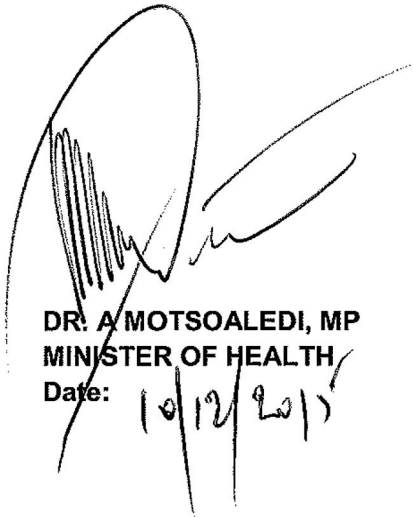

GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

DEPARTMENT OF HEALTH**NO. 1230****11 DECEMBER 2015****NATIONAL HEALTH ACT, 2003****WHITE PAPER ON NATIONAL HEALTH INSURANCE**

I, Dr Aaron Motsoaledi, Minister of Health, intend 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, to determine the policy in the Schedule.

Interested persons are invited to submit any substantiated comments or representations on the proposed policy to the Director-General: Health, Private Bag X828, Pretoria 0001, and Email: nhi@health.gov.za, within a period of three months from the date of publication of this notice.



DR. A MOTSOLEDI, MP
MINISTER OF HEALTH
Date: 10/12/2015



NATIONAL HEALTH INSURANCE FOR SOUTH AFRICA

TOWARDS UNIVERSAL HEALTH COVERAGE

Friday, 11 December 2015

Version 40

Contents

CHAPTER 1: INTRODUCTION AND BACKGROUND	1
1.1 Introduction.....	1
1.2 Background	4
1.2.1 Historical Context of Health Care Financing Reforms.....	4
1.2.2 Progress since the advent of Democracy	5
1.3 International Context	7
CHAPTER 2: DEFINITION, FEATURES AND PRINCIPLES OF NHI	9
2.1 Definition	9
2.2 Features of NHI	9
2.3 Principles	10
CHAPTER 3: PROBLEM STATEMENT	12
3.1 Structural problems in the health sector.....	12
3.1.1 Cost drivers in the public health sector	12
3.1.2 Costly private health sector.....	12
3.1.3 Quality of healthcare services	14
3.1.4 Curative hospi-centric focus of the health system.....	14
3.1.5 Mal-distribution and inadequate Human Resources for Health.....	15
3.1.6 Fragmentation in funding pools.....	15
3.1.7 Out-of Pocket Payments	16
3.1.8 Financing systems that punish the poor.....	17
3.2 Burden of Disease	18
CHAPTER 4: RATIONALE AND BENEFITS OF NHI	21
CHAPTER 5: NATIONAL HEALTH INSURANCE COVERAGE	24
5.1 The Three Dimensions of Universal Health Coverage	24
5.2 Population coverage.....	24
5.3 Service coverage.....	25
5.3.1 Expanding access to pharmaceutical services	28
5.3.2 Expanding access to laboratory services.....	28
5.3.3 Expanding access to radiology services	28
5.4 Cost coverage	29
5.5 A new health service platform	29
CHAPTER 6: ORGANISATION OF THE HEALTH CARE SYSTEM AND SERVICES UNDER NHI	31

6.1	PHC Re-engineering	32
6.1.1	Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs) ...	32
6.1.2	Integrated School Health Programme (ISHP)	33
6.1.3	District Clinical Specialist Teams (DCSTs)	33
6.1.4	Contracting private health care providers	34
6.2	Strategies to enhance effectiveness of the health care system	35
6.2.1	Improving management and governance at PHC level.....	35
6.2.2	District Health Management Offices (DHMOs)	35
6.2.3	Health Promotion and the National Health Commission	36
6.3	Hospitals and Specialised Services under NHI	36
6.3.1	Definitions of services to be delivered in reorganised hospitals.....	37
6.3.2	Role, functions, management and governance of Central Hospitals	38
6.3.3	Role and management of other levels of public hospitals	39
6.3.4	Governance of public hospitals	40
6.4	Establishment of the Office of Health Standards Compliance (OHSC).....	40
6.5	Implementation of National Quality Standards for Health	40
6.6	Enhancing human resources for health.....	41
6.7	Improving access to pharmaceuticals services	42
6.8	Improving the efficiency of National Health Laboratory Services (NHLS).....	42
6.9	Improving access to Emergency Medical Services	44
	CHAPTER 7: FINANCING OF NHI	45
7.1	Expenditure Projections and Cost Estimates for NHI	45
7.1.1	NHI Expenditure Projections: Modified costing from Green Paper	45
7.1.2	Estimates of Public and Private Health Expenditure	47
7.2	Raising Revenue to Finance NHI	48
7.2.1	Economic growth and financing public health expenditure	48
7.2.2	Principles of tax design	48
7.3	Options for expanding public funding of health services	51
7.3.1	Payroll taxes.....	52
7.3.2	Surcharge on taxable income	53
7.3.3	Increase in value-added tax	53
7.3.4	Tax rate scenarios.....	54
7.3.5	Other possible tax instruments.....	57
7.4	Other sources of revenue	58
7.5	Changing landscape of intergovernmental arrangements.....	59
7.6	Pooling of revenue	60

7.6.1 Establishment of the NHI Fund.....	60
7.6.2 Organisation of the NHI Fund.....	61
7.6.3 Governance of the NHI Fund	62
7.7 Linkages to Broader Social Security Reforms.....	62
CHAPTER 8: PURCHASING OF HEALTH SERVICES.....	64
8.1 Purchaser-Provider Split	64
8.2 Accreditation of Providers by NHI Fund	65
8.3 Contracting of health service providers	67
8.4 Treatment guidelines.....	67
8.5 Provider payment mechanisms	69
8.5.1 Provider Payment at Primary Health Care Level	70
8.5.2 Ambulatory private specialist services	71
8.5.3 Provider payment at hospital level	71
8.5.4 Emergency medical services (EMS)	72
8.6 NHI information systems	72
8.6.1 Health patient registration systems	73
8.6.2 Health provider registration system.....	74
8.6.3 National Health Insurance Risk Engine for Fraud Mitigation.....	74
8.7 Health technology assessment	76
8.8 Procurement of pharmaceuticals and goods.....	76
8.9 Containing cost and improving efficiency in resource use	77
8.10 The future role of medical schemes	80
CHAPTER 9: PHASED IMPLEMENTATION	83
9.1 Phase I of the Implementation.....	83
9.1.1 Health System Strengthening Initiatives	83
9.1.2 Moving central hospitals to the national sphere	84
9.1.3 Establishment of the NHI Fund	84
9.1.4 Institutions that will be established.....	84
9.2 Phase II of Implementation.....	85
9.2.1 Purchasing of services to be funded by NHI.....	85
9.2.2 Mobilisation of additional resources.....	85
9.2.3 Establishment of a fully functional NHI Fund	85
9.2.4 Establishment of NHI Fund Management and Governance Structures.....	85
9.2.5 Population Registration Process.....	85
9.2.6 Amendments to the Medical Scheme's Act	86
9.3 Phase III of Implementation.....	86

9.3.1	Introduction of mandatory prepayment for the NHI.....	86
9.3.2	Contracting for accredited private hospital and specialist services	86
9.3.3	Finalisation and implementation of the Medical Scheme's Amendment Act	86
	CHAPTER 10: CONCLUSION	87
	BIBLIOGRAPHY	89

List of Tables

Table 1: Projection of NHI costs adapted from Green Paper	45
Table 2: Health expenditure in SA public and private sectors, 2011/12 – 2017/18	47
Table 3: Potential revenue sources for NHI	51
Table 4: Relative contribution of different taxes	52
Table 5: Alternative tax scenarios to fund a R71.9 billion (2010 prices) NHI funding shortfall by 2025/26	55
Table 6: Average Tax rate changes and changes in tax liability	56
Table 7: Personal income tax structure in 2014/15 and under different scenarios for a surcharge on taxable income in 2025/26 (in 2014 prices)	57
Table 8: Summary of supply side and demand side cost containment measures	78
Table 9 : Alternative roles of voluntary health insurance	81

List of Figures

Figure 1: Comparing total benefit incidence with levels of health care need	18
Figure 2: The three dimensions of moving towards universal coverage.....	24
Figure 3: Funding shortfall under different growth paths	47
Figure 4: Average Tax rate changes and changes in tax liability	56
Figure 5: Sequential external evaluation requirements for NHI	66

