

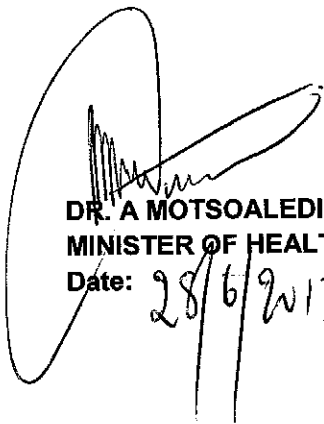
DEPARTMENT OF HEALTH

NATIONAL HEALTH ACT, 2003

NATIONAL HEALTH INSURANCE POLICY

TOWARDS UNIVERSAL HEALTH COVERAGE

I, Dr Aaron Motsoaledi, Minister of Health, in terms of section 85 of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996) and section 3 of the National Health Act, 2003, (Act No. 61 of 2003) after consultation with the National Health Council, determined the Policy in the Schedule.



DR. A MOTSOALEDI, MP
MINISTER OF HEALTH
Date: 28/6/2017



NATIONAL HEALTH INSURANCE FOR SOUTH AFRICA

TOWARDS UNIVERSAL HEALTH COVERAGE

SCHEDULE

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GLOSSARY OF TERMS

- 1. Acute Emergency Care:** Defined as medical care that includes health system components, or care delivery platforms, used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can lead to death or disability without rapid intervention¹. It encompasses a range of clinical health-care functions, including emergency medicine, trauma care, pre-hospital emergency care, acute care surgery, critical care, urgent care and short-term inpatient stabilisation. It is a care that is provided to respond to immediate life-threatening conditions and requires resource redistributions to minimise impending death or disability.
- 2. Allocative Efficiency:** Refers to when resources are allocated so as to maximise the welfare of the community by achieving the right mixture of healthcare programmes to maximise the health of society. It is used to inform resource allocation decisions in this broader context as a global measure of efficiency. It takes into account not only productive efficiency with which healthcare resources are used to produce health outcomes but also the efficiency with which these outcomes are distributed among the community. Such a societal perspective is rooted in welfare economics. In theory, the efficient pattern of resource use is such that any alternative pattern makes at least one person worse off².
- 3. Asylum seeker:** Refers to a person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status³.
- 4. Catastrophic health care expenditure:** Health care expenditure resulting from severe illness/injury that usually requires prolonged hospitalisation and involves high costs for hospitals, doctors and medicines leading to impoverishment or total financial collapse of the household.
- 5. Child mortality:** It includes *peri-natal* and *neonatal mortality*. Peri-natal mortality—is the death of a baby who was born live after 20 weeks of pregnancy or dies within seven completed days after birth measured per 1000 births. It includes stillbirths. Neonatal mortality— refers to the death of a live born baby within 28 days of birth and is measured per 1,000 live births.
- 6. Clinical Governance:** Is described as a system through which healthcare teams are accountable for the quality, safety and experience of patients in the care they delivered. It means specifying the clinical standards delivered by health care staff and showing everyone the measurements made to demonstrate what has been done as initially set out.
- 7. Contracting Unit for Primary Health Care (CUP):** Adapted from Thailand's CUPs where it is described as a unit that can be contracted to provide primary healthcare services such as prevention, promotion, curative, rehabilitative ambulatory, home-based care and community care. Each CUP has its own catchment area and population. It must fulfil certain criteria to be recognised as a CUP, especially in relation to human resources where there must be a doctor, pharmacist, dentist and nurses. The patient has to register with a health facility that is in a CUP catchment area and access services within that area. In rural areas where staff are only available in hospitals, the health centre must associate with the District hospital to constitute a CUP.
- 8. Contracting-out of Providers:** It is based on the theory of combining public finance with private provision and has been used in activities ranging from 'internal market' arrangements in which providers compete for funding from a government payer to purchases of medical and non-medical

inputs by service providers⁴. While contracting-out arrangements for non-medical services have been widely adopted with apparent success, 'market failures' of contracting-out of medical services often arise from inefficient and potential disruption to healthcare delivery. Prerequisites of more extensive contracting models include the development of information systems and human resources⁵.

- 9. Diagnosis Related Groupers (DRGs):** It is a system of patient classification developed to classify patients into groups economically and medically similar, and expected to have comparable hospital resource use and costs. Providers are reimbursed at a fixed rate per discharge based on this classification and has a strong incentive for cost-containment. In a DRG system, quality and monitoring measures are essential to avoid negative effects of premature discharges from hospital, selection of low-cost patients and increase of admissions.
- 10. Emergency Medical Services:** Are defined as any private or state organisation dedicated, staffed and equipped to offer pre-hospital medical treatment and transport of the ill or injured and where appropriate the inter-health establishment referral of patients requiring medical treatment en-route, pre-hospital emergency medical services for events and the medical rescue of patients from medical rescue situations⁶.
- 11. Financial Risk Pooling:** A program created by law where financial resources risks are placed into a pool to provide a safety net for a broad cross section of society with differing medical risks with the purpose of benefiting from cross-subsidisation within the Fund.
- 12. Health Outcomes:** Defined as changes in health status that are usually due to an intervention and can be applied for individuals as well as populations. It requires data about the state of health.
- 13. Health Technology Assessment (HTA):** Defined by the WHO as a systematic evaluation of properties, effects, and/or impacts of health technology. It is a multidisciplinary process to evaluate the social, economic, organizational and ethical issues of a health intervention or health technology. The main purpose of conducting an assessment is to inform a policy decision making.
- 14. International Classification of Diseases (ICD):** Developed by the World Health Organisations as a standard diagnostic tool for epidemiology, health management and clinical purposes. It is used for reimbursement and resource allocation decision making. It is also used to monitor the incidence and prevalence of diseases and other health problems, providing a picture of the general health situation of countries and populations.
- 15. Irregular migrants (or undocumented / illegal migrants):** People who enter a country, usually in search of income-generating activities, without the necessary documents and permits⁷.
- 16. Long-term residency:** Refers to a new visa regime that replaces permanent residency that provides for immigrants to be admitted and sojourn in the Republic for longer periods in respect of prescribed categories, with validity periods and renewals or review in accordance with the purpose of residence. It will not be linked to citizenship⁸.
- 17. Mandatory prepayment:** Refers to paying for health before the person is sick and this is compulsory according to income levels and the funds are pooled for the entire population. This

includes general tax revenue.

- 18. Maternal mortality:** Refers to the number of women who die due to pregnancy related causes. Maternal mortality is measured per 100,000 live births in a given population. It includes any pregnancy related death and is measured from the beginning of pregnancy to six weeks after birth or termination of pregnancy.
- 19. Monopsony:** Refers to a large buyer that controls a large proportion of the market and strategically uses this to drive the prices down.
- 20. Multi-disciplinary Teams:** The concept dates as far back as the 1944 when the Henry Gluckman⁹ recommended that private providers such as GPs, dentists pharmacists, physiotherapists, and others should provide comprehensive primary care services in a team on a 'one-stop shop' basis (i.e. patients should be able to get the full range of primary care services required in one facility or comparable arrangement which does not require the inconvenience or travel costs for the patient).
- 21. Out-of-pocket payment:** Refers to paying cash to a health care provider at the point of care each time a person is sick.
- 22. Passive purchasing:** Refers to a systems that follows a predetermined budget or simply paying bills when presented.
- 23. Prescribed Minimum Benefits(PMB's):** Refer to a set of defined medical benefits that all medical schemes are mandated to cover to ensure that all their members have access to certain minimum health services, irrespective of the particular benefit option that they belong to.
- 24. Primary health care (PHC):** Addresses the main health problems in the community of providing promotive, preventative, curative and rehabilitative services. According to the WHO's 1978 Alma Ata Declaration, "primary health care is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process".
- 25. Priority-setting in health care:** Defined by the WHO as the task of determining the priority to be assigned to a service, a service development or an individual patient at a given point in time in healthcare where health needs are greater than the resources available. Priority-setting also involves allocation of resources to effective healthcare interventions such as high-cost medicines, prevention, or primary care; or even about complex policy interventions such as introducing pay-for-performance schemes for remunerating providers.
- 26. Productive efficiency:** Refers to the maximisation of health outcome through optimal combination of inputs for a given cost. In health care, productive efficiency enables assessment of

the relative value for money of interventions with directly comparable outcomes. It cannot address the impact of reallocating resources at a broader level—for example, from geriatric care to mental illness—because the health outcomes are incommensurate¹⁰.

- 27. Public Administration:** Refers to the aggregate machinery used through managerial, political and legal instruments and processes to fulfil legislative, executive and judicial mandates for the provision of government regulatory and service functions funded through state budgets that uses interaction with other stakeholders in the state, society and external environment in the provision of public services¹¹.
- 28. Quality of Care:** It is the safe, effective, patient-centred, timely, efficient and equitable provision of healthcare services to achieve desired health outcomes. It takes into account patient safety, meaning the prevention of harm to patients and it employs clinical governance processes to assure quality.
- 29. Rationing:** Refers to limiting of service entitlements in one way or another and it is done in all countries, whether rich or poor. Decisions about how to ration benefits influences health system performance in terms of universal health coverage (UHC) goals. All public and private healthcare systems ration patient access to healthcare. The private sector rations access by charging market prices to patients, with demand driven by a person's ability and willingness to pay. Public systems generally ration care on the basis of a patient's need, for example by covering priority cost-effective treatments, and through the use of waiting lists. Patients may also be asked to make a co-payment.
- 30. Refugee:** Refers to a person who, "owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country¹²."
- 31. Risk Adjusted Capitation:** Refers to a fixed payment made to a provider in a defined catchment area per person covered and registered, usually on a monthly basis, regardless of whether they seek care or not.
- 32. Sustainable Development Goals (SDGs):**In 2015 the United Nations adopted Agenda 2030 which is aimed at realising the human rights of all and to achieve gender equality and the empowerment of all women and girls. The Agenda will be achieved through the adoption and implementation of 17 Sustainable Development Goals (SDG's) with 169 targets on each goal to be achieved over the next 15 years. Goal 3 of the SDGs is aimed at ensuring healthy lives and promoting wellbeing for all at all ages.
- 33. Strategic Purchasing:** The WHO describes strategic purchasing as active, evidence-based engagement in defining the service-mix and volume, and selecting the provider-mix in order to maximise societal objectives. Strategic purchasing requires information on a range of issues such as prioritisation, cost-effectiveness, staff and facilities, price, quality and projections on available resources. It is aimed at improving the performance of the health system and make it progress towards universal health coverage. It is undertaken by an active purchaser that pools funds on behalf of a population and purchases health services from accredited and contracted providers.

- 34. Structural imbalances:** Refers to the misalignment between resources and need, which undermines access to health services. In South Africa, this can be equated to costly private health services for the privileged few and schemes for financing care that excludes the poor. It also includes grossly inadequate numbers of staff or the wrong mix of staff, infrastructure or organisation.
- 35. Technical Efficiency:** Refers to the physical relation between resources (capital and labour) and health outcome. It addresses the issue of using given resources to maximum advantage. A technically efficient position is achieved when the maximum possible improvement in outcome is obtained from a set of resource inputs. An intervention is technically inefficient if the same (or greater) outcome could be produced with less of one type of input¹³.
- 36. Temporary residence visa:** Refers to any of the visas issued to a foreign national to enter and temporarily reside in the country. These include transit, visitors, work and business visa¹⁴.
- 37. Treatment Guidelines:** Refers to statements that include recommendations intended to optimize patient care. Such guidelines are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.
- 38. Universal Health Coverage (UHC):**The World Health Organisation (WHO) defines UHC as ensuring that all people can use promotive, preventative, curative, rehabilitative and palliative services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC embodies three related objectives: (1) equity in access to health services – those who need the services should get them, not only those who can pay for them; (2) that the quality of health services is good enough to improve the health of those receiving health services; and (3) financial risk protection-ensuring that the cost of using care does not put the people at risk of financial hardship. UHC brings the hope of better health and protection from poverty for hundreds of millions of people- especially those in the most vulnerable situations.
- 39. Voluntary prepayment:** Refers to paying for health before the person is sick but this is not compulsory and the funds are pooled for only those who contribute. Medical Aids in South Africa is an example of voluntary prepayment.
- 40. Vulnerable groups:** Refers to population groups that include women, children, older persons and people with disabilities as described in Chapter 1, Section 4 (2) (d) of the National Health Act, 61 of 2003) and the various subsequent sections of the NHA.

EXECUTIVE SUMMARY

1. This White Paper lays the foundation for moving South Africa towards universal health coverage (UHC) through the implementation of National Health Insurance (NHI) and establishment of a unified health system. The move towards Universal Health Coverage (UHC) through implementation of NHI is derived from the following: The Reconstruction and Development Programme (RDP); the Constitutional mandate based on the Section 27 of the Constitution; the 1997 White Paper for the Transformation of the Health System; and Vision 2030 of the National Development Plan Vision 2030.
2. South Africa aims to make significant strides in moving towards UHC through the implementation of NHI based on the principle of the Constitutional right of citizens to have access to quality healthcare services that are delivered equitably, affordably, efficiently, effectively and appropriately based on social solidarity, progressive universalism, equity and health as a public good and a social investment.
3. Moving towards UHC is also guided by several international frameworks of the United Nations multilateral system such as Sustainable Development Goals (SDGs) 2030 and in particular SDG 3 as well as the World Health Organisation (WHO) frameworks on moving towards UHC with health equity and the six pillars of the WHO's health systems strengthening framework. Achieving UHC will contribute significantly towards realising the vision of a long and healthy life for South Africans.
4. The White Paper on NHI recognises that good health is an essential value of the social and economic life of humans and is an indispensable prerequisite for poverty reduction, sustained economic growth and socio-economic development. To that effect, the critical role played by Social Determinants of Health (SDH) in contributing towards improved health outcomes and a long and healthy life for all South Africans is recognised. This requires a multi-sectoral approach of addressing SDHs. NHI aims to transform delivery of healthcare services by focussing on health promotion, disease prevention and empowered communities. A multi-sectoral National Health Commission will be established to address non-communicable diseases.
5. National Health Insurance will transform the financing of healthcare in pursuit of financial risk protection, by eliminating fragmentation, ensuring technical and allocative efficiencies in how funds are collected, pooled and used to purchase services, thus creating a unified health system that will move closer to the goal of UHC and SDG 2030.
6. National Health Insurance will extend population coverage, improve the quality and quantity of services that the population will be entitled to, as well as provide financial risk protection to individuals and households whilst reducing the direct costs that the population will be exposed to when accessing healthcare. This will protect individuals and households from out-of-pocket expenses and financial catastrophe related to healthcare.
7. Transforming the health care financing system also requires changing how revenue is collected to fund healthcare services and, even more importantly, how generated funds are pooled and how quality services are purchased. The key focus of the NHI reforms is therefore to create a single, publicly owned and administered strategic purchaser that will actively purchase healthcare services on behalf of the entire population from suitably accredited public and private providers.

8. To successfully implement NHI requires that an NHI Fund must be established through legislation. The sources of revenue for the Fund will be through a combination of pre-payment taxes derived from general taxes and complemented by mandatory payroll and surcharge taxes. The Fund it will pool funds and strategically purchase services on behalf of the population to achieve income and risk cross-subsidisation whilst improving the efficiency in purchasing of comprehensive personal health services.
9. Comprehensive healthcare services that are delivered based on scientific evidence will require a strengthened and reorganised health care system. The health care system will be reorganised in the areas of strengthening primary health care (PHC) including PHC re-engineering, hospital services, and EMS, improving leadership and governance in the health system through reforms to the management and governance of clinics, districts and hospitals. The Office of Health Standards Compliance (OHSC) will oversee certification of health care providers and health establishments to ensure they meet quality standards. The provision of healthcare services will be through an integrated system involving accredited and contracted public and private providers.
10. Strategic purchasing requires that health care providers are accredited based on stipulated criteria and in contracting these providers, alternative reimbursement strategies such as capitation for PHC services and DRGs for in-hospital services are applied. Strategic purchasing requires robust information systems to register and monitor utilisation, and mitigate corruption and fraud. Health Technology assessment and procurement systems must ensure that access is improved whilst also delivering healthcare services affordably, based on scientific-evidence and cost-effectively. It is important for the sustainability of NHI that both supply and demand side measures are put in place. These may include interventions such as gate-keeping, implementation of clinical guidelines and protocols and a strong referral mechanism.
11. The population will be registered and issued with a unique identifier linked to the Department of Home Affairs identification system to enable users to access health care services. Vulnerable population groups such children, women, the elderly and people with disability will be prioritised for registration and delivery of services. The population will access services closest to where they live and the healthcare services will be portable.
12. Equally important, is that NHI requires the establishment of strong governance mechanisms and improved accountability for the use of allocated funds. The introduction of NHI will transform the current intergovernmental fiscal arrangements and relations as well as the current medical scheme environment to address technical and allocative efficiency. Once NHI is fully implemented, medical schemes will transform to providing complimentary cover. Other Social Security Funds such as the Road Accident Fund, Compensation Commissioner for Occupational Diseases in Mines and Works Act (ODMWA) and the Compensation for Occupational Injuries and Diseases Fund will transform so that funding for personal healthcare will be consolidated into the NHI Fund to prevent double-dipping.
13. Implementation of NHI will therefore require amendments to related existing legislation and enactment of new laws to ensure that there is not only legislative alignment but also policy consistency across government departments and spheres of government.

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

1. National Health Insurance (NHI) is a health care financing system that is designed to pool funds to actively purchase and provide access to quality, affordable personal healthcare services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to move South Africa towards Universal Health Coverage (UHC) by ensuring that the population has access to quality health services and that it does not result in financial hardships for individuals and their families.
2. NHI represents a substantial policy shift that will necessitate massive reorganisation of the current health care system, to address structural changes that exist in both the public and private sectors. It reflects the kind of society we wish to live in: one based on the values of justice, fairness and social solidarity. Implementation of NHI is consistent with the global vision that health care should be a social investment.
3. NHI derives its mandate from Section 27 of the Bill of Rights of the Constitution of the Republic of South Africa in which a commitment is made for the State to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health care.
4. The implementation is underpinned by Vision 2030 of the National Development Plan (NDP), which envisions that by 2030, everyone must have access to an equal standard of care, regardless of their income, and that a common Fund should enable equitable access to health care, regardless of what people can afford or how frequently they need to use a service.
5. NHI will cover services that are delivered on a people-centred integrated healthcare service platform to ensure a more responsive and accountable health system that takes into account socio-cultural and socio-economic factors whilst prioritising vulnerable communities^a. Such a people-centred integrated healthcare service platform should also improve user satisfaction, lead to a better quality of life of the citizens and improved health outcomes across all socioeconomic groups. This will contribute towards improved human capital, labour productivity, economic growth, social stability and social cohesion. Therefore, NHI will contribute towards reduction of poverty and inequalities inherited from the past.
6. Universal population coverage under NHI will ensure that all South Africans have access to comprehensive quality healthcare services. This means that people will be able to access healthcare services closest to where they live. The healthcare services will be accessed at appropriate levels of care and will be delivered through certified and accredited public and private providers.
7. The population will be registered at designated health facilities using the unique identifier linked to the Department of Home Affairs identification system. Vulnerable groups will be prioritised for registration.

^a Vulnerable Communities is contained in Chapter 1, Section 4 (2) (d) of the National Health Act

8. Preparatory activities on NHI were aimed at strengthening of the health system and service delivery platform. This included implementation of re-engineering of Primary Health Care (PHC) and the Operation Phakisa Ideal Clinic Realisation Programme to improve performance and quality of health services in the PHC facilities. Other preparatory activities undertaken include infrastructure improvement as well as improving planning for human resources for health.
9. The Office of Health Standards Compliance (OHSC) was established for the inspection and certification of health facilities to ensure compliance with the norms and standards regulations.
10. Central hospitals will be transformed into national assets operating as training platforms, research hubs and centres of excellence locally, regionally and internationally. The central hospitals will be semi-autonomous to improve their management and governance and to position them as providers of choice for highly specialised and affordable services for the whole population.
11. The NHI Fund will be created to actively and progressively purchase personal healthcare services on behalf the entire population. This will be realised through the establishment of a fully functional administrative structure with its governance function. The Fund will be strategic purchaser with accreditation and risk mitigation systems, health technology assessment as well as systems for monitoring and evaluation. Additional resources will be mobilised for revenue for the NHI Fund through the introduction of mandatory prepayment in the latter phases of implementation.
12. Health facilities that are compliant with certification requirement of the OHSC and meet set criteria will be accredited by the NHI Fund as part of strategic purchasing. The Fund will contract directly with accredited public hospitals (including regional, tertiary, central and specialised hospitals). In the latter phases of implementation, NHI will also contract with certified and accredited private providers at higher levels of care based on need.
13. Emergency Medical Services (EMS) and National Laboratory Health Services (NHLS) will be contracted for personal health services by the Fund in the latter stages of implementation. The coverage for EMS will be such that every area of the country is covered and response time between rural and urban are optimised for effective referrals.

