mr M Eobe, Member
Mr K Kwenda, Member
Mr M Madina, Member

National HIV/AIDS/STI/TB Council
Mr J Mwale, Director-Policy and Planning

Pensions and Insurance Authority (PIA)
Mr M Libinga, Registrar
Mr T Nkwale, Deputy Registrar
Ms V Mpundu, Manager-Commercial and Inspection
Mr G Kapaso, Manager-Policy
Mr H Chimuka, Manager-Commercial and Inspection

Zambia Federation of Employers (ZFE)
Mr W C Chishimba, President
Mr H Chibanda, Chief Executive Officer
Ms G Samui, Manager-Industrial Relations/Legal Counsel

Zambia Association of Private Hospitals (ZAPH)
Dr M Siwale, President
Dr R Cheelo, Vice President
Dr G Mutambo, Faculty of General Practitioners President

Health Professions Council of Zambia
Mr F Lungu, Legal Counsel
Mr C Mafungo, Chief Accountant
Mr T Musonda, Public Relations Officer
Dr E M Makasa, Assistant Registrar Examinations

Ministry of Community Development and Social Welfare
Mr H Sikazwe, Permanent Secretary
Mr E Mwakalombe, Assistant Director- Planning
Mr K Mumba, Assistant Director- Social Welfare
Ms N Soko, Parliamentary Liaison Officer
Mr A Ndhlovu, Director- Human Resource and Administration
Mr H Nkhoma, Director- Non Governmental Organisations

University of Zambia School of Public Health
Prof. K S Baboo, Acting Dean
Dr H Halwiindi, Assistant Dean
Dr P Hangoma, Head of Department- Health Policy and Management
Dr M Bulawayo, Staff Development Fellow- Health Policy and Management

Ministry of Labour and Social Security
Mr A Dumingu, Director- Social Security
Mr J Banda, Senior Social Security Officer
Mr G Kashinka, Chief Inspector- Factories
Ms E N Sichone, Assistant Labour Commissioner
Mr M Bili, Director-Planning
Ms D Kasemetete, Assistant Director- Human Resource and Administration

Ministry of Health (MoH)
Dr C Chilufya, MP, Minister of Health
Mr K Malama, Permanent Secretary, (Administration)
Dr A Silumesi, Director-Public Health
Mr M Nthele, Director- Clinical Care
Dr Mujajati, Registrar -Health Professions Council Zambia
Dr M Bwaupe, Director -Policy and Planning
Mr E Malikani, Assistant Director
Mr W Mwambazi, Assistant Director-Parliamentary Liaison Officer
Dr Kaluba, Director-Health Care and Finance
Mr M Kamanga, Director -Special Duties
Mr C Chiluba, Medical Superintendent (Adult Hospital)
Ms M Nsakashalo, Assistant Director-Health Promotion

Ministry of finance
Mr A, Acting Director- Economic Management Department
Mr Namadula, Parliamentary Liaison Officer

Mr J Chifulo, Economist
Mr P Musonda, Principal Analyst
Mr L Kasuba, Senior Accountant
Ms C Malikebo, Economist