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

1. National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families.
2. NHI represents a substantial policy shift that will necessitate a massive reorganisation of the current health care system, both public and private and also derives its mandate from the National Development Plan (NDP) of the country.
3. NHI implementation is consistent with the Constitutional commitment for the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to have access to health care services including reproductive health care. Progressively realising this right will contribute to a healthy population that benefits the entire nation. NHI is a policy shift that will contribute towards poverty reduction and addressing the inequalities inherited from the past.
4. Implementation of NHI is a reflection of 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 seen as a social investment and therefore should not be subjected to market forces where it is treated as a normal commodity of trade.
5. The South African health system has been described as a two-tiered system divided along socio-economic lines. NHI will create a unified health system by improving equity in financing, reducing fragmentation in funding pools, and by making health care delivery more affordable and accessible for the population. NHI will eliminate out-of-pocket payments when the population needs to access health care services. In the long run, households will also benefit from increased disposable income as a result of a significantly lower mandatory prepayment¹.
6. In the current system of medical schemes, only those belonging to medical schemes are able to access health services in both the private and the public sectors. Even they are usually denied access to health care before the year ends because they are supposed to have run out of benefits.
7. Population coverage under NHI will ensure that all South Africans have access to comprehensive quality health care services. This means that people will be able to access health care services closest to where they live. The health care services will be accessed at the appropriate level of care and will be delivered through certified and accredited public and private providers using the NHI Card.

¹ **Mandatory prepayment:** 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.

8. NHI will ensure a more responsive and accountable health system. A more responsive health system is likely to 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.
9. Implementation of NHI will take place in three phases over a fourteen (14) year period. The first phase takes place over a period of five years and includes strengthening of the service delivery platform and the overall improvement of quality in the public health sector.
10. Primary Health Care (PHC)² is being reengineered through four streams to improve timely access and to promote health and prevent disease. These streams are Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs); Integrated School Health Programme (ISHP); District Clinical Specialist Teams (DCSTs); and Contracting of non-specialist Health Professionals.
11. There have been numerous initiatives to improve management and governance of health facilities at PHC and hospital levels, and these will be further strengthened in terms of structure, powers, delegations, financial management and accountability.
12. The Office of Health Standards Compliance (OHSC) has been established to assure quality of health services and it will be key in the certification of health establishments throughout the country. The Inspectorate will ensure compliance with norms and standards. The Ombuds person will enforce accountability and impose corrective measures where necessary.
13. The implementation of Operation Phakisa Ideal Clinic Realisation Programme is aimed at improving the performance and quality of health services in the PHC facilities. Operation Phakisa will later be extended to public hospitals and their quality strengthened.
14. For the proper functioning of NHI, a safe and conducive environment for patients and health workers is essential. One of the key components of such an environment is good quality public health infrastructure complete with bulk services such as provision of electricity, water supply, sanitation and waste management supported by effective transport and communication systems. For sustainability of this important component, a proper and consistent maintenance plan will be consolidated.
15. Basic structures of the NHI Fund are being put in place in preparation for its operationalisation. The creation of the NHI Fund will entail the establishment of functional, governance and accreditation structures and purchasing systems, risk mitigation systems, health technology assessment as well as systems for monitoring and evaluation systems.

²Primary health care addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. According to the WHO's 1978 Alma Ata Declaration, "primary health care is essential health care 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 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 health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process".

16. During the first phase, the structure and financing of central hospitals will be transformed into national assets as well as training platforms, research hubs and centres of excellence locally, regionally and internationally. The central hospitals will be semi-autonomous to improve management and governance so as to position them to be providers of choice for highly specialised and affordable services for the whole population. All these will necessitate central hospitals becoming a competence of the national sphere of government which will require new governance structures. These arrangements will entail strong government oversight, involvement of academia, fiduciary and management expertise and public participation. Their governance and funding model must promote good governance, academic excellence and support to lower levels of care. A transitional funding mechanism that promotes sustainable financing will be created to directly fund central hospitals.
17. The second phase of implementation of the NHI will take place over a period of another five years. In the early part of the second phase the population will be registered and issued with an NHI Card at designated public facilities using the unique identifier linked to the Department of Home Affairs. Vulnerable groups such as children, orphans, the aged, adolescents, and people with disabilities, women and rural communities will be prioritised.
18. In the early stages of phase two, a transitional Fund will be established to purchase PHC services from certified and accredited public and private providers at non-specialist level. All Ideal Clinics will be accredited for contracting with the transitional Fund. In the later stages of this phase, public hospitals certified by the Office of Health Standards Compliance (including district, regional, tertiary, central and specialised), Emergency Medical Services (EMS) and National Laboratory Health Services (NHLS) will be contracted for personal health services by the NHI Fund.
19. User fees in the form of direct out-of-pocket payments in public hospitals will be abolished to improve access to needed health services and to protect households from financial hardships.
20. The health workforce is a key pillar of the health system and the planning, development, provisioning, distribution and management of human resources will be further improved to meet the needs of the population.
21. To better utilise the available human resources for health in the country, there will be strengthening of contracting of private practitioners at the primary health care level. The expansion of contracted providers beyond general practitioners (GPs) will also include amongst others practitioners dealing with physical barriers to learning such as audiologists, speech therapists, oral hygienists, occupational therapists, psychologists, physiotherapists and optometrists for school going children. This will focus especially on those children that have been identified in quintile one and two schools, during the period of piloting of NHI.
22. In the latter years of the second phase the Medical Schemes Act will be amended so as to provide complementary cover when NHI is fully implemented.

23. The third and final phase of implementation will take place over the last four years and will focus on ensuring that the NHI Fund is fully functional. Health facilities that are eligible would have been certified by the OHSC and accredited by the NHI Fund.
24. There will be contracting of accredited private sector providers at higher levels of care such as private hospitals and specialists. During this phase, there will be mobilisation of additional revenue for the NHI through the introduction of mandatory prepayment from those who are eligible.
25. Some of the activities in the three phases will run concurrently as they are interrelated.
26. The process of developing this White Paper was preceded by the publication of the Green Paper on NHI in August 2011. Over 150 written submissions were received from interested individuals and organisations and were carefully reviewed and considered as part of the drafting of this White Paper. Inputs received from consultations with key stakeholders during national and provincial road-shows (which involved more than 60,000 people spanning over a period of four years) have also been taken into account. In addition, consultative meetings and workshops were held, some involving international experts.

1.2 Background

1.2.1 Historical Context of Health Care Financing Reforms

27. South Africa has a rich history of several proposals and attempts to implement health financing reforms namely: the 1928 Commission of Old Age Pension and NHI; 1941 Collie's Committee of Inquiry into NHI; the 1943 African Claims that proposed equal treatment in the scheme of Social Security; the Dr Henry Gluckman National Health Services Commission of 1943 to 1944 that proposed NHI; The Freedom Charter as adopted by the Congress of the People, 1955; the 1994 Ministerial Committee on Health Care Financing; the 1995 Ministerial Committee of Inquiry into NHI (Broomberg and Shisana Report); the 1997 Social Health Insurance Working Group; Professor Taylor's 2002 Committee of Inquiry into a Comprehensive Social Security System; Ministerial Task Team on Social Health Insurance and the 2009-2014 Ministerial Advisory Committee on NHI.
28. Under the African Claims in South Africa the Charter on Health states :

"a drastic overhauling and re-organisation of the health services of the country with due emphasis on preventive medicine with all that it implies in modern public health sense..., strongly urged the establishment of free medical and health services for all sections of the population; ...the establishment of a system of School Medical Service with full staff of medical practitioners, nurses and other health visitors... increased hospitals and clinic facilities both in the rural and in urban areas; Increased facilities for the training of African doctors, dentists, nurses, sanitary inspectors, health visitors (and) a coordinated control finance of health services for the whole Union" (14 December, 1943).
29. From this Health Charter in the African Claims, it is apparent that the problems faced in the 1940's are still with us today and require even more urgent attention. The reforms

described in the African Claims were envisioned to address institutionalised challenges in the health system, particularly through the establishment of a coordinated funding mechanism. The African Claims proposed the introduction of school health services and community based care services coupled with improved staffing. The aim of such a system was to end inequalities in access to care between the rural and urban areas amongst others.

30. At the Congress of the People in Kliptown in 1955 the same problems were identified and articulated in the Freedom Charter, which was adopted then as follows:

"A Preventative health scheme shall be run by the state.