1.2 Background and Historical Context of Health Care Financing Reforms

14. South Africa has endeavoured to implement health financing reforms over the past 89 years through: (a) the 1928 Commission of Old Age Pension and NHI; (b) the 1941 Collie's Committee of Inquiry into NHI; (c) the 1943 African Claims that proposed equal treatment in the scheme of Social Security; (d) the Dr Henry Gluckman National Health Services Commission of 1943 to 1944 proposal for NHI¹⁵; (e) The Freedom Charter as adopted by the Congress of the People in 1955; (f) the 1994 Ministerial Committee on Health Care Financing; (g) the 1995 Ministerial Committee of Inquiry into NHI (Broomberg and Shisana Report); (h) the 1997 Social Health Insurance Working Group; (i) The 2002 Committee of Inquiry into a Comprehensive Social Security System (the Taylor Committee); (j) the Ministerial Task Team on Social Health Insurance; and (k) the 2009-2014 Ministerial Advisory Committee on NHI.
15. The Charter on Health under the 1943 African Claims in South Africa had advocated for major transformation of the health system under the British colonial rule.

16. Another key milestone in the evolution of the transformation of the health system in South Africa was underpinned by the Reconstruction and Development Programme (RDP)¹⁶ in 1994, which provided a framework through which the health of all South Africans would reflect the wealth of the country.
17. Sections 27 as contained in The Bill of Rights of the Constitution, 1996 articulates the constitutional obligation on the State to ensure that everyone has access to healthcare services:

"Everyone has the right to have access to health care services including reproductive health care.....

The State must take reasonable legislative and other measures within its available resources, to achieve the progressive realization of each of these rights.

No one shall be refused emergency medical treatment".
18. The imperatives of the RDP and the Constitutional obligation to 'take reasonable legislative measures' resulted in the 1997 White Paper for the Transformation of the Health System in South Africa provided a framework for the country to develop health care financing policies that promote equity, accessibility and utilisation of health services, to ensure greater equity between people living in rural and urban areas, and between people served by the public and private health sectors within a single, unified national health system.
19. The National Health Act 61 of 2003 and amendments thereof, as well as the development of regulations to effect the National Health Act (NHA) have not gone far enough to establish a single, unified national health system and to develop health care financing policies that promote equity, accessibility and utilisation of health services and to ensure greater equity between people living in rural and urban areas, and between people served by the public and private health sectors.
20. The NDP proposes that an NHI system needs to be implemented in phases, complemented by a reduction in the relative cost of private medical care, improved quality and supported by better human capacity and systems in the health sector. If the above measures and other interventions are implemented, the NDP envisages that by 2030:

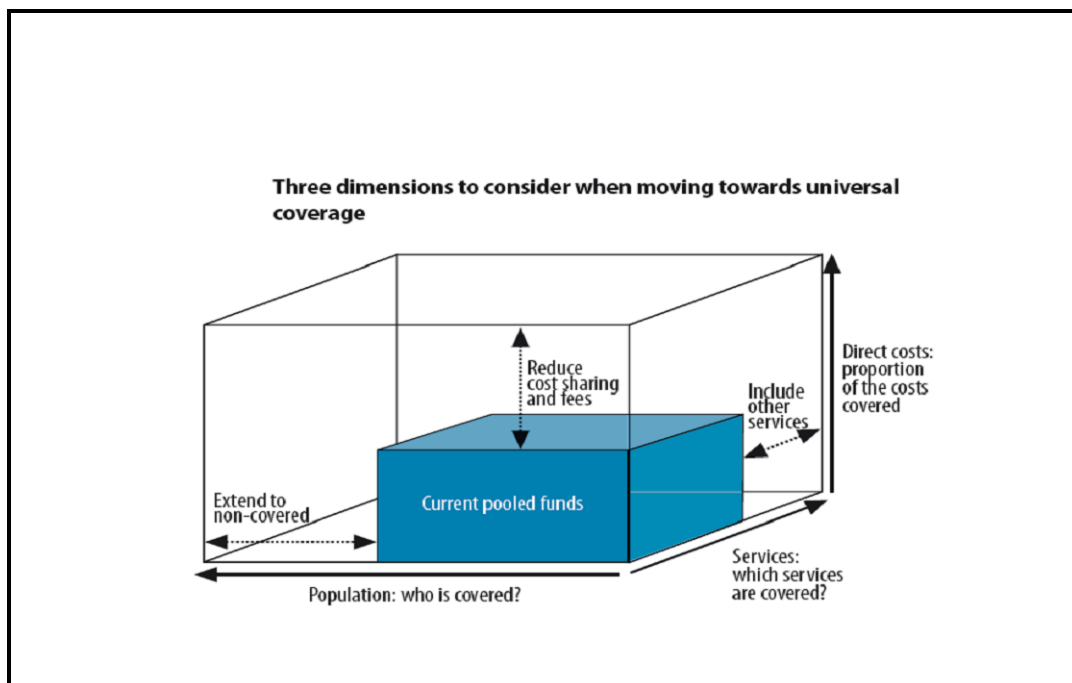
"South Africa will have a life expectancy of at least 70 years for men and women; the generation of under-20 should be largely free of HIV; the quadruple burden of disease will have been radically reduced compared to the two previous decades, with an infant mortality rate of less than 20 deaths per 1000 live births, and the under 5 mortality rate of less than 30 per 1000 live births".
21. Furthermore, the NDP envisions that by 2030 there should have been a significant shift in equity, efficiency, effectiveness and quality of healthcare provision and that universal coverage is available. The risks posed by the social determinants of health and adverse ecological factors should also have been reduced significantly.
22. The 89 year history outlined highlights that many efforts undertaken to establish an equitable, accessible unified national health system for the entire population, that would move South Africa closer to the goal of universal health coverage (UHC) based on an equitable health financing mechanism, have been unattainable.
23. It is thus imperative that South Africa implements NHI in line with the values of the Constitution and the provisions of the NDP, to achieve the goal of an integrated health care system that serves

the needs of all, regardless of race, socio-economic status and ability to pay for services.

1.3 International Context

24. South Africa is signatory to many international treaties and instruments, including the Universal Declaration of Human Rights^b and the International Covenant on Economic, Social and Cultural Rights (ICESCR)^c, in which the right of each individual to health and well being is enshrined.
25. More recently, the United Nations at its Seventieth General Assembly in September 2015 adopted seventeen (17) Sustainable Development Goals (SDG's) with 169 targets to be achieved over the next 15 years¹⁷. Goal 3 of the SDGs is aimed at ensuring healthy lives and promoting wellbeing for all at all ages. Target 3.8 on achieving UHC underpins all the other 9 targets of Goal 3. Goal 3.8 is specifically aimed at ensuring that countries achieve universal health coverage (UHC) through financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
26. Universal Health Coverage is an enabler for inclusive social protection systems¹⁸ and inclusive human development. It is about equity and is fundamental to providing social protection for health. The poorest populations usually face the highest health risks and need more health services. A UHC system aimed at providing healthcare coverage to all will ensure that all groups with a need in the population have access to these needed services¹⁹ without being exposed to financial hardships as shown in **Figure 1**:

Figure 1: The three dimensions of moving towards universal coverage



Source: WHO Report (2010)

^b Adopted by the United Nations in 1948

^c Adopted and opened for signature, ratification and accession by the General Assembly of the UN in 1966 and put into force in Jan 1976

27. Health financing within a UHC system needs to be specifically designed to provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; and to ensure that the use of these services does not expose the user to financial hardship. A key element of financing for UHC is that the health costs for the poor and vulnerable are shared by the whole of society. Furthermore, the health care financing system should aim to spread the financial risks of illness across a wide population, by collecting large pools of prepaid funds that people can draw on to cover their health care costs at times of need, regardless of their ability to pay.
28. South Africa's considered policy approach towards achieving UHC will be through the implementation of NHI. The conceptualisation and design of NHI will take into account the country's experiences and global lessons learnt in the development of systems for UHC.

CHAPTER 2: DEFINITION, FEATURES AND PRINCIPLES OF NHI

2.1 Definition

29. National Health Insurance is a health financing system that is designed to pool funds and actively purchases services with these funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. NHI will be implemented through the creation of a single fund that is publicly financed and publicly administered. The health services covered by NHI will be provided free at the point of care. NHI will provide a mechanism for improving cross-subsidisation in the overall health system. NHI benefits will be in line with an individual's need for health care. Implementation of NHI is based on the need to address structural imbalances in the health system and to reduce the burden of disease.

2.2 Features of NHI

30. NHI will have the following features:

- a) **Progressive universalism:** All South Africans will have access to needed promotive, preventive, curative, rehabilitative and palliative health services that are of sufficient quality and are affordable, without exposing them to financial hardships. The right to access quality health services will be based on need and not socioeconomic status. NHI will seek to protect the poor and vulnerable populations to ensure that they gain as much as those who are better off at every step of implementation, in pursuit of moving towards UHC.
- b) **Mandatory prepayment of health care:** NHI will be financed through mandatory prepayment which is distinct from other modes of payment such as voluntary prepayment and out-of-pocket payments.
- c) **Comprehensive Services:** NHI will cover a comprehensive set of health services that will provide a continuum of care from community outreach, health promotion and prevention to other types and levels of care.
- d) **Financial risk protection:** NHI will ensure that individuals and households do not suffer financial hardship and/or are not deterred from accessing and utilising needed health services. It involves eliminating various forms of direct payments such as user charges, co-payments and other direct out-of-pocket payments.
- e) **Single Fund:** NHI will integrate all sources of funding into a unified health financing pool that caters for the needs of the population.
- f) **Strategic purchaser:** NHI will purchase services for all; and will be an entity that actively utilises its power as a single purchaser to proactively identify population health needs and determine the most appropriate, efficient and effective mechanisms for drawing on existing health care service providers²⁰.
- g) **Single-payer:** NHI will be structured as an entity that pays for all health care costs on behalf of the population. A single-payer contracts for healthcare services from providers. Single-payer

refers to the funding mechanism and not the type of provider.

- h) **Publicly Administered:** NHI will be established as a single fund that is publicly administered and publicly owned. It will be responsible for pooling and purchasing of health services through appropriate structures that are responsible for contracting accredited providers on behalf of the entire population. The aim is to introduce an administratively efficient and sustainable funding mechanism that achieves the best value-for-money with respect to health budget allocations.

2.3 Principles

31. NHI will be based on the following principles:

i. Right to access health care

32. NHI will ensure access to health care as enshrined in the Bill of Rights, Section 27 of the Constitution

ii. Social solidarity

33. NHI will provide financial risk pooling to enable cross-subsidisation between the young and old, rich and poor as well as the healthy and the sick.

iii. Equity

34. NHI will ensure a fair and just health care system for all; those with the greatest health needs will be provided with timely access to health services.

iv. Health care as a Public Good

35. Health care shall not be treated like any other commodity of trade, but as a social investment.

v. Affordability

36. Health services will be procured at reasonable cost taking into account the need for sustainability within the context of the country's resources.

vi. Efficiency

37. Health care resources will be allocated and utilised in a manner that optimizes value for money that combines allocative and productive efficiency²¹ by maximising health outcome for a given cost whilst using the given resources to maximum advantage, and by maximising the welfare of the community by achieving the right mixture of healthcare programmes for the entire population.

vii. Effectiveness

38. The healthcare interventions covered under NHI will result in desired and expected outcomes in every day settings. NHI will ensure that the health system meets acceptable standards of quality and achieves positive health outcomes.

viii. Appropriateness

39. Health care services will be delivered at appropriate levels of care through innovative service delivery models and will be tailored to local needs.

CHAPTER 3: PROBLEM STATEMENT

3.1 Social Determinants of Health (SDH)

40. Health is influenced by the environment in which people are born, grow up, live and work, and societal risk conditions are also more important than individual ones in the spread of a disease. This includes exposure to polluted environments, inadequate housing and poor sanitation. Health is shaped by multiple epidemics, as well as powerful historical and social forces, such as vast income inequalities, unemployment, poverty, racial and gender discrimination, the migrant labour system, the destruction of family life and extreme violence.
41. South Africa's health system is also influenced by these societal risk conditions. It is characterized by the quadruple burden of disease disproportionately affecting lower socio-economic groups compounded by lower health service utilisation rates. Lower socio-economic groups also derive fewer benefits from using health care (both in the public and private sectors), than higher socio-economic groups²².
42. Vision 2030 of the National Development Plan (NDP) recommends that, based on the WHO Commission on the SDH, South Africa must enhance its efforts in the following three areas namely: (a) Improve the conditions of daily life; (b) Tackle the inequitable distribution of power, money, and resources; and (c) Measure the problem, evaluate actions, expand the knowledge base, develop a trained workforce in the social determinants of health and raise public awareness.

3.2 Burden of Disease

43. The South African population is relatively young although trends in the past few years have shown an increase in life expectancy with the steadily increasing numbers of the older age groups. Despite life expectancy showing an increasing trend in the past few years, the average life expectancy is still low at 63.1 years for females and 59.1 years for males²³.
44. The country is facing an increasing burden of diseases that negatively affects the health of the population and has negatively impacted on the poorest groups of the population. Epidemiologically, South Africa is confronted with a quadruple burden of disease because of HIV and AIDS and Tuberculosis; high maternal neonatal and child morbidity and mortality; rising disease burden of non-communicable disease; and high levels of violence and trauma. According to census figures from StatsSA, TB is the biggest contributor to years of life lost followed by pneumonia and influenza; intestinal infectious diseases; other forms of heart diseases; cerebrovascular disease; diabetes mellitus; HIV /AIDS; hypertensive disease; chronic lower respiratory tract disease; and lastly other viral diseases²⁴.
45. The combined impact of these epidemics has influenced the doubling of the death rate between 1997 and 2006 in our country. HIV, AIDS and TB have contributed the most in this increased death rate. In 2012, an estimated 6.4 million people living with HIV resided in South Africa. The estimated number of new HIV infections in South Africa was 1.08% in 2012. According to the UNAIDS estimates, the national HIV prevalence among the general adult population aged 15 – 49 years old has remained stable at around 17.3% since 2005 and the estimated number of people living with HIV and AIDS is 6.4 million in 2012²⁵. Women have borne the brunt of burden of HIV

and AIDS epidemic disproportionately in society.

46. Women remain at higher risk of HIV and are 1.6 times more likely than males to be HIV positive²⁶. In 1990, less than 1% of pregnant women accessing public health services were found to be infected with HIV. By 2004, this figure had increased to 20% and currently the overall national HIV prevalence estimates among 15-49 year pregnant women have increased significantly from the 1990 figure and remain hovering at 29.5% in 2011 and 2012²⁷. The total number of women between the ages of 15-49 years living with HIV has also increased from an estimated 16.7% in 2002 to 18.5% in 2014²⁸, translating to approximately one-fifth of South African women in their reproductive ages being HIV positive.
47. With respect to maternal, new-born and child health, the burden of disease is 2-3 times greater than the average of comparable countries and about 1% of the global burden²⁹. Although the Under-5 (U5MR) and Infant (IMR) mortality rates have decreased to 56 and 40 per 1000 live births respectively, neonatal mortality rates have remained stable at 14 deaths per 1000 live births³⁰.
48. In addition to the aforementioned causes of high burden of diseases, Non-Communicable Diseases (NCDs) are also a key contributor to the mortality and morbidity. NCD's are not contagious and result from conditions such as high blood pressure, diabetes mellitus, cardiovascular diseases, obesity, cancer, respiratory diseases such as asthma, and mental health problems. They are lifestyle diseases driven by four key risk factors that have been identified as the main causative factors and include: tobacco use, alcohol abuse including use of narcoleptic agents, poor diet and eating habits and lack of physical activity. The lack of focused health promotion and prevention programmes and interventions, poor health seeking behaviour and the late detection of diseases are some of the major factors contributing to the high burden of NCDs. Low levels of physical activity affect 45.2% of women and 29.9% of males aggravating the prevalence of NCD's.
49. Despite some efforts to improve mental health services over the past years, mental ill-health continues to pose a huge burden on individuals, society and the economy straddling both communicable and non-communicable disease burden.
50. Violence and injury also contribute significantly to the burden of disease. South Africa has an injury rate of 158 per 100 000. The most recent South African Burden of Disease data indicates that road traffic accidents and interpersonal violence are the leading causes of Years of Life Lost (YLL).
51. There are 17 million workers in South Africa, 13 million of which are in the formal economy and four million in the informal economy. Even though they are the backbone of the economy, their health or occupational health has been inadequate with a lack of human resources and a poor system of delivery of health services in both the public and private sectors. The burden of occupational disease and injury has left many workers, families and affected communities in dire straits and has often shifted the health and social consequences of workplace injuries and diseases to the public health and government social security systems. The system of dealing with occupational health in both public and private healthcare is at best fragmented, uncoordinated and at worst even non-existent for certain sections of workers in some parts of the country.

3.3 Structural problems in the health system

52. In addition to the high burden of disease, there are other challenges facing the health system. These are to a large extent as a consequence of the inability of the health system to effectively implement the six health systems building blocks of: (a) Leadership and governance; (b) Health care financing; (c) Health workforce; (d) Medical products and technologies; (e) Information and research; and (f) Service delivery.

3.3.1 Leadership and Governance

53. Leadership and governance challenges remain prevalent in the various levels of the public sector. Despite efforts by government to inculcate a culture of good leadership and governance, the knowledge and skills amongst managers is still very inadequate. Furthermore, weak accountability mechanisms are linked to inadequate, disparate measures and standards for managing performance (good or poor). Poor accountability is also exacerbated by a semi-federal public sector. The private sector also has weak systems of governance and leadership as it remains poorly regulated and less accountable in terms of quality and costs. Poor clinical governance in the private sector is demonstrated by the caesarean section rate where 62% of women delivering in the private sector had C-sections, and increased delivery-related health costs in the private sector by at least 10-fold, compared with 18% in the public sector³¹.

3.3.2 Service delivery challenges

54. Despite major strides being made since the dawn of democracy in improving access to health care services, the health system is still facing many challenges with regards to poor quality of health services and hospi-centrism. Both the public and private health sectors are encumbered with these challenges whilst the public sector is more predisposed to challenges of quality.

a) Quality of Healthcare Services

55. Quality of healthcare has been associated with dissatisfaction amongst the users of health services with respect to acceptability of the healthcare services and patient experience³². Public sector facilities are regularly assessed against core quality standards. This has revealed that there are quality problems in the areas of staff attitudes, waiting times, cleanliness, drug stock outs, infection control, and safety and security of staff and patients. Although efforts have been made to address these challenges, they continue to persist in the public sector.
56. Quality challenges are aggravated by high levels of inequity due to health expenditure and other resource misalignment between the public and private sectors relative to the populations they serve, and an under-resourced and overburdened public health system. In the private sector, it has been found that the majority of private general practitioners were not aware of the recommended medications, doses, or durations for treatment of sexually transmitted infection where a private–public partnership to educate providers about national guidelines for sexually transmitted disease prevention and control had no effect on practice³³.
57. Furthermore, the lack of a coherent unified health information management system, fragmentation and poor leadership at the different levels of care has exacerbated the situation and resulted in suboptimal conditions of delivering quality health services. The significant increases in utilisation

due to the high burden of disease, and associated increased patient loads have further compromised the quality of care. The public's discontent with the quality of services has escalated medico-legal claims in both the public and private sectors, putting enormous strain on the fiscus and healthcare professional. This challenge needs to be adequately addressed within a unified health system, but more so in the public sector.