Free medical care and hospitalization shall be provided for all with special care for mothers and young children".

1.2.2 Progress since the advent of Democracy

31. Prior to the 1994 democratic breakthrough, South Africa had a fragmented health system designed along racial lines. One system was highly resourced and benefited the white minority. The other was systematically under-resourced and was for the black majority. The Constitution has outlawed any form of racial discrimination and guarantees the principles of socioeconomic rights including the right to health. In 1994, a new single de-racialised public health system was born with national, provincial and local government services to provide comprehensive health care as stipulated in the White Paper on the Transformation of the Health Care System (Department of Health, 1997) and the National Health Act (Department of Health, 2003). These changes were aimed at improving quality, equitable access, efficiency and effectiveness of the health system.
32. Attempts to deal with the abovementioned disparities and to integrate the fragmented services that resulted from fourteen health departments (serving the four race groups, including in the ten Bantustans) did not fully address the inequities. Problems linked to health financing biased towards the privileged few have still not been adequately addressed. Post-1994 attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted. This has entrenched a two-tiered health system, public and private, based on socioeconomic status and this system continues to perpetuate inequalities in the current health system.
33. Primary health care, delivered through the district health system, was made the cornerstone of the health policy, beginning a shift from the earlier hospital-based curative approach. All user fees were abolished for pregnant women, children under six years of age and people living with disabilities. Access to primary health care services, measured in terms of visits per year, increased from 67 million in 1998 to 129 million by December 2014, with the desired concomitant decline in utilisation of public hospitals observed.
34. After 1994, the government implemented a massive infrastructure programme that saw more than 1,500 new and revitalised health facility infrastructure projects being completed, to facilitate access to healthcare facilities within a five kilometre radius of where people live. This was coupled with community based services and outreach services in underserved areas.

35. During this period efforts were also made to enhance human resources for health. To date, more than 44,000 health professionals have been deployed for community service especially in rural and underserved areas. From 1996, a large number of doctors were recruited from Cuba to further expand coverage to these underserved areas. In subsequent years more doctors were also recruited from countries such as Iran and Tunisia.
36. Government also expanded the national training platform for medical students in South Africa. Through the Nelson Mandela-Fidel Castro collaboration, a medical training programme was established in Cuba alongside the recruitment programme. As a result of this collaboration there are 3,344 medical students training in Cuba as at 2014. The domestic training platform has been expanded since 2011 by increasing student intake and plans to build new medical schools or to expand existing ones are in place.
37. Nursing remains the backbone of the South African health system. A Primary Health Care (PHC) category for nursing was introduced to support the PHC system. From 2009 to 2013, the number of nurses trained on Nurse Initiated Management of Anti-Retroviral Therapy (NIMART) increased from 250 to 23,000. This increase contributed to the massive roll out of Anti-Retroviral Therapy (ART) resulting in the largest ART programme in the world.
38. The process of strengthening the nursing colleges as the primary training platform is underway. This has been undertaken in order to reverse the trend that started in 1987 which has undermined nursing colleges through a policy which favoured universities as primary training platforms, resulting in disinvestment in nursing colleges.
39. The changes achieved in the management of health services were also accompanied by changes in procurement of medicines. In 1994 the pharmaceutical sector was characterized by lack of equity in access to essential drugs, with a consequent impact on quality of care. The introduction of a series of reforms including the development of a new drug policy, which included an Essential Drug List (EDL), standard treatment guidelines and improved affordability of medicines contributed to improved access to medicines. The public sector procurement systems were reorganised to achieve the best prices. In the private health sector a transparent pricing system has been implemented, which regulates the price of medicines in the supply chain system from manufacturer through to the patient. This system reduced the cost of medicines in the private sector by over 20% with a compound reduction of the annual price increases as regulated through the Single Exit Price (SEP) mechanism.
40. Over the period since the advent of democracy, South Africa has been able to reduce poverty-related diseases like measles, malnutrition, and malaria and improve the management of non-communicable diseases. The HIV and AIDS epidemic peaked in the 1990s. Initially, government's response to the HIV and AIDS epidemic was ambiguous but has in recent years turned the corner. During the same period the incidence of tuberculosis increased concurrently. In partnership with civil society and development partners, the country has made significant strides in reducing the tide of HIV and AIDS and tuberculosis. This has contributed to the increase in life expectancy.

41. Despite the progress that has been achieved so far including improved life expectancy, the health system's effectiveness and efficiency still remains a huge challenge. These challenges are more pronounced in relation to the inequitable financing of the health care system whereby the poor are still largely marginalised and many other South Africans are at risk of catastrophic health expenditure³.
42. Given the history outlined above, and the need to improve health system's effectiveness and efficiency, South Africa must implement NHI in line with provisions of the NDP. 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 public health sector.
43. If the above measures and other interventions are implemented, the NDP envisages that in 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"*. 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.
44. It is imperative that South Africa implements NHI 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

45. According to the World Health Organization⁴, a health system has six building blocks:
- i. Leadership/governance;
 - ii. Health care financing;
 - iii. Health workforce ;
 - iv. Medical products and technologies;
 - v. Information and research; and
 - vi. Service delivery
46. The absence, weakness and/or inefficiency of any one of these six blocks will render any health care system ineffective and adversely impact on its overall performance.
47. Health care financing is the one building block that has presented a challenge to good performing health systems. Previous attempts of health care reform worldwide that did not encompass reforms to health care financing have not always been successful in some

³ **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.

⁴The World Health Report (2007) *A safer future: global public health security in the 21st century*. WHO, Geneva.

countries whilst countries such as Mexico and Thailand are examples of countries where attempts to transform health financing have been positive.

48. Globally, countries have been encouraged by the WHO to move towards Universal Health Coverage (UHC)⁵. More recently, the United Nations adopted seventeen Sustainable Development Goals (SDGs). Goal 3.8 of the SDGs urges all countries to:

“Achieve universal health coverage including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”

49. Countries such as Brazil, Canada, Finland, Norway, Sweden, Thailand, Turkey and the United Kingdom have successfully implemented UHC systems. Access to health services and health outcomes in these countries has improved significantly taking them closer to UHC. Many countries that do not have UHC systems are actively pursuing this goal. Whether it is called ‘Obamacare’ (as in the USA) or ‘Seguro-Populare’ (as in Mexico) or ‘National Health Insurance’ (as in South Africa), the goal is the same: to ensure that the population has access to needed quality health services at an affordable cost.
50. South Africa’s 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 universal health coverage.

⁵The 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.

CHAPTER 2: DEFINITION, FEATURES AND PRINCIPLES OF NHI

2.1 Definition

51. NHI is a health financing system that is designed to pool 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. Funding will be linked to an individual's ability-to-pay and benefits from health services will be in line with an individual's need for health care. Implementation of NHI is based on the need to address structural imbalances⁶ in the health system and to reduce the burden of disease.

2.2 Features of NHI

52. NHI will have the following features:

- i. **Universal access:** 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 on the basis of need and not socioeconomic status.
- ii. **Mandatory prepayment of health care:** NHI will be financed through mandatory prepayment which is distinct from other modes of payment such as voluntary prepayment⁷ and out-of-pocket payments⁸.
- iii. **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 levels of care.
- iv. **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 direct out-of-pocket payments to accredited health service providers.
- v. **Single fund:** This refers to integrating all sources of funding into a unified health financing pool that caters for the needs of the population.

⁶**Structural imbalances:** This refers to the misalignment between resources and need, such that it 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 punish the poor, as alluded to by Dr Margaret Chan (World Health Assembly, 2012). It also includes grossly inadequate numbers of staff or the wrong mix of staff.

⁷**Voluntary prepayment:** 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 this.

⁸**Out-of-pocket payment:** Paying cash to a health care provider at the point of care each time a person is sick.

- vi. **Strategic purchaser:** In order to purchase services for all, there should 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 service providers⁹.
- vii. **Single-payer:** This refers to an entity that pays for all health care costs on behalf of the population. A single-payer contracts for healthcare services from providers. The term "single-payer" describes the funding mechanism and not the type of provider.

2.3 Principles

53. NHI will be based on the following principles:

- i. **Right to access health care**

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

"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".

- ii. **Social solidarity**

55. NHI will provide financial risk pooling¹⁰ to enable cross-subsidisation between the young and old, rich and poor as well as the healthy and the sick.

- iii. **Equity**

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

- iv. **Health care as a Public Good**

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

- v. **Affordability**

58. Health services will be procured at reasonable cost that recognises the need for sustainability within the context of the country's resources.

- vi. **Efficiency**

59. Health care resources will be allocated and utilised in a manner that optimizes value for money.

⁹ The 2010 World Health Report provides the following definition: "Passive purchasing implies following a predetermined budget or simply paying bills when presented. Strategic purchasing involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom".

¹⁰ A program created by law where 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.

vii. Effectiveness

60. This refers to the extent to which an intervention results in 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

61. The health system will adopt innovative service delivery models that are tailored to local needs of the population and delivered at appropriate levels of care.

CHAPTER 3: PROBLEM STATEMENT

62. The South African health system is presently faced with a multiplicity of problems. Much has been done over the past 20 years to resolve these problems, but two prominent problems remain persistent. These are:

- i. **Structural problems of the health system**
- ii. **Burden of disease**

3.1 Structural problems in the health sector

63. The health system experiences structural problems as a result of the following factors:

- a) Cost drivers in the public health sector;
- b) Costly private health sector;
- c) Poor quality of health services;
- d) Curative hospi-centric focus of the health system;
- e) Mal-distribution and inadequate human resources;
- f) Fragmentation in funding pools;
- g) Out-of-pocket payments; and
- h) Financing systems that punish the poor.

3.1.1 Cost drivers in the public health sector

64. The main cost drivers (other than human resources) in the public health sector are: pharmaceuticals; laboratory services; blood and blood products; equipment; and surgical consumables. These cost drivers adversely impact on efficient and effective service provision. Inefficiencies in the procurement and monitoring of hospital support services such as security, laundry and catering services also contribute to these high costs.

65. One of the key cost drivers in the public health sector is the costs of laboratory services. The National Health Laboratory Services (NHLS) had 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.

3.1.2 Costly private health sector

66. 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 entire private health care sector. Consequently, medical scheme members are not well protected from the escalating costs of health care. 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.

67. Furthermore, the private health sector is characterised by:
- a) Exorbitant costs due largely to a fee- for-service model;
 - b) Imbalance in tariff negotiations between purchasers and providers;
 - c) Small and fragmented risk pools in each medical scheme, where there is limited cross subsidy between the young and old, the sick and healthy, as well as the rich and poor.
68. High costs in the private health sector also contribute to high costs of labour in the public sector as the public sector attempts to match the high salaries in the private sector.
69. In an attempt to remain viable, medical schemes have responded by increasing member contributions at levels that are higher than CPI over the past decade, whilst the health service benefits have been reducing significantly. The schemes contributions for members have been increasing with an annual average increase that is almost double the CPI for 2015 (9.2 % when CPI is approximately 4.6%). Additionally, there are significant non-health care related costs borne by medical scheme members as a result of administration costs; managed healthcare fees; broker fees and marketing costs.
70. Private hospitals prices 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 least affordable when compared to OECD countries even for individuals of higher levels of income¹¹.

3.1.2.1 Fee-for-Service (FFS) Environment

71. 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 delivering these unnecessary services. This has been identified as one of the contributors to escalating costs in the health care system. The threat of medico-legal action has 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.

3.1.2.2 Prescribed Minimum Benefits

72. The current environment of Prescribed Minimum Benefits (PMBs)¹² 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 PMBs are based on a positive list of medical conditions and medical schemes are mandated to cover the costs related to the diagnosis,

¹¹OECD and WHO (2015) International Comparison of South African Private Hospital Price Levels.

¹²PMB'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.

treatment and care of: (1) any emergency medical condition; (2) a limited set of 270 medical conditions (referred to as Diagnosis Treatment Pairs); and (3) 25 chronic conditions (defined in the Chronic Disease List).

73. All medical schemes are mandated to pay for PMBs in full, as provided for under Regulation 8 of the Medical Schemes Act (131 of 1998). This has resulted in several problems linked to cost escalation in the private health sector, primarily because of the dominance of the fee-for-service reimbursement model as well as the increased levels of hospitalisation associated with treatment and management of PMB conditions.
74. According to the CMS 2014 Annual Report¹³, the total cost of prescribed minimum benefits (PMBs) for the schemes included in this analysis amounted to R53.7 billion. For these same schemes, R102.2 billion was paid from the risk pool for all benefits including PMBs. This means PMBs consume more than 50% of the schemes expenditure (constituting 52.5% of the total risk benefits), as opposed to the 47.5% paid to non-PMB related conditions. Prior to the 2010 CMS circulars¹⁴ on PMBs, the crude estimates indicated that in 2008 PMBs consisted of 35% of the risk pool benefits paid for by medical schemes. 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 sick and the healthy;
 - 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 and disease burdens which are 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.

3.1.3 Quality of healthcare services

75. Quality of healthcare must be adequately addressed in both the public and private sectors. 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. In addition, significant increases in utilisation due to the high burden of disease and increased patient loads have further compromised the quality of care.

3.1.4 Curative hospi-centric focus of the health system

76. The current health system is characterised by an emphasis on curative services that leaves prevention by the wayside. Furthermore, the entry level into accessing health services is mostly at an inappropriate level of care (secondary, tertiary and specialist services) rather than at a primary health care level. This has significantly contributed to the high costs of health care and the inefficiency of the health system.

¹³Council for Medical Schemes Annual Report, 2014

¹⁴Circular 56 of 2010: *Status of the code of conduct in respect of PMB benefits* and Circular 66 of 2010: *Prescribed healthcare benefits valid as ever*

3.1.5 Mal-distribution and inadequate Human Resources for Health

77. The main contributor to inequity in health care is the existence of a two-tier healthcare system where the rich pool their health care funds and resources separately from the poor. These inequities have also resulted in mal-distribution of key health professionals between the public and private health sectors, as well as urban and rural areas as well as among the districts. The scarce health professionals naturally migrate towards the private health care system which is better resourced financially relative to the population it serves.
78. Migration of health care professionals to the private sector contributes to high labour costs in the public sector as this sector attempts to retain health professionals. South Africa may have comparable human resources to countries with a similar level of development; however, health outcomes still remain poor due to this mal-distribution of human resources.
79. The shortage of key health professionals is being experienced at a time when there is growth in the size of the population that is dependent on public health services, increased patient visits in the public sector, increasing demands of school-going children for clinical and allied health services, the increasing burden of ill-health among the population, primarily due to the HIV, AIDS and TB epidemic and non-communicable diseases (NCDs), and unpredictable migration patterns. This has placed an extraordinary strain on public sector health services, and on the staff who work in public health facilities.

3.1.6 Fragmentation in funding pools

80. A major characteristic of the South African health system is in the fragmentation of funding pools within and between the public and private sectors.
81. In the private sector, there are 83 medical schemes¹⁵ 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 OECD countries.
82. 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 particular benefit option. The overall consequence of this fragmentation is that there is limited cross-subsidisation within the private medical schemes environment.
83. 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.
84. 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.

¹⁵ Council for Medical Schemes (2015): Annual Report 2014/15 – 15 years on the pulse

Fragmentation is also a key driver of inequality and contributes to inequity in the distribution of health benefits.

3.1.7 Out-of Pocket Payments

85. South Africans are exposed to three forms of out-of-pocket payments (OOPs) namely:
- Every time a patient has to pay cash when they seek healthcare whether in the public or private sectors;
 - Additional payments (co-payments or levies) for those on medical schemes but whose benefit option does not cover all the costs; and
 - Cash payment for those on medical schemes whose benefits are prematurely exhausted before the end of the year.
86. Co-payments are used in some health systems as a deterrent to service use and as a cost-containment (demand-management) measure. However, international evidence indicates that co-payments, by placing a burden on patients at the point of services, disproportionately deters use for the most vulnerable, particularly the lowest socio-economic groups and thereby entrenches inequalities in access to and use of needed health care. 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 hospitalisation.
87. 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 – H3¹⁶ users. These payments are made as OOPs expenses from these users.
88. The South African Human Rights Commission¹⁷ has also raised concerns about user fees and states:
- Primary health care is provided free of charge. Children under six years of age, pregnant women, the disabled and the indigent do not pay user fees for higher levels of care, and the National Health Act allows for free health care to be extended to other categories of users. However, in research presented to the public hearing, it was found that only half of those who visited a public hospital obtained an exemption despite all being eligible. The research also found that general private facilities were more popular than public hospitals despite the costs involved with the former. Of the households interviewed, 20% incurred “unaffordable” costs.*
89. 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