3.3.3 Health workforce challenges

58. The inequities and poor quality in the health system are exacerbated by a skewed distribution of key health professionals between the public and private sectors. The main contributor to this inequity is the creation of a two-tier healthcare system where the affluent pool their healthcare funds separately from the poor. The shortage of key health professionals is being experienced in the face of the growth of the population that is dependent on public healthcare services, and the increasing burden of disease among the population, and unpredictable inward migration patterns. This has placed an extraordinary strain on public sector health services, and on the staff who work in public sector facilities and has contributed to the very poor health outcomes of South Africans, particularly for the lowest income populations and households.
59. In addition to the mismatch between the public and private health sectors relative to the size of the population served, there is a mismatch between urban and rural areas; as well as inefficiencies in the use of available human resources³⁴. Most of the providers work in urban areas while there is a serious shortage in the rural areas. This disproportionate distribution is also prevalent across the provinces, with the Western Cape and Gauteng having higher doctor-to-population ratios when compared with the rest of the provinces. The mal-distribution pattern of health professionals between rural and urban areas, and the public and private sectors has contributed to transforming health into a commodity rather than a social investment or a human right.³⁵
60. The changing population and health profiles in South Africa occur within financial resource constraints and in an environment in which there is mal-distribution of the health workforce³⁶. The impact of the decline in real per capita spending is possibly best illustrated through looking at staffing levels in the public health sector.
61. Other factors that have contributed to human resources shortages and attrition especially relates to job design, performance management systems, remuneration policies, employment relationships, in hospitable physical work environment, shortages of equipment and other tools of trade, workplace cultures and human resource practices, facility workforce planning and career-pathing. These factors have affected the motivation and the ability of the healthcare sector to recruit and retain the health workforce. The education and training of health professionals has lagged behind and the public sector continues to experience insufficient planning and budgeting for clinical posts, resulting in high attrition rates.

3.3.4 Availability of Medical Products and Technologies

62. The health sector is facing increasing costs of medical products and technologies. The main cost drivers in the public sector (other than human resources) are: pharmaceuticals; laboratory services; blood and blood products; equipment; and surgical consumables. These cost drivers are wasteful and adversely impact on efficient and effective service provision. Inefficiencies in

pharmaceutical supply chain, annual inventory procurement costs, medicine stock-outs, trade-deficits on unaccounted stock, and expired medication are common. Lack of human and electronic inventory management systems and replenishment cycles, data and statistical acquisition³⁷, as well as poor monitoring of hospital support services such as, security, laundry and catering services contribute to these high costs. Whilst efforts are in place to streamline procurement and supply chain management through interventions such as non-negotiables, the fiscal federal public system has not succeeded in optimising costs and availability of medical products and technologies.

63. One of the other key cost drivers in the public health sector is the costs of laboratory services. The National Health Laboratory Services (NHLS) has been established as an entity of the National Department of Health and is the main provider of laboratory services for the public sector. It is mandated by its founding legislation and regulations to provide pathology services, teaching and training, and undertaking research. The NHLS receives its funds through fees levied on provinces for laboratory services. The public sector is required to pay for pathology services through a fee-for-service mechanism. Furthermore, the NHLS is required to carry the costs of teaching, training and undertaking research. NHLS has faced several challenges in the recent past as a result of the billing systems used, unnecessary laboratory test requests, and financing training of health professionals through laboratory test tariffs.

3.3.5 Health care financing challenges

3.3.5.1 Costly private health sector

64. Over the years the costs in the private health sector have been increasing. Legislation and other tools have not yet gone far enough to regulate the private health care sector. Consequently, medical scheme members are not well protected from the escalating costs of health care.

a) Escalating costs of medical schemes

65. Private-sector medical scheme coverage has always been unaffordable for the majority of South Africans. This situation has worsened over time as a result of annual contribution rate increases since the 1980s that have exceeded inflation. These increases have been driven in part by the nature of purchasing arrangements between medical schemes and provider groups, non-healthcare related costs and relative lack of economies of scale for many schemes.
66. The main cost drivers of medical schemes expenditure have been private hospitals, medical specialists, medicines, medical scheme administrators and brokers fees. There has also been an imbalance in the relationship between purchasers (medical schemes) and providers. This is particularly the case with private hospitals, where three large hospital groups own in excess of 80% of all private hospital beds in the country. Private hospitals fees in South Africa are expensive relative to the country's wealth and they continuously increase above the rate of inflation. In addition, the private hospitals are the least affordable when compared to OECD countries even for individuals earning higher levels of income³⁸.

b) Benefit Design of Medical Schemes

67. Benefits covered by medical schemes are usually not comprehensive, resulting in medical scheme members having to make substantial out-of-pocket payments, such as where the medical scheme only covers part of the cost of services, where a service is not covered at all by the medical scheme (e.g. outside the scheme's benefit package) and/or where scheme benefits have run out. Many members of schemes face significant problems with regard to selecting the most appropriate benefit option to match their individual and family's health needs. The consequence of this is that inevitably many members and their families run out of the needed financial risk protection and find themselves either having to pay out-of-pocket for their healthcare or simply reverting to the State to meet their health needs.

c) Prescribed Minimum Benefits

68. The current environment of Prescribed Minimum Benefits (PMBs) has contributed to rising costs in the private health sector. PMBs are aimed at providing medical scheme members with continuous care to improve their health and well-being and to promote access to needed healthcare services. The cost of PMBs is mainly driven by amongst others:
- a) The beneficiary profile in which there are low levels of cross-subsidisation between young and old beneficiaries, the healthy and the sick;
 - b) The cost of treatment, which is strongly linked to contracting between schemes and providers in an environment where there is no price regulation mechanism in place;
 - c) The increased prevalence of chronic conditions where treatment is provider driven and where it is mandatory for schemes to reimburse; and
 - d) Lack of healthcare technology assessment resulting in uncontrolled introduction of new healthcare technology. This leads to cost increases without an improvement in the quality of care.

d) Fee-for-Service (FFS) Environment

69. There is a range of reasons for the large increases in medical scheme expenditure over the more recent past, including the dominant fee-for-service reimbursement mechanism which encourages providers to supply more services than may strictly be necessary from a clinical perspective³⁹. Fee-for-service (FFS) is a method of provider payment where there is a separate payment to a health care provider for each medical service rendered to a patient. Medical schemes reimburse for all services regardless of their impact on patient health. In a FFS environment, there is little countervailing pressure to discourage providers from delivering unnecessary services. This has been identified as one of the contributors to escalating costs in the health care system.
70. The threat of medico-legal action has also propelled the over-servicing of patients to unprecedented levels. FFS is also a barrier to integrated care and traditional FFS payment model promotes fragmentation and higher spending.

3.3.5.2 Inequitable Health Care Financing

71. The South African health system is two tiered and fragmented. Almost 50% of Total Health Expenditure (THE) is spent on 16% of the population covered by medical schemes whilst the

other 50% is spent on 84 % of the population in the public sector⁴⁰. The population that accesses services in the public sector is usually poor, rural and encumbered with a high burden of disease. Consequently, financial resource allocation and health care expenditure is not matching with the needs of the majority of the population. Funding for public health services in South Africa is currently at 4.1% of GDP, compared to 6% as the average for middle income countries.

72. Inequity in health care financing and fragmentation are worsened by the health financing system and the system of intergovernmental functions and fiscal relations. The South African health system is underpinned by a financing system that is based on the Intergovernmental Fiscal Relations (IGFR) system. The IGFR system is faced with an institutionalised and structural form of fiscal imbalance as a result of vertical fiscal federalism and other factors that impact on intergovernmental fiscal relations. The main problem that underpins IGFR challenges relates to striking a balance between the need to provide Constitutionally Mandated Basic Services (CMBS) within macroeconomic constraints that limit the available resources and a fiscal federal structure that has its own defined priorities⁴¹. Furthermore, combining distributive justice and the raising of adequate levels of revenues for redistributive purposes is a function of sustained investment, growth and development in the economy.

3.3.5.3 Fragmentation in funding pools

73. A major characteristic of the South African health system is the fragmentation of funding pools within and between the public and private sectors. In the private sector, there are 83 medical schemes⁴² funding the health needs of only 16.2% (8.8 million lives) of the population. Spending through medical schemes in South Africa is the highest in the world and is six times higher than in any OECD country and represents more than six times the 2013 OECD average of 6.3%.
74. Medical schemes are fragmented along the lines of occupational categorisation as well as the ability of individuals to afford the medical scheme contributions associated with a specific benefit option. The overall consequence of this fragmentation is that there is limited cross-subsidisation within the private medical schemes environment.
75. Within the public sector there are multiple funding pools across the three spheres of government. This fragmentation is exacerbated by several funding streams namely equitable share allocations, conditional grants and locally generated revenues. These do not allow for effective planning, and contribute towards uncertainty in the availability of funding for services.
76. The effect of the fragmentation is that a majority of South Africans, particularly the unemployed and poor, are not provided with adequate financial risk protection from catastrophic health expenditures and their health needs are not adequately met.⁴³ Fragmentation is also a key driver of inequality and contributes to inequity in the distribution of health benefits.

3.3.5.4 Out-of Pocket Payments

77. South Africans are exposed to three forms of Out-Of-Pocket payments (OOPs) namely:
- a) Every time a patient must pay cash when they seek healthcare whether in the public or private sectors;
 - b) Additional payments (co-payments or levies) for those on medical schemes but whose benefit option does not cover all the costs; and

c) Cash payment for those on medical schemes whose benefits are prematurely exhausted before the end of the year.

78. Co-payments or user-fees are used in some health systems as a deterrent to service use and as a cost-containment (demand-management) measure. However, international evidence⁴⁴ indicates that co-payments, by placing a burden on patients at the point of service, disproportionately deters use by the most vulnerable, particularly the lowest socio-economic groups and thereby entrenches inequalities in access to and use of needed health care⁴⁵. Co-payments often increase the total cost of health care as the use of needed health care is simply deferred until an illness is serious, requiring more costly services including hospitalisation⁴⁶.
79. Within the public sector certain categories of users of the health system are required to pay a facility-based fee at the hospital level that is based on the economic classification of the patient determined by income levels. The fee is in accordance with the Uniform Patient Fee Schedule (UPFS). On average, approximately R451 million annually is derived from user fees from those that are classified as H1 – H3^d users. These payments are made as OOPs expenses from these users⁴⁷.
80. Within the private health sector, members of medical schemes are subjected to high OOPs. Private hospital fees, specialists' and medicine costs account for the bulk of the OOPs. According to the Council for Medical Schemes annual report, OOPs increased by 11.9% to R20.7 billion between 2013 and 2014. This translates to approximately R6,000 per beneficiary (8.8 million covered beneficiaries) paid out as OOP for accessed services. These figures, according to the Council for Medical Schemes, are an understatement of OOPs as beneficiaries do not claim for all OOPs when they realise that their medical scheme will not reimburse them for these OOPs. The structuring of benefit packages offered by medical schemes is a major contributor to OOPs as beneficiaries are forced to pay for non-covered services. In many instances those beneficiaries whose benefits are not covered or are exhausted seek care in the public sector.

3.3.5.5 Weak Purchasing and Financing systems that punish the poor

81. Analysis of the available South African National Health Accounts data shows that there are three methods of financing health care namely through general tax, medical schemes (private health insurance) contributions and OOPs. South Africa has a relatively low share of mandatory prepayment funding in the context of the goal of UHC. The system has small, fragmented funding and risk pools, which limit the potential for income and risk cross-subsidisation. Health care services are not distributed in line with the need for health care services and the benefit incidence of health care in South Africa is very 'pro-rich', with the richest 20% of the population receiving 36% of total benefits (despite having a 'health need share' of less than 10%) while the poorest 20% receive only 12.5% of the benefits (despite having a 'health need share' of more than 25%)⁴⁸.
82. South Africa also has weak purchasing mechanisms. At present, there is a relatively passive relationship between purchasers (i.e. those who hold a pool of funds and transfer these funds to

^dH1: Income < R36 000 per annum

H2: Income R36 000 - R72 000 per annum

H3: Income > R72 000 per annum

providers) and service providers. Existing ways of paying providers in both the public and the private health sectors are inefficient. The current system of line-item budgeting in the public sector does not provide incentives for efficiency or for providing good quality care. Fee-for-service payments, as used within the private sector environment, creates an incentive to provide as many services as possible, even where these may not be medically necessary or appropriate, again generating inefficiencies.

3.4 Conclusion

83. This chapter has outlined that the challenges facing the health system are as a result of social determinants of health (SDH), an increasing burden of disease and structural problems impacting on its performance, all of which need to be addressed through ongoing health systems strengthening efforts and inter-sectoral collaboration. Furthermore the move towards National Health Insurance will contribute to health system strengthening initiatives, ameliorating challenges in health care financing and eliminating fragmentation in the health system.
84. The policy trajectory pursued under NHI must be based on the clear objective of entrenching income and risk cross-subsidisation mechanisms that will ensure that all citizens are provided with (1) adequate financial risk protection; (2) an opportunity to equitably benefit from the health system; and (3) the ability to contribute towards the funding of the health system based on their ability to pay.
85. The next chapters will outline benefits of NHI as well as interventions aimed at reorganising the health care systems to improve its performance and the quality of health care services delivered, and healthcare financing reforms that are aimed at achieving universal health coverage.

CHAPTER 4: RATIONALE AND BENEFITS OF NHI

86. To address the structural problems outlined above as well as to effectively reduce the burden of disease requires a transformative and redistributive system as envisioned through the phased implementation of NHI.
87. NHI focuses on ensuring progressive realisation of the right to health care by extending coverage of health benefits to the entire population, in an environment of resource constraint whilst benefiting from efficiency gains.
88. The benefits of NHI are multiple and include: improved financial risk protection through prepayment funding and reducing out-of-pocket payments; reduced inequities and fragmentation in both funding and provision of health services in both the public and private health sectors; improved access to quality health care; improved efficiency and cost containment through streamlined strategic purchasing; improved accountability on the use of public funds through appropriate governance mechanisms and transparency in performance reporting; and better health outcomes across all socio-economic groups through improved coverage.
89. Households will benefit from increased disposable income because of a significantly lower mandatory prepayment level than current medical scheme contributions, savings that will be made due to economies of scale, efficiency gains because of reductions in non-health care costs, and affordability of health care as a result of active and strategic, monopsony purchasing arrangements.
90. The NHI reforms are premised on several key interrelated elements, namely:
 - i. **Micro-level reforms** to increase efficiency and quality⁴⁹: These NHI-reforms have been shown to slow the growth of health care costs by reducing wastage as a result of unnecessary care that does not contribute to better health outcomes – thus increasing quality at lower costs. The reforms include active purchasing by a single strategic purchaser, using explicit contracts that set prices; gate-keeping at a primary health care level⁵⁰; and provider-payment reform that move away from a fee-for-service environment to alternative strategies for reimbursement (AMR)⁵¹. The AMRs include capitation for primary health care and ambulatory care or case-based payment systems such as diagnosis-related groupers (DRGs) for in-hospital services whereby the unit prices for reimbursements decline after reaching a fixed budget⁵². Furthermore, in situations where health care providers are salaried, the introduction of an activity-based bonus or capitation has been used to motivate employees.
 - ii. **Macro level reforms** to control costs: These reforms include managing escalation of prices of healthcare services and consumer protection from catastrophic spending through instruments such as: a) Price controls to regulate health care inputs using reference prices for pharmaceutical products and price setting for health services⁵³; b) health care financing reforms that eliminate out-of-pocket spending and prohibiting low-quality benefits and benefit options that limit coverage and predisposing to catastrophic health expenditure; c) Delinking health insurance as an employment benefit, where people rely on their employers for insurance especially in situations of members having pre-existing medical conditions that confine them to a particular job⁵⁴, and instead making financial protection and access to quality care a universal entitlement.

91. The implementation of NHI will provide an opportunity for significant economic and social benefits to South Africa. A well implemented NHI could contribute significantly to improved life expectancy. Economic impact assessments indicate that the NHI can have positive impacts in the long-run in improving the health indicators of the country, including significant improvement in life expectancy and child mortality. Estimates also show that a one-year increase in a nation's 'average life expectancy' can increase GDP per capita by 4% in the long run⁵⁵. This will also translate to increased happiness of the population as it ensures improved quality of life and increased longevity.
92. The health of a country's labour force can impact on its productivity levels. If NHI is successful in its aim to reducing bottlenecks in the provision of healthcare in South Africa, it could lead to an improvement in the health of the labour force in the long term. The better health outcomes and a healthier workforce will translate into significant improvement in labour productivity. International studies have estimated that the increase in labour productivity can be from between 20% and 47.5% in the medium to long term⁵⁶. Other benefits are increases in labour participation rates and reduced absenteeism.
93. Slowing the growth in health care costs also has macroeconomic benefits to the labour market and the general economy. NHI reforms have been shown to create stability in the rate of escalation of NHI-related taxes, thus providing certainty to the tax-payers. In the short term, mandatory prepayment for the NHI, through tax payments, at levels that are lower than current medical scheme contributions, can promote employment by reducing the cost to the employer of hiring additional workers⁵⁷. Reductions in medical scheme contributions paid by employers can be translated into higher wages and increased disposable income, which can be spent on other goods and services to stimulate economic growth.
94. South Africa follows an evidence-based approach to health reforms by implementing a highly effective, fair and cost-effective NHI that promotes health care coverage and financial risk protection for households. The timing of its implementation is appropriate as NHI will help protect the poor, prevent cost escalation and help secure a wealthier and healthier future for South Africans.

CHAPTER 5: NATIONAL HEALTH INSURANCE COVERAGE

5.1 The Three Dimensions of Universal Health Coverage (UHC)

95. The World Health Organisation (WHO)⁵⁸ provides guidance to countries on moving towards universal health coverage (UHC) and has identified three dimensions for progressing towards universal coverage as shown in Figure 1 in section 1.3 namely:
- a) Population coverage
 - b) Service coverage
 - c) Cost coverage
96. This section aims to outline how South Africa, through the implementation of NHI, using the three dimensions, will move towards UHC.

5.2 Population coverage

97. Population coverage refers to the proportion of the population that has access to needed health services.
98. NHI will increase this proportion by extending coverage to all South Africans irrespective of their socio-economic status, including residents with long-term visas. Priority will be given to the population that is in greatest need, including vulnerable groups, and must include those experiencing the greatest difficulty in obtaining care. The unemployed, vulnerable groups will be prioritised. The identification of the population with the greatest need will be based on criteria consistent with the principles of NHI. Progressively, the population will be defined according to need and coverage will be extended to ensure access to defined and comprehensive health care services.
99. NHI requires that users of the health system should be registered and be identifiable at the point of use. Registration of the population in catchment areas will take into account various factors including personal information, the size of the population in the area, disease profile of a catchment area, facilities and structures, living environment, social and health deprivation and other contextual dynamics. In addition, there will be a need to promote equitable distribution of resources and address the rural-urban divide.
100. Registration will take place at designated health facilities. South Africans, including those in possession of a long-term residence visa will register using the Department of Home Affairs' identification system. The information on registration will be encrypted and will be utilised to access services at different levels of the health system.
101. Migrants are not a homogenous group and consist of refugees, asylum seekers and irregular migrants and will receive basic health care services in line with the Refugees Act and international conventions that South Africa is a signatory to.

5.3 Service coverage

102. Service coverage refers to the extent to which a range of quality health services necessary to address the health needs of the population are covered. NHI will cover comprehensive health

care services.