¹⁶ H1: Income < R36 000 per annum

H2: Income R36 000 - R72 000 per annum

H3: Income > R72 000 per annum

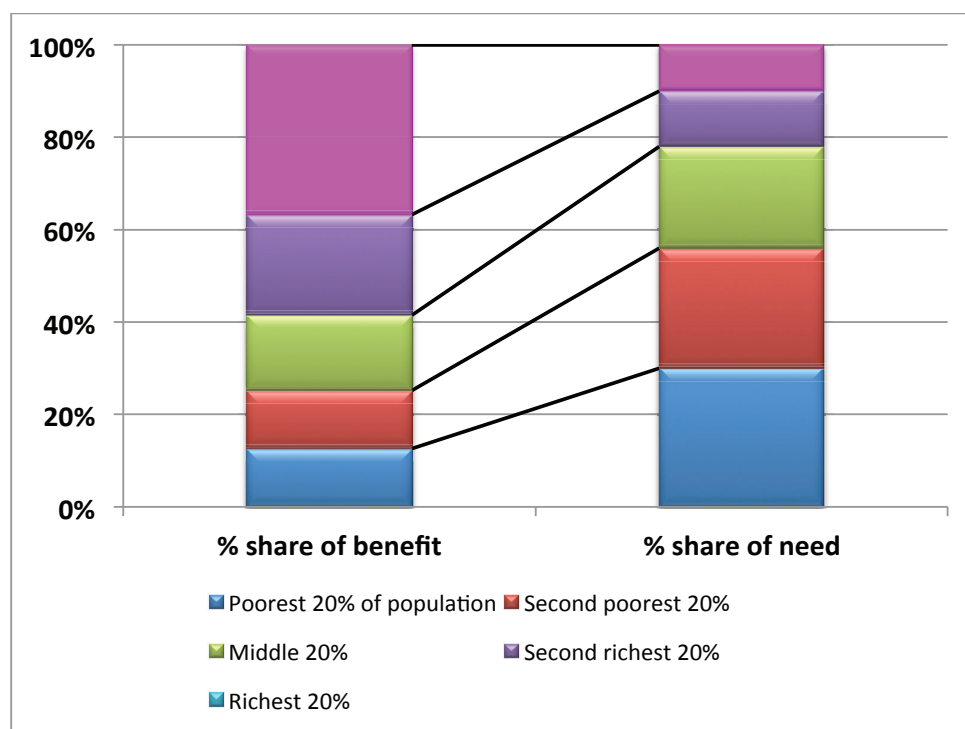
¹⁷ 2009 Report and Recommendations based on Submissions and Proceedings of the Public Hearings conducted in 2007- Public Inquiry: Access to Health Care Services

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.

90. 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.

3.1.8 Financing systems that punish the poor

91. Analysis of the available South African National Health Accounts data shows that there are three methods of financing health care namely the 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.
92. South Africa spends 8.5% of GDP on health and 4.1% of the GDP is spent on 84% of the population, the majority utilizing the public health sector whilst 4.4 % of its GDP is spent on only 16% of the population in 2015/16. Financing through medical schemes and OOPs accounts for a significant proportion of health care financing. The expenditure on medical schemes in South Africa is more than in any OECD country and represents more than 6 times the 2013 OECD average of 6.3%. This type of a financing system disadvantages the poor and leaves many citizens at a high risk of financial ruin due to catastrophic health expenditure.
93. Health care benefits are not distributed in line with the need for health care services as shown in Figure 1 below. 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%).

Figure 1: Comparing total benefit incidence with levels of health care need

Source: McIntyre and Ataguba (2012)

94. To exacerbate the inequities in health financing, both government and state owned enterprises as employers contribute significant amounts of public funds to medical schemes. Preliminary estimates indicate that the contribution by government to medical schemes (open and restricted) in 2015 is well-in-excess of R20 billion annually and these funds are mostly spent within the private health sector. This creates a fiscal problem for government as public funds are used to subsidise state employees to meet the rising costs of health care in the private sector.
95. 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 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, create an incentive to provide as many services as possible, even where these may not be medically necessary or appropriate, again generating inefficiencies.

3.2 Burden of Disease

96. South Africa is faced with a quadruple burden of disease in the form of communicable diseases such as HIV and AIDS and TB; maternal and child mortality¹⁸; NCDs such as

¹⁸ **Maternal mortality** – This is the number of women who die due to pregnancy related causes and 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

hypertension and cardiovascular diseases, diabetes, cancer, mental illnesses, chronic lung diseases such as asthma; as well as Injury and Trauma. The combined impact of these epidemics has had an effect on the doubling of death rate between 1997 and 2006 in South Africa.

97. HIV, AIDS and TB have significantly 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 infections in South Africa was 1.08% in 2012. The number of newly infected children aged 0 – 14 years fell by 56.2%, from 66,000 in 2008 to an estimated 29, 000 in 2011. More than 85% of women in need of Prevention of Mother to Child Transmission (PMTCT) services were estimated to be covered in 2014. 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. The WHO Global TB Control report of 2012, estimates that South Africa has the third highest TB incidence rate and the second highest Multiple-Drug Resistant or MDR-TB incidence globally. The TB incidence has decreased in South Africa over the last few years from being third to sixth highest globally.
98. Maternal and child mortality still contributes significantly to overall mortality even though the specific contributions to overall mortality have decreased over time. The Medical Research Council's (MRC) Rapid Mortality Survey in 2014 reports that the Maternal Mortality Ratio (MMR) has reduced from 281 per 100 000 live births in 2008 to 197 per 100 000 live births in 2011. The Neonatal Mortality Rate (NMR) has also declined from 14 deaths per 1000 live births in 2009 to 11 deaths per 1000 live births in 2011. Under-5 Mortality (U5MR) rate has reduced from 56 deaths per 1000 live births in 2009 to 41 deaths per 1000 live births in 2013. Infant Mortality Rate (IMR) has reduced from 39 deaths per 1000 live births in 2009 to 29 deaths per 1000 live births in 2013.
99. There is an increased need for services for speech, vision, audiology, oral health and psychological services including cognitive assessments for school-going children. The increased prevalence of NCD's globally and in South Africa is contributing at least 33% to the burden of disease. Common risk factors for NCD's include tobacco use; physical inactivity; unhealthy diets, and excessive use of alcohol. The South African National Health and Nutritional Health Survey (SANHANES)-1 published by the Human Science Research Council (HSRC) in 2013 reflects that Government's tobacco control policy has succeeded in reducing adult smoking by half, from 32% in 1993 to 16.4% in 2012.
100. The need to address social determinants of health is highlighted by increasing healthcare costs, morbidity and mortality associated with the management and treatment of communicable and non-communicable diseases impacting adversely on the affordability of the health system.
101. 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).

termination of pregnancy. **Child mortality** 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 7 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.

102. The recent increase in life expectancy and reduction in mortality rates cannot be sustained under the present health care system that is mainly curative, fragmented and unaffordable. The high burden of disease, mal-distribution and inadequate human resources as well as the poorly financed health system has contributed to the inability of the health system to maintain the above gains on a sustained basis.
103. The move towards National Health Insurance must therefore be informed by a deliberate effort to eliminate this fragmentation from the health system. The policy trajectory 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.
104. The solution to these structural shortcomings in health financing will be outlined in subsequent chapters that deal with NHI coverage and healthcare financing.

CHAPTER 4: RATIONALE AND BENEFITS OF NHI

105. 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.
106. NHI focuses on ensuring progressive realisation of the right to health by extending coverage of health benefits to the entire population, in an environment of resource constraint whilst benefiting from efficiency gains.
107. NHI aims to achieve the following objectives:
- a) Ensuring universal health coverage for all South Africans;
 - b) Improving the quality of health care services irrespective of socio-economic status of the user
 - c) Promoting equity and social solidarity through the pooling of risks and funds;
 - d) Creating one public health fund with adequate resources and funds to plan for and to effectively meet the health needs of the entire population;
 - e) Creating a single, strategic health purchaser that will ensure that health services and health products are purchased and procured at reasonable costs;
 - f) Ensuring that health care is regarded as a public good and a social investment;
 - g) Promoting efficient and effective service delivery in both public and private sectors that will be achieved through evidence-based interventions;
 - h) Strengthening the under-resourced and strained public sector so as to improve the health system's performance;
 - i) Adopting appropriate, new and innovative health service delivery models that take account of the local context and acceptability, tailoring the health service delivery platform to respond to local needs; and
 - j) Ensuring continuity and portability of health service benefits across the country.
108. The introduction of NHI is premised on a number of key interrelated elements, namely:
- a) To strategically introduce a single funding pool for meeting the health and healthcare needs of the population. This single funding pool of resources will be used to support the strategic purchasing and procuring of health resources i.e. facilities and human resources through properly articulated contracting mechanisms to supplement government's health services provision and delivery capacities;
 - b) To better and more effectively mobilise and control the key financial resources in the health sector so as to adequately and sustainably enhance the strengthening of the under-resourced and strained public sector. This is directly linked to the State's responsibility to progressively realise the right of all to access affordable health care services and the need for improved efficacy in the delivery of healthcare; and
 - c) To enhance the role of the health sector in improving the social and economic welfare of the population.
109. The implementation of NHI will provide an opportunity for yielding significant and better-spread economic and social benefits to the South African population. The benefits of NHI

are multiple and include improved financial risk protection through prepayment funding; reduced fragmentation in both funding and provision of health services in both the public and private health sectors; reducing inequities; 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.

110. Middle income countries that have implemented NHI have benefited economically from a healthier population. International evidence demonstrates that a properly implemented NHI in countries such as Turkey, Brazil, Costa Rica, Thailand and South Korea, has resulted in significant and sustainable economic and social benefits. These benefits include having a healthier population, which in turn translates into a productive and effective workforce that grows local business, attracts foreign investors and grows the domestic economy.
111. 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 run¹⁹. This will also translate to increased happiness of the population for whom improved quality of life and increased longevity is within their grasp.
112. The health of a country's labour force can impact on its productivity levels. If NHI is successful in its aim to reduce bottlenecks in the provision of public 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 term²⁰. Other benefits are increases in labour participation rates and reduced absenteeism. In the long-run, the higher productivity can lead to economic growth improving by 0.5 percentage points²¹.
113. Households will benefit from increased disposable income as a result of a significantly lower mandatory prepayment level, savings that will be made due to economies of scale, efficiency gains as a result of reductions in non-health care costs, and affordability of health care as a result of strategic, monopsony²² purchasing arrangements.
114. Healthcare expenditure in an economy has been estimated to create a 5% Keynesian macroeconomic multiplier effect²³, i.e. each R1 extra spent on healthcare creates R0.05

¹⁹The effect of Health on Economic Growth: A Production Function Approach, D. Bloom, D. Canning and J. Sevilla, World Development, 2003

²⁰Financing Health Insurance: What can South Africa Afford? Patrick Bond, Dr. Bianca Frogner and Dr. Chris Malikane – presented to the roundtable National Health Insurance: Exploring Key Questions, Oxfam University May 2010.

²¹The Impact of Health on Productivity: Empirical Evidence and Policy Implications – Emile Tompa (2011)

²² A large buyer that controls a large proportion of the market and strategically uses this to drive the prices down.

²³Dr. Bianca Frogner, Presentation to the round table on NHI: exploring key questions, Oxfam Australia, May 2010 in Funding NHI: A spoonful of sugar? An economic analysis of the NHI (2013), NHI economic Impact research, KPMG, South Africa.

extra economic activity in the long run. Therefore, the implementation of NHI could be great for enterprises and improve the country's economic outlook. Increased economic activity ultimately contributes to poverty alleviation, better quality of life and human development and will reverse the significant income inequalities in the country.

115. South Africa will follow the best evidence on health reforms by implementing a highly effective, fair and cost-effective NHI. The timing of its implementation is appropriate as NHI will help protect the poor, prevent cost escalation especially in the private health sector and help secure a wealthier future for South Africans.

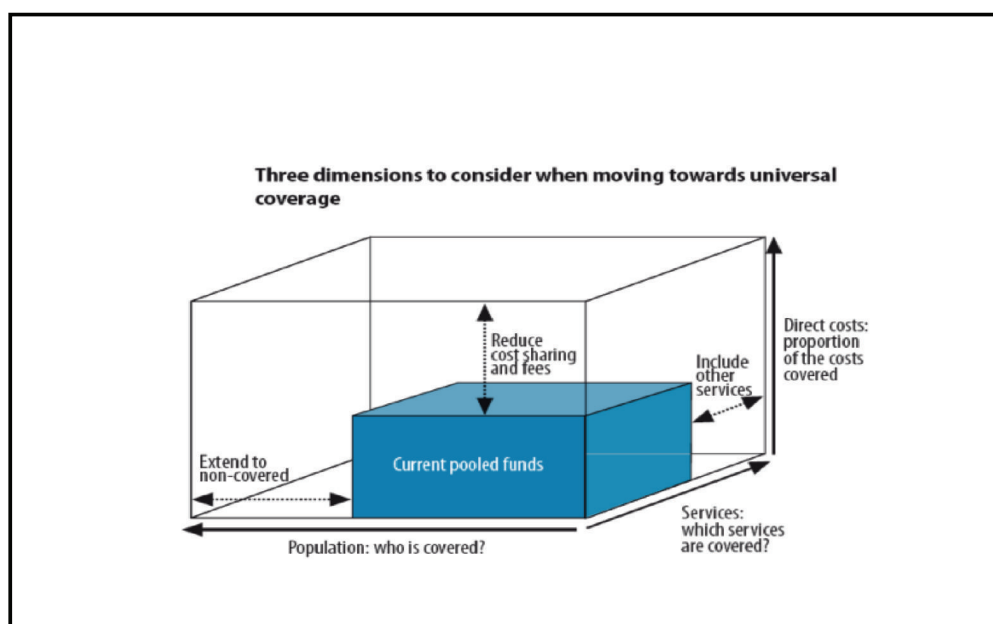
CHAPTER 5: NATIONAL HEALTH INSURANCE COVERAGE

5.1 The Three Dimensions of Universal Health Coverage

116. The World Health Organisation²⁴ provides guidance to countries on moving towards universal health coverage (UHC). The WHO identifies three dimensions for progressing towards universal coverage and these are shown in **Figure 2**:

- i. Population coverage
- ii. Service coverage
- iii. Cost coverage

Figure 2: The three dimensions of moving towards universal coverage



Source: WHO Report (2010)

5.2 Population coverage

117. Population coverage refers to the proportion of the population that has access to needed health services.
118. NHI will extend coverage to all South Africans irrespective of their socio-economic status. Coverage will also extend to legal permanent residents. In extending effective population coverage (i.e. ensuring that those in need can in reality access quality services), priority will be given to the population that is in greatest need and must include those experiencing the greatest difficulty in obtaining care. The identification of the population with the greatest need will be based on criteria consistent with the principles of NHI. Vulnerable groups will be prioritised.

²⁴The World Health Report 2010: *Health system financing – The path to universal coverage*. WHO, Geneva.

119. NHI can only work optimally if the intended beneficiary population is fully covered for the needed services. This means legal beneficiaries must 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 required for registration purposes, the size of the population in the area, disease profile of a catchment area, topography, 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 through a mix of accredited and contracted public and private providers.
120. Registration will take place at designated public facilities. South Africans that have been registered will be issued with an NHI card linked to the Department of Home Affairs' smart identification system. The information on the NHI card will be encrypted and will be utilised to access services at different levels of the health system.
121. Refugees²⁵ will be covered in line with section 27 (g) of the Refugees Act 130 of 1998 as amended. A special contingency fund will be established to provide basic health coverage for this category of people.
122. Asylum seekers²⁶ who have not been granted refugee status as defined in the Refugees Act, but are in possession of valid permits issued by the Department of Home Affairs, will access emergency health care services and services for notifiable conditions of public health concern.
123. Temporary residents, foreign nationals (with and without visas), foreign students and tourists will be required to have their own medical insurance.

5.3 Service coverage

124. 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.
125. NHI will provide a comprehensive package of personal health services. As resources are limited, the delivery of a comprehensive package will take into account the need to progressively realise the personal health benefits whilst undertaking priority setting. NHI will not cover everything for everyone.
126. South Africans will be able to access personal²⁷ health services covered by NHI closest to where they reside using the NHI card. These services will be delivered through certified²⁸ and accredited²⁹ public and private providers to improve access and coverage.
127. 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. PHC services will be delivered by accredited integrated teams of providers or networks structured as

²⁵ Refugee means any person who has been granted asylum in terms of the Refugees Act 130 of 1998 as amended

²⁶ Asylum seeker means a person who is seeking recognition as a refugee in the Republic in terms of the Refugees Act 130 of 1998 as amended

²⁷ The term personal denotes individual health care services. These include preventive, promotive, curative and rehabilitative services. In contrast non-personal PHC services include such things as environmental health services (e.g. water and air pollution)

²⁸ Certified by Office of Health Standards Compliance (OHSC)

²⁹ Accredited by the NHI Fund

multidisciplinary practices of a wide range of health care professionals such as medical practitioners, dentists, nursing professionals, pharmacists, audiologists, optometrists, physiotherapist and oral health practitioners amongst others. Those who practice as individual practitioners will have to be part of referral networks. The PHC providers will serve a catchment population that takes into account geographic, demographic and epidemiological profiles of the community.