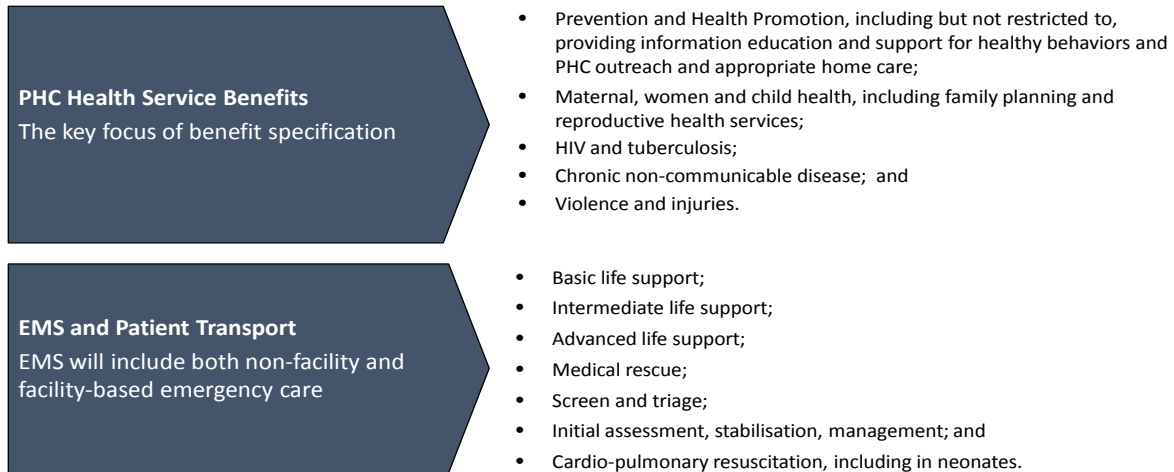
103. South Africans will be able to access personal health services covered by NHI closest to where they reside. The point of entry to accessing health services will be at the primary health care level with referrals to higher levels of care by providers at the PHC level. Properly delivered PHC could eliminate 21% to 38% of the burden of premature mortality and disability in children under-15 years of age, and 10% to 18% of the burden in adults.
104. These services will be delivered through certified^e and accredited^f health care providers located closest to the covered population to improve coverage from an allocative efficiency, affordability and sustainability perspective. PHC services will cover a catchment population that takes into account geographic, demographic and epidemiological profiles of the community. PHC services delivered by private providers will take into account the need to integrate providers into the delivery platform. There are several ways in which private providers could participate in offering PHC services including contracting-in or contracting-out.⁵⁹
105. At a PHC level, contracted-in services will be delivered by accredited providers normally practicing in the private sector but allocating a certain amount of time to render services in a public health facility such as a clinic. Contracted-out PHC healthcare services will be purchased from integrated teams of providers or networks structured as multidisciplinary practices of a wide range of health care professionals such as medical practitioners, dentists, nursing professionals, pharmacists, psychologists, audiologists, optometrists, physiotherapist, oral health practitioners and social workers amongst others. Those who practice as individual practitioners should be part of referral networks.
106. The comprehensive set of personal health services will include a continuum of care from community outreach, PHC level based on the ideal clinic model, health promotion and prevention to other levels of curative, specialised, rehabilitative, palliative care, and acute emergency care. Health service benefits will be provided and described in terms of the types of services to be provided at each level of care with guidance on referral mechanisms. Services covered under NHI will also include access to pharmacies, and Emergency Medical Services. The comprehensive health services will cover (but not be limited to) the following:

^e Certified by Office of Health Standards Compliance (OHSC)

^f Accredited by the NHI Fund

Figure 2: PHC and EMS

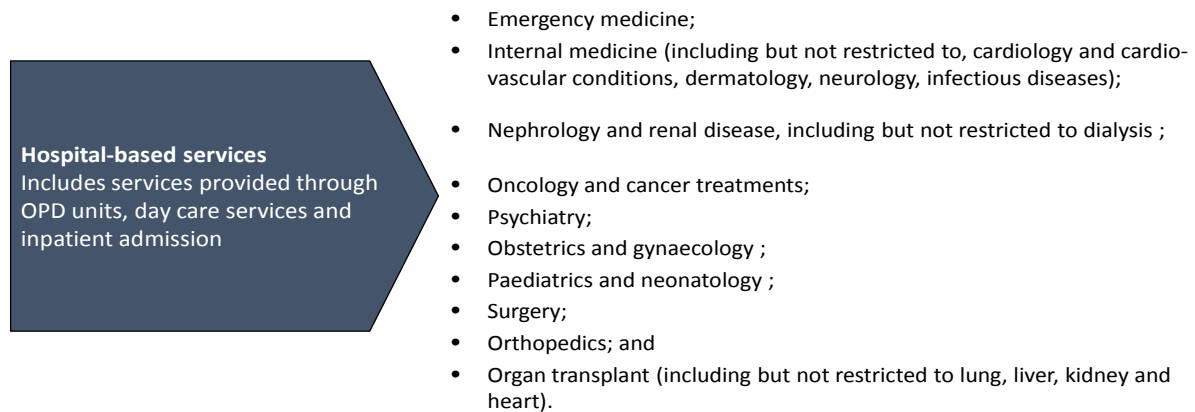
Service Benefits under NHI



Note: This is not an exhaustive list

Figure 3: Hospital-based Services

Service Benefits under NHI



Note: This is not an exhaustive list

Figure 4: Additional Services

Service Benefits under NHI



Note: This is not an exhaustive list

107. NHI healthcare benefits will be portable throughout the country. Mobile healthcare services will be organised within a CUP. The contracting of accredited private providers will be prioritised with the aim of ameliorating geographical access challenges. Whilst assuring continuum of care communities, vulnerable groups (especially people with disabilities and the elderly) and those domiciled in rural settings may still experience limited access as a result of topography, and unaffordable transport costs. NHI will provide coverage for planned transportation in times of need and for the elderly and people with disabilities in rural and topographically inaccessible and rural localities.
108. Mental healthcare services will be fully integrated into PHC and higher levels of care with a view to increasing prevention, screening, care, treatment and rehabilitation including community mental health services. These services will include health promotion, and monitoring of related health outcomes delivered through registered councillors. There will be an appropriate referral system which also strengthens community mental health services.
109. Disability healthcare services will also be fully integrated into PHC with a view to increasing care, treatment and rehabilitation. Health infrastructure at all levels of care will provide for comprehensive rehabilitative services. These services will include provision of assistive devices, prosthesis and devices for assisting mobility.
110. NHI will cover comprehensive integrated occupational healthcare services that are responsive to diseases and injuries. The cornerstone of the delivery of occupational healthcare services will be based within the PHC model and integrated into the referral system to ensure the provision of treatment, care and support as well as rehabilitation assessments and services.
111. NHI will not cover non-personal health care compensation as this will still remain the responsibility of funds such as Compensation for Occupational Injuries and Diseases (COIDA) and Compensation Commissioner for Occupational Diseases in Mines and Works (ODMWA).

workplace will remain the responsibility of the employer and will not be funded through NHI but will be governed through the National Institute of Occupational and Communicable Diseases (NIOCD provisions).

112. The NHI Benefits Advisory Committee (BAC) will develop the comprehensive health care services for all levels of care (primary, secondary, tertiary and quaternary). The healthcare services will also include sexual and reproductive health, rare diseases and dread diseases. The NHI Benefits Advisory Committee supported by various committees will make evidence-based recommendations on what services, including surgical interventions are covered and the coverage for planned patient transport.
113. A process of priority setting⁶⁰ and health technology assessment (HTA)⁶¹ will be used to inform the decision-making processes of the NHI Benefits Advisory Committee to determine the benefits to be covered. The range of services will be regularly reviewed using the best available evidence on cost-effectiveness, allocative, productive and technical efficiency⁶² and HTA.
114. The NHI healthcare services will not be based on a negative or positive list nor on a PMBs type of package. NHI priority setting will be through explicit guarantees⁶³ using gate keeping at PHC level, a clearly articulated referral system, the use of clinical guidelines and protocols and HTA on the process of priority setting.
115. Detailed treatment guidelines, which are based on available evidence about the most cost-effective interventions, will be used to guide the delivery of the comprehensive health care services. Additional guidelines will be developed for interventions where such guidelines do not exist such as in surgical disciplines. All treatment guidelines will be routinely reviewed to take into account the assessment and appropriateness of new technologies. Efforts will be put into place to ensure that the general public is provided with the relevant information to support access and ensure empowerment regarding these guidelines.
116. Changes to the comprehensive health care service - including diagnostic tests covered under NHI will be informed by changes in the burden of disease, the demographic profile of the population and the evidence on cost-effectiveness and efficacy of health treatments, interventions and/or technology development locally and internationally. Changes and adjustments to the service benefits will be accompanied by a budget impact analysis.
117. An inventory of pharmaceutical, medical supplies and devices will be linked to the Essential Medicine List (EML) and will be updated on a regular basis by the EML Subcommittee of the NHI Benefits Advisory Committee.
118. Although the NHI healthcare service will be comprehensive and evidence-based, effort will be directed at ensuring that the covered services are medically necessary and have a positive impact on population health outcomes.
119. To ensure continuity of care, access to healthcare services covered will be portable. This will ensure that internal migrant populations visiting a different part of the country where they were not initially registered, can still access NHI healthcare services. Migrant populations must provide notice to the NHI Fund prior to embarking on the journey.

5.3.1 Expanding access to Hospital Services

120. NHI will contract with accredited public and private providers at specialist and hospital levels based on need. Services to be rendered at the hospital level will be based on comprehensive healthcare services that are appropriate to the various levels of care. These services will include diagnostic, curative, allied, palliative and rehabilitative services.
121. Patients who need to be treated by specialists or in hospitals will have to be referred by PHC providers to certified and accredited hospitals and specialists. This means, except in acute emergency medical contexts, patients cannot self-refer to a specialist or a hospital without being seen at the PHC level either at a clinic or by a general practitioner.
122. Hospital services will be provided based on the existing classification of hospitals in the public sector and taking into account the level of care to be provided. Using this classification, level 1 (district) services will be provided by generalist medical (and dental) practitioners including surgical interventions under anaesthesia. The scope of services to be rendered at level 2 facilities (regional) will include services that can be provided by general specialists in anaesthesiology, general surgery, internal medicine, obstetrics and gynaecology, orthopaedics, paediatrics, psychiatry, diagnostic radiology, pathology and allied health services.
123. Tertiary services will be rendered through level 3 facilities. The comprehensive health care services at this level will include sophisticated diagnostic and treatment services. The services will be provided by general specialists in anaesthesiology, general surgery, internal medicine, obstetrics and gynaecology, orthopaedics, paediatrics, psychiatry, radiology and diagnostic services such as pathology.
124. Quaternary and other tertiary services will be rendered through national and central referral centres. The services rendered will include sub-specialist and super-specialist services such as advanced trauma care, organ transplantation and have technologically complex equipment and clinical support services.
125. Hospital and medical specialist healthcare services will be specified by the NHI Benefits Advisory Committee based on evidence of efficacy, quality, safety and cost-effectiveness. Accredited hospitals and specialists will deliver healthcare services in accordance with clinical protocols and referral guidelines⁹. This will provide guidance on the referral system and on what services should be rendered or performed at designated levels. Ambulatory specialist healthcare services will be delivered through duly accredited public and private providers. Specialists will be required to comply with guidelines, treatment protocols, prescribed quality and other standards and the prescribed referral system.
126. Identified providers of health care services for priority areas such as Obstetrics and Gynaecology, Paediatrics and Trauma Services in the private sector will be contracted based on need. As NHI matures, these high priority services will be more widely available to the population from a wider network of accredited providers.

5.3.2 Expanding access to pharmaceutical services

⁹ The channelling of a patient to another level of care, either at a higher or lower level for continuity of care

127. To ensure equitable access to medicines and related pharmaceutical products, NHI will in addition to public provision, accredit and contract with private retail pharmacies based on need. Accredited and contracted retail pharmacies will be able to order medicines and other health products from the nationally agreed pharmaceutical contracts and will be required to dispense medicines that are procured at subsidised prices. There will be strong mechanisms put in place to monitor medicine dispensing to ensure that such medicines and other health products only benefit NHI patients. The NHI Fund will then reimburse the cost of the subsidised medicines and other health product as well as pay a capitated administration fee to the retail pharmacies.

5.3.3 Expanding access to laboratory services

128. Pathology services will be provided in line with the National Health Act (No. 61 of 2003) which requires the setting, monitoring and enforcing of quality control standards applicable to pathology services to ensure patient safety. NHI will cover comprehensive pathology services delivered at the different levels of care and as defined by the NHLS Act and the NHI Benefits Advisory Committee. NHI will also contract with certified and accredited private laboratory service providers based on need.

129. The NHI Benefits Advisory Committee will determine the laboratory services to be covered under NHI. The laboratory investigations to be covered should be requisitioned for a specified clinical indication and not merely as a routine procedure. Laboratory services at the PHC level will be in line with the Essential Laboratory List.

130. NHI will cover diagnostic pathology laboratory services provided that when referring patients to higher level of care, all previous relevant information including all the available and pending laboratory test results are provided to avoid unnecessary duplication and repeat testing.

5.3.4 Expanding access to radiology services

131. NHI will cover radiology services that are delivered at primary, district, regional and tertiary levels as well as those radiology services that are delivered at central/national referral levels comprehensive healthcare services defined by the NHI Benefits Advisory Committee and based on need. The covered services will include:

- i. Radiology and imaging sciences;
- ii. Telemedicine;
- iii. Nuclear medicine; and
- iv. Radiation oncology

132. Radiology services to be covered under NHI will be located at the lowest and most appropriate level that could sustainably deliver the services that have been determined by the NHI Benefits Advisory Committee for that level of care using defined referral protocols.

5.4 Cost coverage

133. Cost coverage refers to the extent to which the population is protected from direct costs as well as from catastrophic health expenditure. Improving financial protection can be achieved with⁶⁴: (a) Increasing government expenditure on health; (b) reducing out-of-pocket payments (OOP) in the broader funding context; (c) Implementing national measures of financial protection; (d)

Ensuring the poor are not left behind; and (e) Supporting positive trends in financial protection.

134. The covered population will be protected from financial hardships as they will not be required to pay directly at the point of accessing and utilising health care services. Services provided will be paid for through the NHI Fund. The covered population will not be expected to make any OOP.
135. To prevent inappropriate and excessive use of health services and to ensure long-term sustainability and affordability of the health system, gate-keeping, selective contracting, provider reimbursement strategies, through the use of clinical guidelines and protocols will be implemented at the primary care level with strict referral procedures, and providing suitable incentives to health care providers. By-pass fees will be imposed only for non-adherence to referral pathways whilst ensuring that they do not prevent rural communities from accessing health care. Nevertheless, careful attention will be paid to the process of introducing this policy to avoid potential adverse consequences for those accessing hospital-based services.
136. Services to which there is no coverage, such as elective cosmetic surgery, must be paid for in full by the user.

CHAPTER 6: REORGANISATION OF THE HEALTH CARE SYSTEM AND SERVICES UNDER NHI

137. The provision of healthcare services will be through an integrated system involving accredited and contracted public and private providers.
138. The reorganisation is aimed at achieving: a) improved health (level and equity); b) responsiveness; c) financial risk protection; and d) improved efficiency. Several initiatives have been introduced to improve the performance of the health system, in terms of the service delivery, management and quality of health care. The planned interventions outlined will be undertaken throughout the 14-year phased implementation of NHI.

6.1 Service Delivery

139. The health system is organised into three areas of health care service delivery. These are:
- i. Primary Health Care (PHC) Services;
 - ii. Hospital and Specialised Services; and
 - iii. Emergency Medical Services (EMS).

6.1.1 Primary Health Care (PHC) Services

140. PHC is the heart-beat of NHI. The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services (including social services).
141. The PHC level being the first point of contact with the health system is critical to ensure health system sustainability as it is associated with fewer visits to specialists and to emergency rooms. Patients will be able to present at the PHC level with any health care requirement (whether for promotive, preventive, curative; rehabilitative, palliative or community-based mental health) and will either receive the care they need at this level or will be referred to a hospital if more specialised services are necessary.
142. PHC starts in the communities and in addition to the clinics, multidisciplinary networks of practices in the private sector will form part of the first level of contact. Facility based services offered at community clinics and Community Health Centres (CHC's) and multidisciplinary practices will conform to the Ideal Clinic model. PHC services will be comprehensive and integrated and will be supported by a strong feedback referral system and planned patient transportation between the levels of care where appropriate. The referral system will be upward and downward (bi-directional) and within and across the entire health system.
143. PHC Re-engineering is a key health reform that is implemented through four streams namely:
- a) Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs);
 - b) Integrated School Health Programme;
 - c) District Clinical Specialist Teams; and
 - d) Contracting-in of private health practitioners at non-specialist level.

a) Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs)

144. The Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs) form a pivotal

part of South Africa's PHC re-engineering strategy. The outreach teams consist of Community Health Workers (CHWs), led by a nurse and are linked to a PHC facility. CHWs assess the health status of individuals in the households. They provide health promotion education, identify those in need of preventive, curative or rehabilitative services, and health related counselling, and refer those in need of services to the relevant PHC facility.

b) Integrated School Health Programme (ISHP)

145. School health services are being provided to improve the physical, mental and general well-being of children of school-going age. The ISHP provides a range of promotive, preventive and curative services and include a focus on screening for health-related barriers to learning like, vision, hearing, mental health, cognitive and related developmental impairment. It will include oral health, immunisation against missed EPI vaccines, de-worming, nutritional services, risky behaviour including substance abuse, sexual and reproductive health rights including family planning services, and HIV and AIDS-related programmes. The programme also includes routine vaccination of Grade 4 learners (girls who are 9years old) against the Human Papilloma Virus (HPV). Services of private oral, eye and audiology practitioners will be contracted based on need, to provide corrective interventions to address the problems that have been diagnosed through the ISHP.

c) District Clinical Specialist Teams (DCSTs)

146. Significant progress has been made in establishing DCSTs across the country. The DCSTs will support capacity building and mentorship, strengthening the use of clinical guidelines and protocols and strengthening the use of information to improve health outcomes. Deployment of DCSTs also contributes to reduction in institutional maternal and neonatal mortality rates ⁶⁵.The composition of the DCST will be reviewed on an ongoing basis to ensure that issues of public health care are continuously monitored. The review may entail the inclusion of a public health medicine specialist.

d) Contracting private healthcare providers

147. An essential step in strengthening PHC and ensuring integrated services at PHC-level is the contracting-in and contracting out of private health practitioners to address the health needs of the population and will be aimed not only at improving access but also at reducing the burden of disease. Contracting-in will be undertaken to reduce patient-overload in public health facilities whilst not depleting the numbers of salaried employees of the state. Contracting-out of PHC services will require that multi-disciplinary practices should be configured into horizontal networks that are contracted through the Contracting Unit for PHC (CUPs).Contracting for pharmaceutical services will also be undertaken to facilitate improved access for patients that have been stabilised. The contracted private providers will be reimbursed through a capitation model instead of a FFS as is happening currently.
148. Outcomes will be measured and monitored through a performance management framework and will be in accordance with agreed upon performance standards. Eventually performance management will cover public health outcomes in a specified catchment population. For this model to be successful the clinic settings and environment must comply with the Ideal Clinic model specifications.

6.1.2 Implementation of Quality Improvement Initiatives

149. NHI aims to provide coverage to quality health services for all South Africans. Therefore, NHI will accredit and contract eligible health facilities that meet nationally approved standards. To meet these standards, health facilities must be certified by the Office of Health Standards Compliance (OHSC). The OHSC was established in 2013 through amendments to the National Health Act of 2003. The role of the OHSC is to ensure compliance with National Quality Standards for Health by all health establishments in both the public and private health sectors. The role of the Inspectorate within the OHSC is to enforce compliance with the norms and standards. The Health Ombud function of the OHSC which became operational in 2016 ensures that complaints lodged by users of health care services are appropriately and speedily investigated.
150. The National Quality Standards for Health are based on seven domains and six national core standards. The seven domains include patient rights; patient safety, clinical governance and care; clinical support services; public health; leadership and corporate governance; operational management including financial, asset and human resources management; and facilities and infrastructure. In addition, facilities must comply with National Core Standards that measure the following areas: cleanliness; attitude of staff towards patients; infection control; safety and security of staff and patients; reduction of waiting times; and availability of medicines at facilities. All health facilities must be fully compliant with national norms and standards for quality at all times. For compliance with these standards, essential health support services such as laundry, safety and security must be provided on a continuous and uninterrupted basis. Support services such as security, food supply, cleaning services, and laundry services, must not be outsourced but be provided in-house within the public health system.
151. Health facilities in the public sector have been implementing quality improvement interventions to comply with the quality norms and standards to varying degrees in preparation for NHI. These interventions include: (a) the scaling up of the Ideal Clinic model; (b) infrastructure improvement across the health sector; and (c) implementation of the World Health Organisation's Workload Indicators for Staffing Needs (WISN) tool.
152. The interventions in public health facilities have had variable results with regards to meeting the core quality standards, mostly with poor scores for PHC facilities and slightly better scores for hospitals being recorded. However, the information obtained from the inspections has been used to develop and implement action plans across clinics and hospitals in and around the NHI pilot districts to support quality improvement plans. The OHSC inspection results are utilised to inform Operation Phakisa's Ideal Clinic Realisation project to strengthen the implementation and monitoring of progress achieved by target facilities to achieve the National Core Standards for quality.
153. Patient satisfaction will be measured systematically through collaboration with the OHSC, other statutory bodies and stakeholders. This information will be used to identify gaps and put into place action plans to ensure sustained patient satisfaction.
154. The implementation of the Patients' Rights Charter will be strengthened to ensure physical and mental well-being; to participate in the development of health policies and participate in decision-making on matters affecting their health; to access healthcare including timely emergency care in any health facility that is open regardless of their ability to pay; to information related to the type

of health coverage; to choose a health provider or facility for treatment provided that such choice shall not be contrary to ethical standards and service delivery guidelines; to be treated by a named healthcare provider; to confidentiality and privacy and disclosure of information through informed consent except when required in terms of law or an order of court; to informed consent; to right of refusal of treatment provided it does not endanger the health of others; to be referred for a second opinion; to continuity of care; and to complain about health services.

6.1.3 Improving access to Emergency Medical Services

155. Emergency Medical Services (EMS) form a key component of the service offering that will be covered by NHI. NHI will contract with accredited providers of EMS in the public and private sectors. As defined in the National Health Act (2003) and Regulations and any amendments thereof⁶⁶ and is more than merely ambulance services. The provision of EMS is in line with Section 27 (3) of the Bill of Rights of the Constitution.
156. A uniform level of quality for Emergency Medical Services (EMS) and Facility-based Emergency Care will be provided across the country according to nationally determined norms and standards in relation to the level of care, staffing requirements, prescribed equipment, suitability of response vehicles and ambulances and other relevant components based on the level of care.
157. Emergency care delivery will be multi-disciplinary and team-based. The clinical teams need to have the competencies to assess, stabilize and provide essential acute emergency care and clinical interventions for all presenting clients. Further care or referral will be guided by the clinical condition of the patient.
158. Provincial Emergency Medical Services will work closely with Emergency Medicine specialists to implement appropriate referral guidelines, to ensure a seamless continuum of emergency care along the referral pathway.

6.2 Improving Leadership and Governance

6.2.1 Improving management and governance at PHC level

159. Strengthening PHC services is critically dependent on improved management at facility (clinics and community health centres) and district levels. In addition to strengthening management capacity (e.g. through improving managers' skills and upgrading information systems), there will be a need to delegate greater management responsibilities to the district level in the early phases so that the necessary decisions related to service delivery can be made and managers held accountable for their performance.
160. Taking into account the need for separating purchasing functions from provision of services and given capacity constraints in financial management and planning, it will not be feasible to delegate management to individual PHC facilities. The Contracting Unit for PHC (CUP) located at the district level and in a co-operative management arrangement with the district hospital linked to a number of PHC facilities thus creating a contracting unit for the NHI. As the system matures with the full implementation of the Ideal Clinic model, appropriate delegations and management functions may be devolved to the PHC facilities.

161. In addition, given that PHC services will be provided through a range of providers (including WBPHCOTs, school health teams, fixed and mobile public sector facilities and contracted private providers), the PHC re-engineering vision of integrated comprehensive services would best be promoted through coordination and management of these services at the district level.
162. Clinic Committees will be strengthened for all PHC facilities to provide advice and play an advocacy role for the communities they represent. They will also focus on public health campaigns in the catchment areas of their respective clinics. Guidelines have been developed on how these Clinic Committees will be strengthened and how they will function to represent the needs of communities.

6.2.2 District Health Management Offices (DHMOs)

163. Within the District Health System, the District Health Management Offices (DHMOs) will be strengthened to manage public health programmes. The DHMOs will be structures to which management, planning and coordination of non-personal health service provision responsibilities are delegated, taking into account national health policy priorities and guidelines as well as health needs in the district. The structure and functioning of the DHMOs will take into account the need to separate the function of the purchasing of personal healthcare services from the function of provision of health services.

6.2.3 Health Promotion and the National Health Commission

164. Health promotion and disease prevention will form an important aspect of contributing to the reduction in the burden of disease and rising costs of healthcare. The NDP 2030 envisions promoting health and wellness as critical, preventing and managing diseases of lifestyle that are likely to pose a major threat over the next three decades. Optimal collaboration between stakeholders from government and non-government sectors is required to address the risk factors that contribute to diseases of lifestyle. The National Health Commission will be established through an enabling framework to ensure the required multi-sectoral collaboration.

6.2.4 Role, functions, management and governance of Central Hospitals

165. Central hospitals are a platform for conducting research, the training of health workers as well as being centres of excellence for innovation nationally, continentally and globally. They are a national resource and irrespective of the province in which they are located, must provide health services to the entire population.
166. Central hospitals will be reformed to be semi-autonomous. Full decentralisation of their management functions and responsibilities will be prioritised to ensure their effective functioning and sustainability. This will also contribute to improved quality of care, responsiveness to patient needs, hospital effectiveness and affordability of healthcare. Their management will have full delegations and decision making powers including control over financial management, human resource management, infrastructure and technology, as well as planning and decision making. Central hospitals will contract directly with the NHI Fund.
167. Central hospitals will be required to establish cost centres. These cost centres will be responsible for managing meaningful units of business activities (Functional Business Units) and the related

cost drivers at the level where the operations/activities are directed and controlled. Through this system, greater levels of responsibility and accountability will be afforded to departmental heads within the central hospital. The role played by Heads of Academic Departments in central hospitals will therefore be significantly enhanced.

168. The Functional Business Units (FBUs) will be disaggregated into smaller units with the lowest cost centre level being a ward or out-patient clinic. Cost centre management will include: Implementation of International Classification of Diseases 10th edition^h (ICD-10), the use of Diagnosis Related Groupers (DRGs)⁶⁷ to determine costing and case-mix, cost accounting, statistics, practice management, budgeting, forecasting and expenditure control. Within the central hospitals, work is currently underway to pilot the implementation of the Diagnosis-Related Groupers (DRGs) in the ten central hospitals. In addition, phase 2 of the implementation of the International Classification of Diseases-version 10 (ICD10) coding system is taking place in all the central hospitals.
169. In line with regulations on management and governance of hospitals, central hospitals will be governed by appropriately constituted Boards. The composition, role and function of the Boards will be amended in line with the objectives of the NHI, including ensuring that they have greater oversight responsibilities. These boards will have a delegated oversight responsibility of all the functions of the hospital and represent the interest of the users of the facility and affected stakeholders.
170. All these reforms will necessitate central hospitals becoming a competence of the national sphere of government which will require new governance structures. This is important as all tertiary health services and the facilities in which they are delivered form a pivotal component of a unified national health system. This organisational change will also ensure that the expertise within these institutions benefits the entire health system.

6.2.5 Role and management of other levels of public hospitals

171. As is the case for central hospitals, the roles, functions and responsibilities of management and governance structures for the district, regional, tertiary and specialised hospitals will have to change. Hospitals will be contracted to render quality health services in accordance with the norms and standards as determined by the Office of Health Standards Compliance (OHSC) and in line with healthcare services that will be determined by the NHI Benefits Advisory Committee.
172. In order to improve accountability, quality of health services, performance and effectiveness, managers will be provided with more decision making space in critical management domains. This will include delegations on the management of human resources, finance and supply chain/procurement. Strengthened management will also be vital in the areas of facility management, cost centre management, and management and maintenance of essential equipment and infrastructure. This will be achieved through enhancement of management competencies in these areas and strengthening the role of Hospital Boards. For establishment of minimum competency requirements and continuous professional development of health managers, all health facility managers will be required to have a health management

^h There are different versions of ICD starting from the 1st to the 10th edition (hence ICD-10). As part of NHI, South Africa will implement the 10th edition.

qualification.

173. The NHI Fund will contract directly with the hospitals. The hospitals will be required to assume increasing degrees of managerial autonomy in preparation for NHI.

6.2.6 Governance of other levels of public hospitals

174. The role and function of the hospital boards will be significantly enhanced commensurate with the level of autonomy afforded to the hospital over which they exercise oversight. The roles of hospital boards will include a greater oversight function for improving quality of care, and adherence to national quality standards.
175. Hospital Boards will be strengthened in order to improve the governance of hospital management and staff in line with good corporate governance. The Hospital Boards will represent the views of the community in the general management of hospitals. This will take into account priority needs and any concerns that the community may have about the hospital.

6.3 Enhancing the Health Workforce

176. A number of strategies have been implemented to increase the production of health professionals, including expanding the platforms for international collaboration such as with the Mandela-Castro Collaboration Program in Cuba. A range of health professionals working in the private sector will be engaged through innovative contractual arrangements to contribute to addressing the human resources gap.
177. Medical schools will also be supported to increase their intake of students as part of broader human resources for health production strategy of increasing health professionals' throughput. In collaboration with the Department of Higher Education and Training, provision of scholarships for health science students will be increased. Post-graduate training and specialisation will be supported through, amongst other strategies, additional registrar posts.
178. The primary training platform for nursing training will be at nursing colleges located inside hospitals to provide a platform for practical training at the hospital bedside. Additional nursing colleges will be opened to increase the training numbers for nurses and related professionals. Relevant legislation and regulations governing the nursing profession and its education sector have been identified and reviewed in partnership with the Department of Higher Education and Training (DHET) and South African Nursing Council (SANC). SANC will strengthen its role in determining the practice standards of the Nursing profession.
179. Adequate provision must be made for other (allied) healthcare professionals registered through the HPCSA to ensure that the needs of the population are met. Additionally the need arising from the school health programme requires adequate numbers of these categories of health professionals.
180. Whilst it is important to increase the quantity and quality of health professionals to meet local needs, it will be equally important to ensure that those recruited are satisfied and motivated enough to be productive and likely to be retained. Improving the quality of life of health professionals working in rural areas will require a multi-sectoral response to providing basic

social infrastructure and amenities.

6.4 Medical products and technologies

6.4.1 Improving access to pharmaceutical services

181. A key element of improving service delivery is to ensure that the full range of essential medicines and other medical supplies are available in all public health facilities. Various interventions are currently being assessed and initiated to improve the distribution of medicines, including direct delivery by suppliers to health facilities of pharmaceuticals, dry dispensary and related supplies to facilities by suppliers to ensure improved turnaround times and prompt payment of suppliers. Other strategies include the implementation of the Direct Delivery Strategy (DDS), Central Chronic Medicine Dispensing and Distribution Programme (CCMDD), the operationalisation of the Control Tower and Provincial Medicine Procurement Units (PMPU); end-to-end visibility in the supply chain and electronic data interchanges and direct purchasing.
182. A national surveillance centre to monitor medicine availability in all districts has been established as a Control Tower. The surveillance centre serves as the national hub for contract management, including overall efficiency and effectiveness monitoring. The centre will have responsibility to monitor stock availability in facilities and serve as an early warning system of when stocks are not available. Provincial Control Towers have been established for the direct delivery of medicines in order to improve availability of medicines at facilities, reduce the risk related to depot holding stock. The PMPU serve as tactical operational units responsible for managing the procurement of medicines within the provinces, using the modern delivery methods and supported by modern systems and processes. Additionally, an electronic system for the early detection of stock outs of medicines at hospitals and clinic has been implemented through stock management done on two electronic systems.
183. The direct purchasing method enables hospitals to place orders directly with contracted suppliers and manage the full procurement cycle. This method enables facilities to proactively manage their medicines stocks and to minimise or eliminate stock-outs. The central procurement mechanism for Antiretrovirals (ARVs), small volume parenteral, insulin and devices has also been initiated.
184. Chronic stable patients in the public sector are usually required to travel to a health facility and wait several hours to collect their chronic medication on a monthly basis. Ultimately, this system will be eliminated so that patients will not be required to travel long distances and wait long hours for their medication. There are several alternatives that are more efficient, including the use of chronic medicine pre-dispensing and delivery to a point closest to the patient. These alternatives are already being piloted in some areas.
185. To improve patient access to needed medicines, especially for patients on chronic medication, as well as to assist with decongesting public clinics, the Department implemented the Centralised Chronic Medication Dispensing and Distribution (CCMDD) programme. The program is comprised of two program components, Central Chronic Medicines Dispensing and Distribution (CCMDD)¹ and Pick-up Points (PuPs)¹. These collection points comply with good pharmacy

¹ Relates to individual patients' medicines being centrally dispensed and distributed to the point of service delivery

practices (GPP) standards⁶⁸.

186. To-date, the implementation of CCMDD has focused primarily on the provision of ARVs, Fixed-dose Combination (FDC) in particular, to stable HIV patients receiving Antiretroviral Treatment (ART); however, the program is eventually intended to encompass all stable patients with chronic conditions whose management consists of bi-annual clinical visits and check-ups.

6.4.2 Improving the efficiency of National Health Laboratory Services (NHLS)

187. The reimbursement of laboratory services currently occurs through a fee-for-service (FFS) model. A strong criticism of the NHLS's use of the FFS model is that it produces financial driven perverse incentives, i.e. tests are conducted as a means of revenue generation and not from an appropriateness of need for care perspective. Fee-for-service perpetuates fragmentation in healthcare and does not address the quality of testing or the results produced.
188. A number of interventions that include the implementation of a gate-keeping tool that identifies unnecessary test requests, provincial verification of billing, an alternative financing model for training and a review of the current fee for service model used for billing. It is for this reason that a new funding model for NHLS is required to reduce the costs associated with the NHLS. The objective of reforming the funding model of laboratory services, is linked to:
- a) Reducing inefficiencies; and
 - b) Closer alignment with the health needs of the populations.
189. The reforms are premised on making appropriate health risk adjustments to deliver services, in the volume and at the point where required to improve efficiency and thereby health outcomes, i.e. based on the volume specification, the correct number of laboratories staffed and functioning at an optimal level is determined for each province. This is a fundamental shift from raising fees from tests to cover an existing cost structure.
190. The goal is to change the way the NHLS is reimbursed in order to emphasize higher quality at lower costs—in other words, to improve value. The NHLS reforms are aimed at delivering an efficient laboratory service. There are three fundamental components to the reform:
- a) Defining an essential set of tests that will get funded. Currently, 127 tests comprise of 90% of the total volume of tests ordered across all public health facilities. These tests will be categorized into individual patient healthcare needs that are linked to specific disease incidence at a provincial level. This will include developing disease based volume specifications.
 - b) Using clinical governance rules to manage demand and/or utilisation. As the new funding model will be volume driven, a service specification outlining a volume threshold for each specific test in the basket will be developed. Service volume thresholds are needed to mitigate the potential risk of wastage or inappropriate ordering of tests. In this case a 5% margin of fluctuation is proposed as acceptable. When the target volume exceeds 5% on a monthly or quarterly basis, fee-for-service will apply.

^j Relates to the provision of pre-dispensed medicines at private sector pharmacies, or 'Pick-Up-Points' (PuP), that is conveniently located for patients

- i. Based on current standard treatment guidelines and protocols, a set of clinical rules have been developed and operate by defining conditions for outright rejection, restrictions are put on each test method using predetermined evaluation criteria as well as multiple conditions for when a test is allowed. If none of the allowed conditions based on the rules are met, the test will be rejected.
 - ii. The new funding model further specifies authorization levels by category of health professional, seniority and type of facility.
- c) Moving towards a capitation based reimbursement model, based on the needs of the catchment population requires a cost-based tariff schedule. Cost per test will be adjusted against the demographic (or disease) profile of the specific province, giving a cost per person for laboratory services.
191. The laboratory investigations to be covered by NHI would be requisitioned for a specified clinical indication and not merely as a routine procedure. The authorised requisitioning healthcare professional will be required to decide on and define the purpose or reason for each laboratory investigation taking into account the following factors:
- a) If the investigation is clinically justifiable
 - b) Whether the previous results still have clinical relevance
 - c) If the investigation is required to ensure patient safety
 - d) If the investigation is required for quality assurance purposes

6.5 Information and Research for Monitoring of progress to UHC

192. Information and research for monitoring UHC and equity of access combines the experiences of users of health services across socioeconomic groups, especially the socially disadvantaged, taking into account social determinants of health such as vulnerability, livelihoods, empowerment, health seeking and navigation skills; whilst also monitoring the characteristic of the health system in terms of resources, the organisation, service outreach, participation and permeability. Measuring and monitoring the equity dimension entails understanding health needs, availability of services, accessibility, utilisation patterns and whether coverage is effective or not⁶⁹.
193. A monitoring system for NHI implementation will be established. UHC consists of three dimensions namely: health services, finance, and population coverage and these dimensions are influenced by demographic, epidemiological and technological trends⁷⁰. Health service coverage indicators that are being developed include: (a) services for health promotion and illness prevention; and (b) treatment including rehabilitation and palliative care services⁷¹.
194. For financial protection⁷², indicators that are being developed include: (i) the incidence of impoverishment resulting from Out-of-pocket (OOP) health payments, and (ii) the incidence of financial catastrophe from the same cause. Other indicators that will be monitored include collecting data on the extent to which people are pushed further into poverty, and the severity of financial catastrophe.

CHAPTER 7: FINANCING OF NHI

7.1 Aims of Health Financing Reform

195. There are several important aims of these financing reforms, as follows:
- a) To move beyond the existing fragmented public and private health financing systems to create a common modern universal health financing system which is cost-effective, trusted by citizens and provides protection against costly health services
 - b) To move from voluntary to mandatory prepayment system
 - c) To raise additional revenue for healthcare
 - d) To improve pooling arrangements so as to better spread risk and improve cross-subsidisation
 - e) To purchase from a mix of public and private providers
 - f) To use economies of scale and purchasing methods to achieve cost-efficiency
 - g) To deliver quality services and continual improvements in health outcomes

7.2 Economic Environment

196. At the time of the publication of the NHI Green Paper in 2011 GDP growth was 3.2 per cent. The NHI White Paper published in 2015 included scenarios based on growth projections of 5 per cent, 3.5 per cent and 2 per cent throughout the estimated period beginning in 2013/14 to 2025/26. However, the recovery from the global financial crisis appears to have been short-lived as economic growth has gradually deteriorated, to 0.3 per cent in 2016.
197. The underperformance in economic growth has directly led to a shortfall in expected tax revenue. Notwithstanding tax increases in previous years, the 2017 Budget raised an additional R28 billion in tax revenue, predominantly through higher personal income taxes and fuel levies, to fund existing expenditure programmes. A significant expansion in social expenditure programmes requires a sustained increase in economic growth, and the extent of this growth will determine whether large tax policy adjustments are required to fund NHI. Strong economic growth will limit the need for additional tax measures.
198. In this White Paper, after considering several scenarios the following preferred costing option was arrived at, which is a modified costing from the Green Paper on NHI.

7.3 NHI Expenditure Projections: and Cost Estimates

199. In its research brief on the Costing of Health Care Reforms to Move towards Universal Health Coverage (UHC)⁷³, the World Health Organisation (WHO) indicates that the costs associated with implementing a UHC programme are influenced by many factors, including design elements and the pace of implementation.
200. The WHO further cautions that while costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the exact number indicating the estimated costs. This is because evidence has shown that countries that have gone down this path have ended up tied to an endless cycle of revisions and efforts to dream up new revenue sources – thus focusing on issues that have more to do with tax policy than health policy. Therefore, focusing on the question of “what will NHI cost” is the wrong approach as it is better to frame the question around the implications of different

scenarios for the design and implementation of reforms to move towards UHC.

201. The financing requirement will be dependent on the services covered in the NHI, the resources needed for the NHI fund to provide comprehensive healthcare services for the population.. The funding requirements will be determined, discussed and announced during the annual budgeting process. The current subsidy to contributions through the medical tax credit will be reviewed during the phased implementation.

7.3.1 NHI Expenditure Scenarios

202. The projections set out in the Green Paper were derived from a model of aggregate costs built on projected utilisation based on demographic trends. A revised version of these projections is summarised in Table 1, based on more recent estimates of the costs of the NHI pilots and other reforms currently being implemented. In this scenario, total NHI costs in 2025 are shown as R256 billion (in 2010 terms) as in the Green Paper, but the cost increase in the early years is more moderate.