128. Patients who need to be treated by specialists or in hospitals will have to be referred by PHC providers to certified and accredited public and private hospitals and specialists. This means, except in emergencies, patients cannot go straight to a specialist or a hospital without being seen at the PHC level be it at a clinic or a general practitioner. The accredited specialists and hospitals will deliver the appropriate package of services in accordance with clinical protocols and referral guidelines³⁰.
129. 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 and palliative 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.
130. The NHI Benefits Advisory Committee will develop the service entitlements for all levels of care (primary, secondary, tertiary and quaternary). The range of services will be regularly reviewed using the best available evidence on cost-effectiveness, efficacy and health technology assessments. The service entitlements will be specified in terms of the type of services that will be delivered by different kinds of accredited and contracted providers.
131. The comprehensive package of health services delivered will cover (but not limited to) the following:
 - i. Preventive, community outreach and promotion services
 - ii. Reproductive health services
 - iii. Maternal health services
 - iv. Paediatric and child health services
 - v. HIV and AIDS and Tuberculosis services
 - vi. Health counselling and testing services
 - vii. Chronic disease management services
 - viii. Optometry services
 - ix. Speech and Hearing services
 - x. Mental health services including substance abuse
 - xi. Oral health services
 - xii. Emergency medical services
 - xiii. Prescription medicines
 - xiv. Rehabilitation care
 - xv. Palliative services
 - xvi. Diagnostic radiology and pathology services

³⁰ The channelling of a patient to another level of care, either at a higher or lower level for continuity of care

132. Under NHI, the health services will not be based on a PMBs type of package. This is because PMBs cover a limited number of health conditions, are essentially hospi-centric without fully addressing the burden of disease.
133. Detailed treatment guidelines³¹, which are based on available evidence about the most cost-effective interventions, will be used to guide the delivery of the comprehensive health entitlements. The treatment guidelines will be based on available evidence regarding the most cost-effective interventions. Additional guidelines will be developed for interventions where such guidelines do not exist. 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.
134. Changes to the comprehensive service benefits including diagnostic tests covered by 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. Health technology assessment will be used in priority setting and therapies that have little impact on positive health outcomes will not be paid for under NHI whilst the most cost-effective evidence-based strategies will be deployed. Changes and adjustments to the service benefits over time will be accompanied by a budget impact analysis.
135. An inventory of pharmaceutical, medical supplies and devices will be linked to the Essential Drug List (EDL) and will be updated on a regular basis by the NHI Benefits Advisory Committee.
136. Though the NHI service entitlements will be comprehensive, effort will be directed at ensuring that the covered evidence-based services are medically necessary and have a positive impact on population health outcomes.
137. Moral hazard³² may occur when beneficiaries of NHI get involved in undue risky behaviour and/or incur unnecessary expenditure because they are protected against the associated health risks. Some beneficiaries may also expose themselves to risky behaviour such as smoking, taking excessive alcohol or eating poor diets with the knowledge that they are covered by NHI.
138. In order to effectively manage moral hazard, a strict referral system supported by effective gate-keeping will be implemented supported by health promotion and disease prevention programmes. Measures will be put into place to prevent moral hazard of abusing portability of services and to ensure that resources are available to meet the health needs of patients.

³¹ Described as statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

³² Refers to risky behavior undertaken by the insured or incurring of unnecessary expenditure when the insured knows that the costs are borne by the other party and the insured are protected from the consequences of the action.

5.3.1 Expanding access to pharmaceutical services

139. To ensure equitable access to medicines and related pharmaceutical products, NHI will accredit and contract with private retail pharmacies based on need. Accredited and contracted retail pharmacies will be able to order drugs and other health products from the nationally agreed pharmaceutical contracts and will be required to dispense drugs that are procured at subsidised prices. There will be strong mechanisms put into 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 drugs and other health product as well as pay a capitated administration fee to the retail pharmacies.

5.3.2 Expanding access to laboratory services

140. Under NHI, 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 a package of pathology services delivered at the different levels of care and as defined by the NHLS Act. NHI will also contract with certified and accredited private laboratory service providers based on need.
141. The NHI Benefits Advisory Committee will determine the package of 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 as currently approved by the Minister of Health.
142. 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.

5.3.3 Expanding access to radiology services

143. 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 based on a defined package of services. The package of radiology services covered will be located at the lowest and most appropriate level that could sustainably deliver the defined service for that level of care using defined referral protocols.
144. The covered services will include:
- i. Radiology and imaging sciences;
 - ii. Telemedicine;
 - iii. Nuclear medicine; and
 - iv. Radiation oncology.

5.4 Cost coverage

145. Cost coverage refers to the extent to which the population is protected from direct costs as well as from catastrophic health expenditure.
146. Those who are legally entitled to benefit from NHI 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. NHI card holders will not be expected to make any out-of-pocket payments such as co-payments and user fees at the point of health care delivery. This will assist in preventing demands for informal payments or the practice of balance-billing by providers.
147. In the transition to full implementation of NHI, the Uniform Patient Fee Schedule (UPFS) in the public sector will be abolished. This will be done in the early stages of the transition to NHI in order to improve financial risk protection for the population. This means that during the early phases of the transition, no fees will be levied at public sector hospitals, except to non-citizens, third-party payers such as medical schemes, Road Accident Fund and Compensation for Occupational Injuries and Diseases.
148. To prevent inappropriate and excessive use of health services and to ensure long-term sustainability and affordability of the health system, gate-keeping 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 for non-adherence to referral pathways. Nevertheless, careful attention will be paid to the process of introducing this policy to avoid potential adverse consequences for those accessing hospital-based services.
149. Services to which there is no coverage, such as elective cosmetic surgery, must be paid for in full by the patient. Where an individual is not entitled to benefit from the NHI, such as a tourist, full payment for services will be required. In both cases, the individual may pay for these services directly or via a medical scheme (e.g. a complementary top-up insurance in the case of services not covered by NHI or travel medical insurance in the case of tourists).
150. The removal of user-fees and out-of-pocket payment will improve financial risk protection for households and individuals. South Africans will only pay out-of-pocket and/or co-payments for services that are not covered under NHI.

5.5 A new health service platform

151. To move towards UHC through expansion of population coverage, service coverage and cost coverage as indicated in **Figure 2** will not be feasible in South Africa under the present public and private health care platform.
152. Therefore, massive reorganisation of the health system would be required to create a new platform for service provision and health care financing. This may require legislative changes, rearrangements of functions, responsibilities and relationships within the three

spheres of government pertaining to governance, concurrency, financing and delivery of health services.

153. The financing and provision of services in the private sector will also have to comply with the principles of access, social solidarity, equity, efficiency, health as a public good, affordability and effectiveness.
154. The next two chapters will outline the reforms that are to be undertaken in reorganising the health care system and the financing of health care services.

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

155. The public sector currently provides health services to the majority of the population and will continue to be the backbone of the health care system. However, many of its institutions are seriously challenged and significant changes are required to improve service quality. A number of initiatives must be introduced to improve the performance of the health care health system, the service delivery, management and quality of health care.
156. 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).
157. The Green Paper on NHI identified activities to be undertaken in selected districts. These activities were implemented in the NHI Pilot districts. Lessons that have been learnt from the pilots and will be used to further strengthen service delivery.
158. PHC will be the heart-beat of NHI. The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services.
159. PHC starts in the communities and is the first level of contact with the health system by individuals, the family and community. In addition, multidisciplinary and 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. An Ideal clinic is a health facility that possesses the following characteristics:

"It is a clinic that opens on time in the morning according to its set operating hours and does not close until the last patient has been assisted, even if it is beyond the normal closing hours. It is staffed by health care providers who treat people with dignity, and observe the Batho Pele principles of Access, Consultation, Courtesy, Information, Service Standards, Openness and Transparency, Redress and Value for Money.....It is very clean, promotes hygiene, and takes all precautionary measures to prevent the spread of disease. It has reasonable waiting times and community members do not have to sacrifice their entire working day to seek health care. It provides a comprehensive package of good quality health services every day and community members do not have to return on different days for different services. It has the basic necessities available such as essential medicines. It refers people to higher levels of care timeously when this is required. It works together with the community it serves with diverse stakeholders, in promoting health and socio-economic development. Finally, community members would say an ideal clinic is one that we can be proud of, and call it 'our own clinic' rather than 'a government clinic' or a 'state health facility' ”³³.