Table 1: Projection of NHI costs adapted from Green Paper

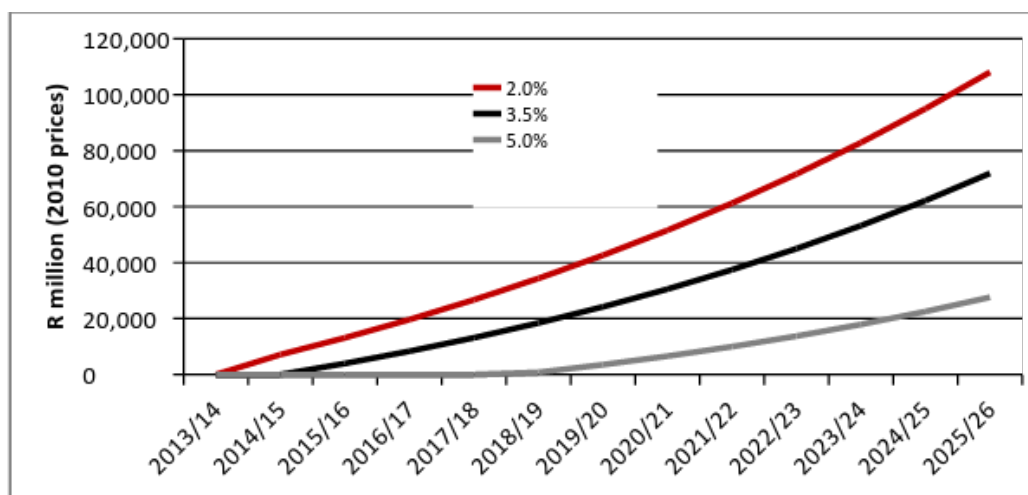
		Average annual per cent real increase	Cost Projection R m (2010 prices)
Baseline public health budget:	2010/11		109 769
Projected NHI expenditure:	2015/16	4.1%	134 324
	2020/21	6.7%	185 370
	2025/26	6.7%	255 815
Funding shortfall in 2025/26 if baseline increases by:		2.0%	108 080
		3.5%	71 914
		5.0%	27 613

Source: National Treasury projection (2012)

203. In this projection, NHI expenditure increases by 6.7 per cent a year in real terms after 2015/16, resulting in a cost projection in 2025/26 of R256 billion in 2010 prices. These projections would take the level of public health spending from around 4 per cent of GDP currently to 6.2 per cent of GDP by 2025/26, assuming the economy grows at an annual rate of 3.5 per cent. This increase would be below the level of public spending (as a percentage of GDP) of many developed countries.
204. There are many factors that influence health expenditure. These include trends in population health service needs and utilisation (e.g. epidemiological trends, rates of hospitalisation and use of outpatient services). It also depends on supply capacity, such as availability of health facilities and professional personnel as well as the prices of supplies and services. Policy options that will impact on costs include the range of private service providers from whom services are purchased and the reimbursement arrangements. Costs will also depend on the extent to which economies of scale are achieved through active purchasing and the effectiveness of cost controls.

205. In making long-term forward estimates of health service expenditure, it must be anticipated that medical costs will rise over time – independent of NHI implementation – because of factors such as population ageing, technological advances and higher demand for healthcare. Total health expenditure growth will be influenced by expansion of comprehensive healthcare services, the extent to which users come to trust the health services covered by the NHI Fund and choose to reduce voluntary health insurance cover.
206. The main cost estimate used by the National Treasury for the purposes of modelling revenue raising options is presented here. These are set out in 2010/11 constant prices and can be compared with the public health spending baseline of around R110 billion in 2010/11. It must be stressed that these are illustrative projections and do not represent the actual expenditure commitments that will occur from the phased implementation of NHI. Figure 2 illustrates the funding shortfall for alternative baseline resource growth projections.

Figure 5: Funding shortfall under different growth paths



207. The funding shortfall is R71.9 billion in 2025/26 if the baseline increases by 3.5 per cent a year. It would be R27.6 billion if baseline resources grow by 5.0 per cent a year (in real terms) and would be R108 billion if baseline resources grow by 2.0 per cent per year. Over the long run, the pace of economic growth is an important indicator of overall growth rate in health expenditure.
208. This projection also does not take into account the health system’s absorptive capacity and personnel requirements or the dynamics of the accompanying public and private sector health service reforms. As people make greater use of health services under NHI, their expenditure on private health services would decrease.

7.3.2 Estimates of Public and Private Health Expenditure

209. South Africa spent approximately 8.6 per cent of GDP on health services in 2013/14, with an annual average real increase in spending of 1 per cent a year over the past three years (Table 2).

Table 2: Health expenditure in SA public and private sectors, 2012/13 – 2019/20

Rand million	13/14	14/15	15/16	16/17	17/18	18/19	19/20	Annual nominal change
Public sector								
National Department of health core	2 243	3 955	4 610	4 526	5 105	5 450	5 770	15.9%
Provincial Departments of Health	130 672	140 868	154 074	166 406	177 838	188 044	201 211	7.4%
Defence	3 734	4 053	4 243	4 474	4 587	4 906	5 371	6.0%
Correctional services	727	763	820	844	838	912	957	5.4%
Local government (own revenue)	2 869	3 389	3 730	3 927	4 163	4 409	4 660	7.5%
Workmens Compensation	2 130	1 461	2 620	2 759	2 924	3 097	3 273	12.8%
Road Accident Fund	1 009	1 155	1 216	1 280	1 357	1 437	1 519	4.0%
Education	5 561	5 875	6 133	6 458	6 901	7 305	7 716	5.6%
Total public sector health	148 944	161 518	177 446	190 676	203 714	215 559	230 478	8.2%
Private sector								
Medical schemes	129 814	140 206	151 600	164 334	177 481	191 502	206 248	8.5%
Out of pocket	22 208	23 896	25 617	27 256	28 892	30 596	32 340	6.8%
Medical insurance	3 687	4 007	4 356	4 635	4 913	5 203	5 499	7.4%
Employer private	1 762	1 915	2 081	2 215	2 348	2 486	2 628	7.4%
Total private sector health	157 471	170 024	183 654	198 440	213 633	229 787	246 715	8.2%
Donors or NGOs	7 970	8 369	8 787	9 349	9 910	10 495	11 093	11.1%
Total	308 824	334 036	363 754	392 007	420 356	448 537	480 570	8.0%
<i>Total as % of GDP</i>	8.5%	8.6%	8.9%	8.9%	8.9%	8.7%	8.7%	
<i>Public as % of GDP</i>	4.1%	4.2%	4.3%	4.3%	4.3%	4.2%	4.2%	
Public as % of total government expenditure (non-interest, main budget)	15.1%	15.3%	15.2%	15.7%	15.7%	15.4%	15.2%	
Private financing as % of total	51.0%	50.9%	50.5%	50.6%	50.8%	51.2%	51.3%	

Source: National Treasury, 2017

210. Within the estimated health expenditure total for 2016/17, 4.3 per cent of GDP (R190.7 billion) was accounted for in the public sector, 4.4 per cent of GDP through private financing streams (R198.4 billion) and 0.2 per cent through donors. The largest public spending is by provincial Departments of Health at 3.8 per cent of GDP and the largest private spending channel is through medical schemes (3.7 per cent of GDP).

211. The table above shows the total spending in the health system (public and private). The private sector health expenditure by medical schemes in 2016/17 is estimated at R164.3 billion. This amount includes preliminary estimates of R20 billion which is the State's contribution to some medical schemes as a subsidy for state employees (This figure excludes contributions by the state to Polmed, Parmed and State-owned entities). The Medical Tax Credit provides a tax credit to individuals for their own contributions and contributions on behalf of dependents to medical schemes. The tax revenue foregone for this purpose amounted to R18.5 billion in 2014/15, covering workers employed in the public and private sector. These amounts are not available for the uninsured population.

7.4 Raising Revenue to Finance NHI

7.4.1 Economic growth and financing public health expenditure

212. The implementation of NHI will result in growth in public care health financing. The share of public expenditure on health will also be affected by restructuring of medical scheme

arrangements in response to the services covered by the NHI Fund. Over the medium to long term, a moderate rise in the share of health services in GDP is possible – many countries have exhibited a rise in the ratio of health expenditure to GDP over the past century.

213. Mobilisation of fiscal resources as a result of economic growth need not require significant changes in the tax structure. Raising revenue associated with a shift from private spending to public health expenditure requires careful planning. Within the income accounts of households, this means a declining burden of medical scheme contributions, offset by a rise in general tax allocations to be directed towards NHI. However, the impact on individuals and families will vary, depending on details of NHI design, and depending also on household choices or behaviour. The transition is easier to manage if GDP growth is more rapid, so that tax changes can be introduced without unduly impacting on household's disposable income.

7.4.2 Principles of tax design

214. The options for raising tax revenue to meet the health expenditure requirements as the phased implementation of NHI progresses are based on the following principles:
- a) Equity
 - b) Efficiency
 - c) Simplicity
 - d) Transparency and certainty
 - e) Tax buoyancy
215. The aim is to seek a revenue mix that meets these principles best and which will foster social solidarity and public acceptability. The proposed funding mechanism must be sustainable over the long term and ensures that the NHI reforms are appropriately funded. These tax design objectives correspond closely with the guiding principles of NHI, which include social solidarity, right to access, equity, efficiency, effectiveness, affordability and appropriateness.
216. A tax system can support specific social objectives in addition to its revenue raising function. Progressive income tax contributes to social cohesion by redistributing resources across income levels. Tax design can also assist in addressing externalities or other market failures, including several important health objectives. For instance, the South African tax structure includes excise taxes on alcohol and tobacco products, in view of the social cost associated with their consumption.
217. Finding the right balance in its financing arrangements is a key element to implementing a sustainable, efficient and equitable NHI system. Key choices need to be made regarding the following: (1) the appropriate tax base; (2) the appropriate tax mix; (3) the appropriate trade-off between efficiency and equity; and (4) the degree of progressivity. These concepts are discussed in more detail below.

7.4.2.1 Efficiency and Equity

218. Many tax reforms over the past two decades were aimed at broadening the tax bases and lowering rates. Increasing tax rates may generate higher revenue, but only up to a point, above which higher tax rates are counter-productive and revenue may decline. This is largely as a result of induced changes in behaviour and, in some instances, tax avoidance (and evasion) responses that have negative effects on the morale of taxpayers and the sustainability of revenues.

219. Economic growth is needed to ensure an expansion of the tax base, and if tax revenue is re-channelled into the economy in the form of productive public expenditure, it will support and stimulate growth. An efficient and cost-effective health sector will lead to improved health outcomes that will improve productivity and enhance economic growth. Crucially, in order for taxes to play a role in promoting economic growth, revenues need to be collected, allocated and spent in an efficient manner.

7.4.2.2 Tax Mix

220. Tax instruments can be classified as direct or indirect taxes. A direct tax is a tax imposed on a source of income (e.g. personal income tax, corporate income tax). An indirect tax is imposed on the use of income (e.g. consumption expenditure), such as goods, services or financial flows. The appropriate mix between direct and indirect taxation is relevant to the question of how NHI should be financed.

221. Direct taxes can best address equity concerns, while indirect taxes are important sources of revenue and can also influence behaviour, for example through taxes on alcohol, tobacco, and fuel. Indirect taxes also derive revenues from those outside the income tax net, such as informal enterprises. Consumption or expenditure taxes tend to be more conducive to economic growth, although concerns about their potential regressive impact should be taken into account.

222. Personal income tax is more effective from a redistribution and vertical equity perspective, but high marginal rates might have distortionary economic impacts. Payroll taxes raise the cost of employment and may have adverse effects on job creation. Value-added tax is less distortionary and more conducive to economic growth, but it is perceived to be regressive.

7.4.2.3 Progressivity

223. When the tax payable as a percentage of income remains constant (irrespective of the level of the income), the tax instrument is said to be proportional. When the tax liability as a percentage of income increases as income increases, the tax instrument is said to be progressive, and where this ratio decreases as income increases the tax instrument is said to be regressive. A progressive tax system plays an important role in redistributing resources to facilitate a more equitable society.

224. When expressing a view on the distributive impact of taxes, it is important to take into account the overall incidence of the entire tax system (or fiscal system, including taxes and expenditure), rather than focus on one tax instrument in isolation.

7.5 Options for public funding of NHI

225. There are several options for raising revenue to fund NHI and the funding will be through a combination of various sources. The three main sources of general tax revenue in South Africa are personal income tax, value-added tax and corporate income tax. These three tax instruments accounted for 80.3 per cent of total tax revenues in 2011/12.

7.5.1 Payroll taxes

226. Payroll taxes are sometimes used as mandatory membership contributions and can be significant revenue sources. Payroll-based social security taxes usually take the form of a fixed rate of tax on earnings, levied on employees or employers, or both. An earnings ceiling may be prescribed, at which the tax is capped in nominal terms, but this results in these taxes becoming regressive.
227. A payroll tax has potential as a further extension of the South African tax structure: the present payroll tax burden is low, it would be a buoyant and stable source of revenue and it would be administratively straightforward and health is one amongst several social benefits that could be financed in this way. It is administratively feasible as it will be based on an existing administrative framework and will require minimal changes to the existing tax administration system. However, it does not draw revenue from high income individuals who are not necessarily 'employed' (e.g. those whose income is from inherited wealth, investments, etc.) and may have a negative impact on formal sector employment creation, especially for entry-level jobs.

7.5.2 Surcharge on taxable income

228. A surcharge on taxable personal income is a further option for financing NHI. The current personal income tax structure is progressive, beginning with a marginal tax rate of 18 per cent and increasing to a maximum marginal rate of 40 per cent – raised to 45 per cent with effect from the 2017/18 tax year. Taxable income is calculated as gross income minus allowable deductions (including business expenses and contributions to retirement funds). Gross income includes income from employment and capital income (interest and profits in the case of unincorporated businesses). A personal income tax surcharge would be administratively feasible in South Africa as it would be based on a well-established system.
229. A higher overall personal income tax burden would impact on the disposable income of households and could be phased in with due regard to its impact on consumption expenditure and economic activity.
230. Australia introduced a surcharge on taxable income, known as the Medicare Levy, when the Medicare programme was started in 1984. It is a supplement to other tax revenue which enables the government to meet the additional cost of providing a prescribed set of health benefits for the whole population, whereas the previous system was limited to subsidies for healthcare to groups with low incomes. However, the general tax revenue remains as the main source of funding for publicly funded health services in Australia.

7.5.3 Value-Added Tax

231. From a tax efficiency perspective, there are several arguments for favouring an increase in value-added tax. The present value-added tax rate of 14 per cent is moderate by comparison with the international average (16.4 per cent) and its base is broad, reaching both the formal and informal economies. Value-added tax is robust (buoyant) in that it generates a substantial and stable share of national income in tax revenue. Consumption taxes are generally considered less distortionary in their impact on the productive allocation of resources, they do not impact negatively on formal sector employment and they do not discourage savings, which is important for economic growth.

232. However, from an equity perspective, there is concern that value-added tax is regressive. To some extent this is offset by zero-rating basic necessities, though this relief probably benefits middle and higher income earners more than the poor (because of their higher absolute levels of spending), and some of the benefit goes to suppliers rather than benefiting consumers through lower prices.

7.5.4 Other possible tax instruments

233. While taxes on consumption and income are the main available sources of revenue, there are various other taxes and levies that could contribute to financing NHI.

234. There is an obvious appeal in the idea that duties on alcohol and tobacco products should contribute to financing health services, as their consumption adds substantially to the burden of disease and injury. This is a route that some countries have followed, though it is unrealistic to expect a major share of financing to come from these taxes. There are two main drawbacks. Firstly, high rates of tax on alcohol and tobacco products lead to an increase in illicit trade (resulting, for example, in higher consumption of tobacco products that are neither taxed, nor subject to health regulations). Secondly, the revenue-raising potential is insufficient relative to the quantum of health financing required.

235. For the 2015/16 tax year, about R17.3 billion in revenue was raised from cigarette sales and R21.7 billion from taxes on alcohol sales. Even substantially higher rates of tax would not yield sufficient revenue to meet long-term health financing needs, in part because of the loss to illicit trade and in part because these products make up a small and possibly declining share of overall consumption. Excises or duties on other non-essential goods and services, and taxes on wealth or property, are sometimes proposed as options for health service funding. The securities transfer tax (STT), currently payable at a rate of 0.25 per cent, contributed R 5.5 billion to the fiscus in 2015/16. The Estate Duty is a form of wealth tax, which yielded R2 billion in 2015/16.

236. While these are possible revenue sources, there are no clear reasons why they should be dedicated to health expenditure rather than general revenue. In respect of their revenue collecting potential, these options have little to offer by comparison with taxes on income and consumption. Furthermore, it is impractical to base health financing arrangements on taxes that are intrinsically unreliable or volatile as sources of finance, or costly to collect.

237. In exploring NHI financing options, consideration might also be given to the implications of the carbon tax proposed as part of South Africa's efforts to mitigate the effects of climate change. During the first phase, the proposed carbon tax regime, which will allow a minimum tax-free threshold of 60 per cent, is projected to generate over R8 billion per annum. It is not intended to increase the overall tax burden, and offsetting measures to address adverse impacts on low-income households and industry competitiveness will be introduced. Depending on the exact quantum of tax revenues raised and the amount of such tax revenues that will remain after funding various revenue recycling initiatives, there may be scope to reduce other taxes.

238. This might be viewed as a suitable way of contributing to NHI for two reasons. Firstly, the carbon tax can be linked to health concerns through adverse impacts on the environment and quality of life associated with climate change. Secondly, the revenue raising potential is higher than the other taxes explored and could possibly increase in subsequent phases (from 2020) as the tax

free thresholds are progressively decreased. However, this should not be seen as a tax base that will continue to expand indefinitely. The primary objective of the carbon tax is to encourage a change in behaviour through the pricing of an externality, and the ideal is to see an eventual decline in the carbon intensity of the economy that should ultimately lead to a decrease in associated tax revenues over time.

7.5.5 Tax rate scenarios

239. NHI's financing requirements are uncertain, and in part depend on public health system improvements and medical scheme regulatory reforms which have not yet been fully articulated. It is nonetheless possible to indicate the broad magnitude of tax changes that might be required. The estimates in this section are based on the projected NHI funding gap in Table 5: Projection of NHI costs adapted from Green Paper where the baseline health budget is assumed to increase by 3.5 per cent. Tax rate changes are illustrated for the three main tax bases identified above (value-added tax, payroll taxes and personal income tax surcharge).
240. It must be stressed that these are not proposed as overall tax increases, but illustrate the tax implications of a shift from private insurance to NHI funding equivalent to about 2.2 percentage points of GDP, thereby raising an additional R71.9 billion in 2010 prices by 2025/26.
241. Table 3 sets out five alternative tax scenarios for funding the NHI shortfall by 2025/26. In scenario A, the financing measures for NHI would include the introduction of a payroll tax, a surcharge on taxable income and increases in the rate of value added tax, in several stages. Alternative tax scenarios could utilise a combination of the surcharge with a payroll tax (scenario B), a surcharge on taxable income with an increase in value added tax (scenario C), a payroll tax with a surcharge on taxable income (scenario D) or a surcharge on taxable income alone (scenario E).

Table 3: Alternative tax scenarios in 2025/26 to fund a R71.9 billion (2010 prices) NHI funding shortfall

	Payroll tax	Surcharge on taxable income	Increase in value-added tax
Scenario A: Surcharge on taxable income, VAT increase and payroll tax	1.0%	1.0%	1.0%
Scenario B: Payroll tax and surcharge on taxable income	2.0%	2.0%	
Scenario C: Surcharge on taxable income and VAT increase		2.0%	1.5%
Scenario D: Payroll tax and VAT increase	2.0%		1.5%
Scenario E: Surcharge on taxable income		4.0%	

242. The most preferred option for revenue generation for NHI will be through Scenario B which is predominantly funded through general revenue allocations, supplemented by: (1) a payroll tax

payable by employers and employees, and (2) a surcharge on individuals' taxable income. The regressive aspects of a value-added tax increase would contradict the principles upon which NHI is based.

243. As the NHI evolves, the tax treatment of medical expenses and medical scheme contributions will be reviewed. It is also expected that there will be a reduction in the need for medical scheme contributions and/or the level of coverage required. The resulting saving in tax expenditure could help to reduce to proposed tax increases. With the implementation of NHI, the role of medical schemes in the health system must change. A key step in leading to this change is that the State will have to identify all the funding for medical scheme contribution subsidies and tax credits paid to various medical schemes (such as the Government Employees Medical Scheme, the Police Medical Scheme, Parliamentary Medical Scheme, Municipal Workers Union Medical Scheme, State entity medical schemes e.g. Transmed as well as various private medical schemes to which State employees belong) and reallocate these funds towards the funding required for NHI.
244. However, it is necessary to take into account the reality that irrespective of how comprehensive the NHI entitlements will be, some personal healthcare services will not be covered. This may be as a result of these health services not fitting into the mainstream of medically necessary and efficacy-proven interventions approved for NHI. Attention will have to be given to the distributional impact of such reforms especially on those with special healthcare needs such as the disabled and the elderly.
245. Furthermore, the component of the Road Accident Fund (RAF) and the Compensation for Occupational Injuries and Diseases (COID) covering provision of healthcare services will be a source of revenue for NHI. In anticipation of broader Comprehensive Social Security Reform, it is important that there is alignment of funding allocated to compensation funds to avoid double dipping and fragmented funding. Once fully implemented, NHI coverage will also include medical benefits currently reimbursed through the Compensation Fund for Occupational Diseases and Injury (COIDA), Compensation Commissioner for Occupational Diseases in Mines and Works Act (ODMWA) and the Roads Accident Fund (RAF). Legislative amendments will accommodate these changes.

7.6 Changing landscape of Intergovernmental Arrangements

246. NHI will cover personal healthcare services that are delivered through a platform that is organised into three elements of care, namely PHC services, hospital and specialised services; and emergency medical services. The NHI Fund's purchasing of personal health services will be implemented through a phased approach.
247. Chapter 6 highlighted the importance of reorganising PHC services and hospital services to achieve improved healthcare, responsiveness, financial risk protection and improved efficiency. This will require reforms to existing practices in the delivery of public healthcare services, including moving central hospitals to the national sphere. The implementation of NHI requires that service provision management authority is increasingly delegated to the relevant/appropriate level of facility responsible for service delivery. The Department of Health will play a key role in supporting managers at these levels and monitoring and evaluating service provision.

248. The current system of public health provision, shared between national, provincial and local government, will need to be reconfigured in line with the policies contained in this White Paper and the principles contained in the Constitution. The Constitution, amongst others, requires a balance between the duty on the state to respect, protect, promote and fulfil the rights in the Bill of Rights (section 7) and the principles of cooperative governance (sections 40 and 41). Consequently, the National Health Act will be amended to re-determine functional areas, the role and responsibilities of the three spheres of Government with respect to the delivery of Health Care Services to enable the implementation of NHI. These legislative reforms will clarify the roles of the different spheres as they relate to, amongst others, PHC and level 1 (or district hospital services); secondary (regional), tertiary and specialised hospital services; emergency medical services; and environmental health services. As part of the process of amending the National Health Act, the national Department of Health will collaborate with appropriate stakeholders to finalise proposals in this regard.
249. Any reconfiguration of how public health functions are assigned and regulated amongst the three spheres of government will necessitate the concomitant reforms to intergovernmental fiscal relations in the health sector. NHI will imply some changes to the existing system of intergovernmental funding arrangements as they pertain to the health sector. The degree to which changes in intergovernmental funding arrangements are made will depend on the extent to which the NHI is structured and organised and the central pooling of funds to meet technical and allocative efficiency.
250. Functions determined by the National Health Act to be the responsibility of Provincial and Local Government will be funded through equitable share allocations and any identified conditional grants. Section 214(1) of the Constitution requires that every year a Division of Revenue Act (DoRA) will determine the equitable division of nationally raised revenue between national government, the nine provinces and 257 municipalities. The Intergovernmental Fiscal Relations Act (1997) prescribes the process for determining the equitable sharing and allocation of nationally raised revenue.
251. Any proposed changes on Intergovernmental Relations and Fiscal Arrangements (IGFR) will only be made after consultation with the Health MINMEC, Budget Council and Presidential Coordination Committee (PCC). The Financial and Fiscal Commission will be consulted once the PCC on IGFR have been consulted on the revised role of Provinces to accommodate a more unified and distributive approach to healthcare in the national interest.

7.7 Pooling of Revenue

252. NHI will be established as a single-payer and single-purchaser fund responsible for the pooling of funds and the purchasing of personal health services on behalf of the entire population⁷⁴. To reduce fragmentation and to maximize income and risk cross-subsidisation, the NHI Fund will be a single national pool of funds that will be used to purchase personal health services. The NHI Fund will be appropriately financed in order to be able to actively purchase personal health services for all who are entitled to benefit.
253. The NHI Fund will be publicly administered and the administration costs will be kept to a minimum. It will leverage its monopsony power to strategically purchase services that will benefit the entire population. Acting as a single-payer,⁷⁵ the NHI Fund will be able to yield the efficiency

benefits of economies of scale and ensure that incentive structures for healthcare providers are integrated and coherent. Pooling of financial resources will strengthen the NHI Fund's purchasing power resulting in the reduction of costs of delivering personal healthcare services and expansion of the scope of personal healthcare services offered to the entire population.

7.8 Organisation of the NHI Fund

254. The NHI Fund will be publicly administered and established through legislation as an autonomous public entity. Its functions, roles and responsibilities, governance structures and accountability mechanisms will be clearly specified. The NHI Fund will operate at a national level as a single payer and single purchaser that is publicly administered. The functions of the NHI Fund will be as follows: In addition to the internal administrative structures such as corporate services, legal, human resources, and marketing, the NHI Fund will have specific technical functional units, namely:

- a) Planning and Forecasting Unit
- b) Benefits Design Unit
- c) Price Determination Unit
- d) Accreditation Unit
- e) Purchasing and Contracting Unit
- f) Procurement Unit
- g) Information Technology Unit
- h) Provider Payment Unit
- i) Performance Monitoring Unit
- j) Risk and Fraud Prevention Unit
- k) Legislative Unit
- l) International Cooperation Unit

7.9 Governance of the NHI Fund

255. Appropriate governance mechanisms put into place for the NHI Fund, which will function as a Schedule 3A public entity. In this regard, the NHI Fund will be governed by the NHI Board that will exercise oversight over the entity. The NHI Board will report to the Minister of Health and will be accountable to Parliament. This will be an external oversight mechanism that will ensure that the NHI Fund is held accountable and that the interests of the general public are taken into account.

256. The NHI Board will not be a stakeholder representative body, but a Board with a specific mandate of ensuring that the NHIF is functional, effective and accountable. The composition of the NHI Board will be based on experts in relevant fields which may include: healthcare financing, health economics, public health, health policy and planning, monitoring and evaluation, epidemiology, statistics, health law, labour, actuarial sciences, taxation, social security, information technology and communication. The Board will also include civil society representatives. No one with a conflict of interest in the functions of the NHI Fund may be appointed to the NHI Board. As the NHI Fund will be tax funded, it is not appropriate to appoint

members representing specific interest groups.^{76, k}

257. The NHI Fund will report on at least a quarterly basis to the NHI Board and on an annual basis to Parliament. The Fund will also prepare and disseminate publicly an annual report, which will report on financial and non-financial performance, as audited by the Auditor General. Specific performance indicators will be developed against which the Fund will be routinely assessed. Through making information available and transparent, the NHI Fund will be held accountable by government as well as the general public.

7.10 Containing costs and improving management

258. Irrespective of the structure and financing arrangements for the health system, there will continue to be upward pressures on costs, and a need to control health cost escalation through both demand and supply side measures.
259. Sustainability and value for money are key concepts in health financing globally at present. For the past 50 years, the rise of healthcare spending has consistently outpaced economic growth. Health spending in developed countries has increased at double the pace of income, with the public sector carrying two-thirds of this growth. In the context of a rapidly ageing population, concerns about growing healthcare demand and its rising costs weigh heavily on the long-term fiscal sustainability of these economies.
260. Policy efforts have sought to tackle 'excess cost growth'^l by changing incentives to providers or consumers, or a combination of both, and have also aimed to reduce administration costs. As South Africa transforms its health financing system, important lessons can be learnt from other countries' experience to tackle growing health spending and promote efficiency in the health sector. Three principal areas of cost control, supply-side, demand-side and governance measures are briefly discussed below.

7.10.1 Supply-side measures

261. International experience shows that the way in which hospitals and service providers are paid influences health expenditure patterns. Costs can be contained through volume-based global budgets and case-load payment systems for hospitals, such as DRGs, introduced in many countries without leading to deteriorating quality of care. This is explained in more detail under 8.3 Provider Payment Mechanisms.
262. Capitation payments rather than fee-for-service charges for general practitioners and other primary care providers have typically succeeded in containing overall costs, without leading to cost-shifting to higher levels of care. However, this brings complexity into the negotiation and management of alternative reimbursement arrangements and it will take time to implement such

^k While some countries have established these Supervisory Boards or Committees with membership from government, employers and employees, it has been found that such a composition often does not serve the best interests of the population. In particular, having representation of specific interest groups has made these oversight committees "incapable of making hard choices or serving as an adequate and timely forum for decision making" (Savedoff and Gottret, 2008: 207). International experience indicates that "rather than by[securing] the interests of specific economic groups, representation is increasingly shaped by the desire to incorporate a wider range of social actors, increase transparency, and involve professionals with technical expertise" (Savedoff and Gottret, 2008: 206).

^l In the health sector, spending grows faster than income ('excess cost growth'). This is associated with the organisation, financing and delivery of services, e.g. changes in medical practice and uptake of new technologies, and accounts for up to two thirds of spending growth in the OECD.

reforms in South Africa.

263. Other supply side measures include coverage rules and pre-authorization, two common methods used by purchasers to limit unjustified tests and therapies and nudge providers towards proven standard treatment pathways. Some countries have opted to control supply-side prices of both health services and medical or pharmaceutical supplies. Price-setting has been more effective in hospitals.
264. International evidence suggests that professional entry barriers and wage controls have been ineffective in containing health expenditure, and may have increased costs due to the resultant increase in the wage bill for protected professionals. More indirect measures such as the adoption of electronic health records may save money through better diagnoses, fewer duplicative tests and medical errors, and less time spent in archiving and transporting records.

7.10.2 Demand-side measures

265. Public health policy requires a coordinated strategy towards health promotion, prevention, and patient safety to limit the overall burden on hospitals and clinics. To this end, the focus in South African health policy on primary healthcare is a critical and necessary element in reducing the disease burden as far as possible. A healthy, active lifestyle and responsible behaviour should be encouraged. Entry into the health system at the lowest and most appropriate level should be incentivized through reliable local services. Evidence suggests that General Practitioner gate keeping can lead to the effective curtailment of therapies that are not clinically- or cost-effective. Appropriate information can also promote responsible use of services. A potential application for user charges is as a 'bypass fee' where individuals are required to pay some or all of the cost if referral gatekeepers are bypassed.

7.10.3 Public management and financing reforms

266. The introduction of pricing and reimbursement mechanism and other regulations (such as mandated generic drugs substitution) in pharmaceutical markets internationally has proved an effective policy lever to contain health expenditures. Other public management reforms include enhancing the role and quality of health technology assessment (HTA), promoting efficiency in health system funding allocation and freeing up resources, thus attenuating pressures on the public budget.
267. In respect of the employment of health professionals, there are also administrative improvements to consider. There is concern that limited private practice arrangements are abused, resulting in absence from duty or negligence of care in some public health facilities. But there are also examples of well-managed arrangements that bring specialist capacity into the public service, sometimes associated with teaching or consultancy duties, while allowing for private practice on reasonable terms.
268. In preparing the ground for NHI, there is a clear imperative to improve the administration and effectiveness of public health delivery, to draw on lessons of current practice and to pilot innovative approaches to partnering between public and private service providers. In the longer term, NHI reforms should narrow the gap between public and private facilities in terms of quality of care, coverage, costs and accessibility. Bridging this gap is important for increasing patient

choice, achieving efficiencies and establishing cost-effective arrangements that take advantage of both public and private sector capacity.

7.11 Linkages to Broader Social Security Reforms

269. A key pillar within the social protection framework is an equitably funded health system that promotes social solidarity, affordability and fair access to needed health services that cover the full spectrum of health promotion, prevention, curative and rehabilitative care. In countries where social protection and health are pivotally important in the developmental programme of the State, this has played a significant role in reducing high poverty levels and improving overall population health.
270. The implementation of NHI is part of government's broader programme of action as outlined in the NDP. Health forms an integral part of any country's developmental programme. The NDP recognises the integral role that social protection plays in reducing inequality and poverty. The NDP focuses on improving the opportunities for South Africans to build good, healthy lives for themselves and strategically focuses on empowering vulnerable groups such as the young, disabled and the elderly. The NDP goes on further to outline the vision for 2030 regarding a broader social protection agenda for South Africa.
271. In recognition of the proposals outlined in the draft Comprehensive Social Security Reform discussion paper, there will be an alignment of medical benefits provided by compensation funds to mitigate the challenge of double dipping. Once fully implemented, NHI coverage will include medical benefits currently reimbursed through the Compensation Fund for Occupational Diseases and Injury Act (COIDA), Compensation Commissioner for Occupational Diseases in Mines and Works Act (ODMWA) and the Road Accident Fund (RAF).
272. During the transitional phase, alignment of the benefits covered through the COIDA, ODMWA and the RAF as well as the reimbursement strategies for contracted providers will be aligned with those of NHI institutional and organisational reforms. In the short term, the NHI will contract with the various benefit funds for occupational health related diseases and injuries. However, at the maturity of NHI, all health services, including services for occupational health, will be provided for by the NHI, funded from relevant social security funds to prevent double dipping.
273. As the single purchaser of personal health services for all South Africans, the NHI Fund will take full responsibility for the pooling and disbursement of funds to strategically purchase health services from accredited and contracted public and private providers. Administratively efficient systems and mechanisms will be implemented to ensure that all funding allocated to existing compensation funds meant for personal health services are appropriately channelled into the NHI Fund as part of the broader pool for financing the purchasing of needed personal health services.
274. The actual process of implementing the shifting of funds will be undertaken through a consultative process with the relevant government departments under which the respective compensation funds fall. This will also require legislative and regulatory changes that will form part of the drafting and gazetting of the NHI Bill.

CHAPTER 8: PURCHASING OF HEALTH SERVICES

275. A key element of the NHI reforms is to create a purchaser-provider split by creating an institution that will strategically purchase healthcare services⁷⁷. Currently personal services are purchased passively in the health sector but under NHI, the Fund will be an active purchasing organisation. The NHI Fund will receive and pool funds that it will use to strategically purchase services for the entire population.
276. As an active purchaser, the NHI Fund will assess the population needs to determine health service requirements and to ensure that the required services are available through purchasing these services from accredited providers. Acting as a single-payer and single purchaser, the NHI Fund will be able to reap the efficiency benefits of monopsony purchasing power and economies of scale, and ensure that incentive structures for healthcare providers are integrated and coherent.

8.1 Purchaser-Provider Split

277. A purchaser-provider split refers to the separation of institutional and organisational components that are responsible for the purchasing and provision of health services. The purchaser is responsible for identifying population health needs and determining the most appropriate means to meet these needs. The providers are responsible for service provision and will be contracted by the purchaser to deliver health services based on the health needs of the population.
278. The NHI Fund will be the single, strategic purchaser of personal health services for the population. As a strategic purchaser, the Fund will contract directly with accredited public and private facilities at the relevant level of care, including emergency medical services through selective contracting arrangements.

8.2 Accreditation of Providers by NHI Fund

279. The accreditation process will require providers to firstly meet the minimum quality norms and standards and be certified by the OHSC, and where relevant by the appropriate statutory professional council, which will continue to register and license professionals in line with national health legislation.
280. Accreditation by the NHI Fund will be based on the health needs of the population and will require provider compliance with specific information and performance criteria. One of the criteria for accreditation of a provider to be eligible for contracting with the NHI Fund will be the routine submission of specified information.
281. The information collected will be used to monitor health outcomes and should include detailed information on the demographic (age-sex) composition and epidemiological profile of the resident or catchment population in each district, and can be used to determine the global budget on a risk-adjusted capitation basis. Providers, both the public and private, will be assessed against indicators of clinical care, health outcomes and clinical governance rather than simply on

⁷⁷Part of the active purchaser function requires that providers are contracted taking into account the cost of services to be rendered by a specific type of provider.

perceived quality of services.

282. Licensing and Accreditation criteria and standards for public and private EMS will be the same and EMS providers will be required to comply with provisions contained in the EMS Regulations⁷⁸ and any amendments thereof on Licensing and Inspections, as well as any provisions that may be stipulated by the Office of Health Standards Compliance (OHSC).
283. A key feature of the new EMS is that all medical emergency vehicles will be of a standard colour regardless of whether they are publicly or privately operated and there will be a single national emergency number to serve both public and private operators to improve services and effective response to the needs of the population.

8.3 Treatment Guidelines

284. An extensive set of treatment guidelinesⁿ already exists within the public health sector, in the form of the 'Standard Treatment Guidelines' associated with the Essential Medicine List (EML). There are three main sets of EML guidelines:
- a) Guidelines for primary health care services, which are targeted mainly at nurse prescribers but also medical officers;
 - b) Guidelines for adult care at district and regional hospitals (combined), which are targeted at medical officers and specialists (excluding sub-specialties and oncology); and
 - c) Guidelines for paediatric care at district and regional hospitals, targeted at medical officers and specialists (excluding sub-specialties and oncology). Guidelines for highly specialised services are in existence even though they are still simply brief reviews of the international evidence.
285. The NHI Fund will establish Clinical Peer Review Committees with transparent and accountable processes to mitigate the potential impact of perceived inflexibility of treatment guidelines by clinicians. This will be applicable in the management of complications and/or co-morbidities. There should also be room for flexibility in the context of local circumstances (e.g. it may not be feasible to discharge a particular patient due to lack of community level care support and no family members to provide support).

8.4 Provider Payment Mechanisms

286. The existing provider payment mechanisms currently function within the budget and associated accountability. Under NHI the provider payment mechanisms must contribute to a responsive health system by incentivising improved quality in the public sector whilst they also making delivery of healthcare efficient, affordable and sustainable. As a strategic purchaser, the NHI Fund will pay providers in a way that creates appropriate incentives for efficiency and for the provision of quality and accessible care. NHI will pay a uniform reimbursement strategy and there will be no balanced or split billing under NHI.
287. The NHI Fund in consultation with the Minister will determine its own pricing and reimbursement

ⁿThe way in which guidelines are developed, implemented and monitored, influences the likelihood that they will be followed. Trustworthy guidelines should be based on a systematic evidence review, developed by panel of multidisciplinary experts, provide a clear explanation of the logical relationships between alternative care options and health outcomes, and provide ratings of both the quality of evidence and the strength of the recommendations

mechanisms. Providers who wish to contract with the NHI Fund must comply with the stipulated pricing and reimbursement mechanisms.

288. Performance will be monitored and appropriate sanctions will be applied where there is deviation from contractual obligations. The contracts will also stipulate the reimbursement strategy that will be applied. Contracts will be reviewed on a regular basis taking into account health system priorities, epidemiological changes and provider performance. The performance of the contracted providers will be monitored and evaluated by the Performance Monitoring Unit of the NHI Fund.
289. The NHI Fund will use its various payment mechanisms to leverage the provision of efficient and quality services through linking provider payment to their performance and compliance with accreditation criteria. The reimbursement system will be regularly reviewed and refined taking into account implementation experiences and budget impact assessments.

8.4.1 Provider Payment at Primary Health Care Level

290. At the PHC level, the main mechanism that will be used to pay contracted providers will be a risk-adjusted capitation system with an element of performance-based payment. Capitation-based provider reimbursement systems are best suited for PHC services, and will take into account the re-engineered PHC. A key issue will be to determine the capitation rate (i.e. the average cost of providing the clinic and community-based services per person and similarly for CHC services, and later on appropriately adjusted according to age-sex categories).
291. There will be a gradual phasing in of the provider payment mechanisms over the implementation period of NHI. Once routine and reliable data becomes more readily available on the diagnoses of patients and services provided, additional steps will include refining the risk-adjusted capitation formula that is used to determine the global budget for each clinic and contracted multidisciplinary group practices. This would particularly relate to taking account of the epidemiological profile of the catchment population.
292. The annual capitation amount will be linked to the registered population, target utilisation and cost levels. Contracted public and private providers will be paid in a manner appropriate to their contract which may include price and volume contracts.
293. Consideration will be directed towards the introduction of complementary payment methods to enhance incentives for providers. The types of payments will be carefully designed and monitored to mitigate some reported adverse consequences of 'pay-for-performance' initiatives.
294. To deal with any potential adverse effects of capitation funding, there will be routine monitoring of provider practices, particularly in relation to the use of treatment protocols and clinical guidelines for key diagnoses and referral patterns.
295. Fee-for-Service (FFS) will not be used in general as a mechanism for provider payment at PHC level because by its nature, payment is limited to one provider for one interaction.

^oIt should be noted that a recent systematic review of evidence on the impact of alternative provider payment mechanisms (Lagarde *et al.*, 2010) found no evidence supporting the 'conventional wisdom' that capitation leads to decreased service provision. The review found some evidence contradicting this hypothesis about the impact of capitation payments.

8.4.2 Provider Payment for ambulatory private specialist services

296. Services purchased from private specialists will initially be reimbursed using a capped case-based fee adjusted for complexity where. This will be continuously reviewed taking into account access and budget impact assessment. Purchasing of diagnostic services such as pathology and radiology services will employ a cost-based tariff schedule and volume contracts based on the needs of the catchment population and using a capitation based reimbursement model. These contracts will specify the expected volume of services to be provided and the cost that will be reimbursed for the specified volumes. Such contracts will also specify the case-based fee that will be paid for services above the specified volume threshold, which is usually set at the marginal cost of providing these services.

8.4.3 Provider payment at hospital level

297. Payment related to services delivered would be determined through a system of case-mix activity adjusted payments (such as Diagnosis-Related Groups or DRGs).
298. As with PHC providers, moving towards this payment system should be phased in over time, with a gradual transition to global budgeting based on crude activity estimates (as opposed to line-item budgeting) for hospitals. The gradual transition will allow hospitals to adjust their service organisations and provision arrangements in preparation for moving to the next phase. The development of a base DRG started in 2014 and the full DRG will be implemented in the central hospitals and extended to other tertiary, regional and district hospitals.

8.4.4 Payment for Emergency medical services (EMS)

299. EMS will be provided by accredited and contracted public and private providers. Payments for EMS will largely be a capped case-based fee with some adjustments made for case severity where necessary.

8.5 NHI information systems

300. The NHI Fund will contribute to an integrated and enhanced National Health Information Repository and Data System. This system will be crucial for the implementation and effective management of the NHI and the portability of services for the population.
301. The NHI Fund's information system will be based on an electronic platform, with linkages between the NHI Fund membership database and the accredited and contracted healthcare providers. The information system will be crucial for the implementation of the NHI and the portability of services for the population.
302. The information systems of the NHI Fund will be developed to support:
- a) Monitoring of the extension of coverage in all population sectors;
 - b) Tracking of health status of the population and production of disease profile data for use in computing capitation allocations;
 - c) All the financial and management functions;
 - d) Utilisation of healthcare services by those entitled to NHI services and how this information

must be used to support planning and decision making around contracting, purchasing and communication strategies;

- e) Quality assurance programmes for healthcare providers;
- f) Production of reports for health facilities and health system management; and
- g) Research and documentation to support changes as the healthcare needs of the population change.

8.6 Health Technology Assessment

303. The practice of Health Technology Assessment (HTA) is still at its infancy stage. While there are some research institutions grappling with the field of HTA and its applicability within the health care system, there remains a significant gap with regards to overall HTA coordination, systematic application within the policy and decision making spaces, as well as how best HTA can be applied to ensure cost-effectiveness and accessibility of needed interventions and priority setting more generally. Currently, HTA in one form or another is undertaken by various players within the health sector, but there is no single national policy that is implemented through an appropriately legislated entity.
304. In implementing NHI, HTA will inform prioritisation, selection, distribution, management and introduction of interventions for health promotion, disease prevention, diagnosis, treatment and rehabilitation. Efficient use of resources is a crucial factor for achieving a sustainable health system especially when significant increase in access to essential medicines, including generic medicines, medical devices, procedures and other healthcare interventions are envisaged. A single national policy using a legislated entity will conduct HTA.

8.7 The future role of Medical Schemes

305. Making progress towards universal health coverage requires transformation and reconfiguration of institutions for pooling of funds and purchasing of services to achieve income and risk cross-subsidisation whilst improving the efficiency in purchasing of personal health services. NHI funding will be mobilised through mandatory prepayment. Individuals will not be allowed opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise NHI healthcare services.
306. One of the core objectives of NHI is to optimise the utilisation of available resources, including financial and human resources. To this effect, it is important that mechanisms are put into place to streamline healthcare services to ensure value for money and to eliminate duplicative cover and double dipping.
307. Medical schemes currently operate as voluntary prepayment health financing intermediaries, offering private medical insurance cover to those that can afford it and are employed. Medical schemes are funded from the contributions of employees and employers in various permutations. The State makes contributions to medical schemes on behalf of its employees, mainly in the form of subsidy contributions and tax credits administered via the tax system. In many instances, medical scheme benefits for many individuals and households ends with the termination of a person's employment, such as upon retirement or retrenchment, which means that such individuals and households will then fall back onto the State for the healthcare they need.

308. With the implementation of NHI, the role of medical schemes in the health system will change and once NHI is fully implemented medical schemes will offer complementary cover to fill gaps in the service coverage offered by the NHI. A key step in leading to this change is the consolidation of Government funding on medical schemes. The State will identify all the funding for medical scheme contribution subsidies and tax credits paid to various medical schemes (such as the Government Employees Medical Scheme, the Police Medical Scheme, Parliamentary Medical Scheme, Municipal Workers Union Medical Scheme, State-owned entity medical schemes e.g. Transmed as well as various private medical schemes to which State employees belong) and consolidate these into the NHI funding arrangement.
309. Government recognises that there is existing expertise residing in the medical schemes industry. Where necessary and relevant, this expertise may be drawn upon to support the implementation activities for the establishment of a single payer, publicly-administered NHI Fund to build in-house capacity.

CHAPTER 9: PHASED IMPLEMENTATION

310. The process of policy development started in 2012 and included piloting of health system strengthening initiatives. Activities in the initial phase were funded through a combination of sources which included National Health Conditional Grant such as the direct and indirect NHI Conditional Grants as well as the Health Infrastructure Grants. Workstreams were established to further refine the policy and incorporate comments as well as make recommendations for the phased implementation of NHI. As the NHI pilots phase has come to an end, some useful lessons have been learnt in the implementation of integrated school health services, maternal and child health initiatives, district clinical specialist teams and the PHC outreach teams will be taken forward during this phase. These lessons will be scaled up in the next phases of implementation.
311. The next phase extends from 2017 to 2022, which will focus on the development of the NHI legislation and amendments to other legislation. Initiatives will be undertaken that are aimed at establishing institutions that will be the foundation for a fully functional NHI Fund. This phase will also entail purchasing of personal healthcare services for vulnerable groups such as children, women, people with disability and the elderly. Health systems strengthening initiatives will continue to be implemented.
312. The following institutions will be established during the second phase of implementation:
- a) Establishment of National Tertiary Health Services Committee**
313. The National Tertiary Health Services Committee will be a technical implementation committee established by the Minister of Health in terms of section 91(1) of the National Health Act, 2003. It will be responsible for developing the framework governing the Tertiary services platform in South Africa. It will also be responsible for overseeing the establishment of Central Hospitals as semi-autonomous entities.
- b) Establishment of National Governing Body on Training and Development**
314. This Committee will be established by the Minister of Health in terms of section 91(1) of the National Health Act, 2003. The Committee will, amongst others, be responsible for advising on the vision for health workforce matters and for recommending policy related to health sciences student education and training to the Minister of Health, including a human resources for health development plan. It will also oversee and monitor implementation of the policy and evaluate its impact. The committee will coordinate and align strategy, policy and financing of health sciences education.
- c) Establishment of Contracting Unit for Primary Healthcare Services**
315. The Contracting Unit for PHC (CUP) will be established at the District level. The CUP will be structured in a cooperative management arrangement with the district hospital linked to a number of PHC facilities.

d) Establishment of the NHI Fund

316. The NHI Fund will be established through legislation and will require the development of systems and processes to ensure its effective functioning and administration in anticipation of a fully functional Fund. The systems that must be developed concurrently with the legislative process include the development of a provider payment system (such as Capitation and the DRG systems), health patient registration system, health provider registration system and fraud and risk mitigation system.
317. An NHI implementation team will be established as a government component reporting to the Minister of Health. The team will act as transitional structure responsible for implementation of the service benefits, pricing and reimbursement framework, purchasing of healthcare services for vulnerable groups in the population.

e) Establishment of other Interim Structures in Preparation for the NHI Fund

318. Several interim structures will be established prior to the finalisation of the NHI Legislation. These structures will be precursors to the functional units of the NHI Fund and the NHI Board. The following are the interim structures that will be established during this phase:

i. Ministerial Advisory Committee on Health Care Benefits for National Health Insurance

319. Ministerial Advisory Committee on Health Care benefits will be established as a precursor to the NHI Benefits Advisory Committee. This Committee will advise the Minister on a process of priority setting to inform the decision-making processes of the NHI to determine the benefits to be covered. This committee will consist of a panel of medical and other experts to recommend healthcare services covered under NHI and to advise the Minister of Health on the clinical, social, financial and health impact of benefits to be covered under NHI.

ii. National Health Service Pricing Advisory Committee

320. The NHI Fund in consultation with the Minister will determine its own pricing and reimbursement mechanisms. This Committee will also advise the Minister on strategies to address the escalating costs of delivering healthcare services that will ensure sustainability of the NHI Fund.

iii. National Advisory Committee on Consolidation of Financing Arrangements

321. This Committee will advise the Minister on the strategies to be followed in consolidating current fragmented funding pools in the medical schemes environment. Furthermore, this Committee will advise during the transition phase, on the alignment of the benefits covered through the social security funds, COIDA, ODMWA, and the RAF. During the transition, the tax credits and subsidies paid to various medical schemes will be consolidated these into a single pool NHI funding arrangement.
322. Amendments to the Medical Schemes Act will be initiated as part of the broad phased implementation. Medical schemes will evolve and consolidate during this phase to provide complementary cover. In the initial stages, all benefit options in the various schemes will be consolidated from the current 323 benefit options in 83 schemes to one option per scheme.

Schemes covering state employees will be consolidated into one scheme, the Government Employee Medical Scheme (GEMS). The other activities to be undertaken will involve the creation of a uniform information system and standardisation of healthcare services across the medical schemes to be aligned to comprehensive healthcare services for NHI.

iv. Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance

323. This Committee will be established to advise the Minister on Health Technology Assessment (HTA). It will be a precursor to the HTA agency that will regularly review the range of health interventions and technology using the best available evidence on cost-effectiveness, allocative, productive and technical efficiency and HTA. It will consist of a panel of multi-disciplinary experts to recommend prioritisation, selection, distribution, management and introduction of interventions for health promotion, disease prevention, diagnosis, treatment and rehabilitation.

324. Activities to be undertaken by the Implementation Team include:

f) Health Patient Registration Process (HPRS)

325. Health Patient Registration is an activity that will take place throughout the life-cycle of the population and NHI. Vulnerable groups, such as women, children, older persons and people with disabilities, orphans, adolescents and rural populations will be prioritised. The identification of the population with the greatest need will be based on criteria consistent with the principles of the Constitution. The population will be registered using the unique identifier that is linked to the Department of Home Affairs' identification system. The registration information will be from cradle to grave and will be encrypted. The information will be utilised to access services at different levels of the health system.

g) Accreditation of Health Care Providers

326. In preparation for a fully functional NHI Fund that can contract with providers, accrediting NHI ready Clinics, private PHC providers and public hospitals will be initiated. This would require that health establishments are inspected and certified by the Office of Health Standards Compliance (OHSC), health professionals are licensed by respective statutory bodies and health care providers comply with criteria for accreditation in readiness for contracting with the NHI Fund.

h) Development of Provider Payment Mechanisms

327. Alternative reimbursement mechanisms will be developed for NHI during this phase of implementation. At a PHC level, a Risk Adjusted Capitation will be the main mechanism that will be used to pay contracted providers will be a risk-adjusted capitation system with an element of performance-based payment. This system will be developed during this phase

328. At a hospital level, a case-mix system for the reimbursement for hospitals' and medical specialists' services will be developed. The payment will be related to services delivered and would be determined through a system of case-mix activity adjusted payments (such as Diagnosis-Related Groups or DRGs).

- i. Defined as the whole set of activities and interventions of the hospital and medical specialist resulting from the first consultation and diagnosis of the medical specialist in the hospital
- ii. These tariffs apply to all hospitals and include two separate components: a reimbursement of hospital costs and an honorarium for medical specialists.

i) Phased Implementation of Purchasing of NHI Service Benefits

329. During the early stages of this phase the NHI Fund will purchase personal health services such as PHC 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 PHC level focusing on disease prevention, health promotion, provision of PHC services and addressing certain critical backlogs. The implementation of prioritised NHI service benefits will be phased in over the next two years starting with the following services:

- i. Common set of maternal health services: All pregnant women will access antenatal care provided within the public and private sector. Benefits will include up to eight antenatal visits and delivery. The costs of delivery in-facility will be covered with progressive inclusion of private facilities over time. Family planning services including oral contraceptives, injectables and sub-dermal implants will be available for females from age 15 to 40.
- ii. Expansion of the integrated school health programme: Previously screened children with identified problems will receive follow up-care from relevant professionals in both the public and private sectors, including any assistive devices (e.g. hearing aids, spectacles, and other corrective devices). In addition, all children entering Grade 1 in 2017 will be screened and referred for follow up-care from relevant professionals in both the public and private sectors, including any assistive devices (e.g. hearing aids, spectacles, and other corrective devices). The school health service programme will be expanded to all primary schools in South Africa. In the medium to long term, all children in Grade 1-12 will be screened and referred for follow up-care from relevant professionals in both the public and private sectors including any assistive devices.
- iii. The elderly will be prioritized and targeted for interventions to remove surgical backlogs, starting such cataracts and hip and knee replacements.
- iv. Mental Health Services will be prioritized for screening, referral and care.

330. The initial funding will be required to establish the Fund as a separate public entity and to enable the establishment of institutional arrangements as well as for purchasing initial priority healthcare services. In line with the 2017 Budget Speech, additional revenue of approximately R2-3 billion will be raised to establish the NHI Fund. Over the MTEF further restructuring of the tax rebate and medical schemes tax credit will allow for the increased revenue into the Fund. This revenue will be used to purchase services on behalf of the vulnerable groups in the population as identified above.

j) Legislative Reforms

331. The NHI legislation will be developed to establish the NHI Fund as a single fund that will pool financial resources and to strategically purchase comprehensive services on behalf of the entire population.
332. To enable the introduction of NHI, a number of existing legislation will need to be changed. These include:
- i. The National Health Act
 - ii. The Mental Health Care Act
 - iii. The Occupational Diseases in Mines and Works Act
 - iv. The Health Professions Act
 - v. The Traditional Health Practitioners Act
 - vi. The Allied Health Professions Act
 - vii. The Dental Technicians Act
 - viii. The Medical Schemes Act
 - ix. Medicines and Related Substances Act
 - x. The Provincial Health Acts
 - xi. The Nursing Act
333. There are many other pieces of legislation across all spheres of government that may be impacted upon by the introduction of NHI. These will be identified as the NHI Act is promulgated. The NHI Bill, amendments to the National Health Act and the Medical Schemes Act will be prioritized during this second phase of implementation.

k) Establishment of Governance Structures

334. The NHI Fund will be governed by the NHI Fund Board as an oversight mechanism. Relevant expertise in the fields of health care financing, health economics, public health, health policy and planning, monitoring and evaluation, epidemiology, statistics, health law, labour, actuarial sciences, taxation, social security, information technology and communication will be identified. The Board will also include civil society representatives. Once the NHI Legislation has been finalised, the NHI Board will be appointed.

l) Establishment of a fully functional NHI Fund

335. In the later stages of the second phase, a fully functional NHI Fund will be established once the NHI Act has been enacted and proclaimed. The NHI Fund will have the capabilities of purchasing personal health services from accredited and contracted public and private providers at PHC level and public hospitals.

m) Purchasing of Hospital Services to be Funded by NHI

336. During the latter stages of this phase, the NHI Fund will expand the personal health services purchased to higher levels of care from public hospitals (central, tertiary, regional and district hospitals) and Emergency Medical Services (EMS). Pathology services provided by NHLS Services will also be purchased in the latter stages of this phase.

337. The last phase will extend from 2022-2026. Health systems strengthening activities are an ongoing process and will be undertaken throughout the lifecycle of the health system in perpetuity. Other activities that will be undertaken during the last phase will be to initiate the mobilisation of additional resources as approved by Cabinet. Selective contracting of healthcare services from private providers will be undertaken during this phase. The following activities will be undertaken:

n) Introduction of Mandatory Prepayment for the NHI

338. The fully established NHI Fund will require supplementary funding mobilised through mandatory prepayment as NHI-specific taxes that are approved by Cabinet taking into account prevailing tax policies. The process of consolidating funding paid by the State towards medical scheme contribution subsidies and tax credits paid to various medical schemes to consolidate these into the single pool NHI funding arrangement would have been finalised in phase two.. The alignment and consolidation of funding sources personal healthcare services previously covered through the COIDA, ODMWA and the RAF would have been consolidated and will form part of additional revenue sources for the NHI Fund.

o) Contracting for Accredited Private Hospital and Specialist Services

339. The fully implemented NHI Fund will purchase services from accredited private specialists and private hospitals that comply with performance criteria as determined by the Fund and based on the needs in the population through selective contracting.

CHAPTER 10: CONCLUSION

340. This White Paper is aimed at achieving the goal of universal coverage in South Africa through the implementation of NHI. Implementation of NHI is consistent with the Constitutional commitment to the progressive realisation of the right of access to health services which will lead to a healthy and productive nation in the future to the benefit of all the country's inhabitants. Most importantly, the universal health system is a reflection of the kind of society we wish to live in; one based on the values of justice, fairness and social solidarity. It is consistent with the global vision that health care should be seen as a social investment and not be subject to trading as a normal commodity. The National Development Plan that also envisages universal health coverage as critical to realising the vision of a long and healthy life for South Africans,
341. National Health Insurance seeks to transform the national health system financing mechanisms. The focus of the transformation is to create a single, publicly owned and administered NHI Fund that strategically purchases personal healthcare services on behalf of the entire population from suitably accredited providers.
342. Moving towards UHC requires transformation of health service delivery and management, particularly to improve the quality in the health sector. Primary Health Care will form the heartbeat of NHI.
343. Transforming the health care financing system requires changing how revenue is collected and, even more importantly, addressing how generated funds are pooled and how quality services are purchased; this is critical for improving the use of available financial resources and the health of the population. Services will be provided free at point use meaning that hardships arising from paying for using health care will be avoided.
344. Equally importantly, making progress towards universal health coverage requires transformation in the governance of the health system and reconfiguration of institutions for pooling of funds and purchasing of services to achieve income and risk cross-subsidisation whilst improving the efficiency in purchasing of personal health services. NHI requires the establishment of strong governance mechanisms and improved accountability to the public for the use of allocated funds.
345. The success of NHI will require building a responsive health care system that is people-centred. Community involvement will be essential at all levels of the transformed systems to ensure that there is participatory governance, and accountability.
346. Implementation of NHI will require amendment of related legislation and enactment of new laws to ensure that there is not only legislative alignment but also policy consistence across government departments and spheres of government. The policy will also be subject to reviews as implementation happens to ensure that problems are addressed on time and appropriately.

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