³³ Address by President Zuma at launch of Operation Phakisa 2: Ideal Clinic and Maintenance. Pretoria, 18 November 2014

160. The district health service delivery platform will be comprehensive and integrated and will include PHC services (public and private) and district hospitals. This 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.

6.1 PHC Re-engineering

161. The Green Paper on NHI indicated that a key health reform that would be implemented as part of the phased approach is the re-engineered PHC platform. The re-engineering of PHC services was implemented through three streams namely: (1) Municipal Ward-based Primary Health Care Agents; (2) Integrated School Health Programme; (3) District Clinical Specialist Support Teams.
162. During the first phase of implementation, piloting of these activities was undertaken and lessons have been learnt. In taking these lessons forward, a fourth stream has been added to the three that were in the Green Paper on NHI. Hence, the four streams of PHC reengineering that are being implemented are:
- a) Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs);
 - b) Integrated School Health Programme;
 - c) District Clinical Specialist Teams; and
 - d) Contracting of private health practitioners at non-specialist level.

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

163. The Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs) form a pivotal part of South Africa's PHC re-engineering strategy. The outreach team will be led by a nurse and linked to a PHC facility. The CHWs will assess the health status of individuals in the households. They will also provide health promotion education, identify those in need of preventive, curative or rehabilitative services, and refer those in need of services to the relevant PHC facility. If implemented well, the WBPHCOTs will be a game changer.
164. The WBPHCOTs are responsible for a given number of households in a municipal ward. South Africa is divided into approximately 4,000 municipal wards. Teams are allocated based on various criteria such as the size of the population, disease profile, geography, the living environment, and social and health deprivation. The data collected by the WBPHCOTs reflects that a total of 407,090 households have been profiled since 2012 in the 10 pilot districts.
165. A study was done during 2014 to understand the impact of the WBPHCOTs visit to households. In total 5,801 households (with 19,480 persons) were recorded in the study (the breakdown is as follows: 212 households in Cacadu; 1313 households in Gert Sibande; 2609 households in Thabo Mofutsanyana; and 947 households in uMgungundlovu District respectively).
166. In the households visited, 82% of persons were 5 years and older, and the remaining 18% were under 5 years old.

167. The following five reasons were provided by the WBPHCOTs as the reason for the visit to a household: (a) 242 related to pregnancy visits; (b) 163 post-natal visits; (c) 2,007 child health visits for children under 5 years old; (d) 3,967 were adherence support visits; and (e) 347 were home based care (HBC) visits. The majority of visits in each district were recorded as providing adherence support (78.1%), followed by child health services (39.5%).
168. Given the progress in the pilot districts, an additional 20,000 CHWs that are part of the WBPHCOTs will be deployed in those municipal wards where at least 60% of the households are poor.

6.1.2 Integrated School Health Programme (ISHP)

169. Currently there are 12 million learners in South African schools. 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 health promotion, preventive and curative services and also include a focus on screening for health-related barriers to learning such as vision, hearing, cognitive and related developmental impairment.
170. The Department has deployed 70 school mobiles in all pilot districts to provide general, oral health services, eye health services as well as audiology services. The number of learners seen through school mobiles in schools for Grades 1; 4; 8 and 10 were 380,929 in 2013 and 497,933 in 2014 with the following ratios: 19.3% of Grade 1 learners (during April 2013 to March 2014) and 23.2% of Grade 1 learners (during April 2014 to March 2015) of Grade 1 learners.
171. A total of 201,770 learners were identified as experiencing physical barriers to learning (hearing, speech, eyesight and oral health) and have been referred for appropriate interventions. Most of the learners (66% or 133,947 learners) were referred for oral health services, followed by 21% (or 43,319 learners), that were referred for eye care. Learners were also referred for hearing problems (7% or 14,202 learners), and those suspected of suffering from tuberculosis (TB) constituted 4% or 7 988 learners). In addition, learners with speech problems were also identified (1.1% or 2,314 learners).
172. Additionally, a total of 645,138 Grade 4 girls have been vaccinated against the Human Papilloma Virus. All these interventions have helped to expand access to needed health services, particularly for vulnerable groups located within disadvantaged and generally far-to-reach areas.
173. In the next phase of implementation, the ISHP will be expanded to more schools beyond the pilot districts. Services of private oral, eye and audiology practitioners will be contracted to provide corrective interventions to address the problems that have been diagnosed through the ISHP.

6.1.3 District Clinical Specialist Teams (DCSTs)

174. Significant progress has been made in establishing DCSTs across the country. A total of 228 health professionals have been appointed into the DCSTs. All 52 districts have

DCSTs appointed with 90% having at least three of the required seven member team. The value that the DCSTs have been adding is in the areas of capacity building and mentorship, strengthening the use of clinical guidelines and protocols and strengthening the use of information to improve health outcomes. An independent review³⁴ conducted in 2015 suggested that decreases in institutional maternal and neonatal mortality rates in selected districts can be attributable to the DCSTs.

175. In the next phase of implementation, the remaining members of DCSTs will be appointed and provincial specialists in Obstetrics and Gynaecology and Paediatrics will be appointed in those provinces that have not yet appointed them. The recommendations of the independent review will be implemented in all 52 districts.

6.1.4 Contracting private health care providers

176. An essential step in strengthening PHC and ensuring integrated services is the contracting of private health practitioners to render services. Contracting will be undertaken 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. With regard to children, to address early childhood development as well as physical bearers to learning, in addition to general practitioner services, the services of nutritionists, dental therapists, audiologists, speech and hearing therapists, psychologists, optometrists oral hygienists and other relevant allied health professionals will be prioritised.
177. 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.
178. Contracting of general practitioners to provide PHC services at clinics located within the pilot districts was implemented in the 2013/14 financial year. Over 302 general practitioners have been contracted since. Available data indicates that 152 contracted general practitioners are providing services 260 PHC facilities in eight pilot districts. Preliminary data indicates that for the 2014/15 financial year, approximately 34,330 patients received services delivered through these general practitioners contributing to the reduction in waiting times and improving access to needed services for the catchment populations served.
179. The general practitioner contracting model has provided a platform for expanding implementation to include other health care professionals such as audiologists, optometrists, speech therapist, physiotherapists and occupational therapist amongst others. The contracting also requires a strong regulatory framework for determining the costs for health services and the tariffs that should be charged. This will influence the cost of health service delivery and the ability of the NHI to sustainably contract with all accredited providers.

³⁴ Review of the National District Clinical Specialist Teams (DCST) Stream of the Primary Health Care Reengineering Strategy: Final Report 24 August 2015

180. Contracting for pharmaceutical services will also be undertaken to facilitate improved access for patients that have been stabilised. This will be achieved through determining medicine collection points in the community such as schools, churches and community pharmacies.
181. In the next phases of implementation, private providers at the PHC level will be contracted and reimbursed through a capitation model where appropriate instead of a FFS as it is happening currently.

6.2 Strategies to enhance effectiveness of the health care system

6.2.1 Improving management and governance at PHC level

182. Strengthening PHC services is critically dependent on improved management at facility (clinics and community health centres) and district levels.
183. 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.
184. Taking into account the need for separating purchasing functions from provision of services and given capacity constraints in financial management and planning, it may not be feasible in the early phases to delegate management to individual PHC facilities. The district may delegate these functions to 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 will be devolved to the PHC facilities.
185. 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.
186. Functioning Clinic Committees will be established for all PHC facilities. They will 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 constituted, their responsibilities and how they will function.

6.2.2 District Health Management Offices (DHMOs)

187. DHMOs will be established to manage district health services. The DHMOs will be structures to which management, planning and coordination of personal and 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 health care services from the function of provision of health services. The DHMOs will also be responsible for delivery of non-personal health services at the district level.

6.2.3 Health Promotion and the National Health Commission

188. Health promotion and disease prevention will form an important aspect of contributing to the reduction in the burden of disease and rising costs of health care. 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. A National Health Commission will be established to ensure the required multi-sectoral collaboration.

6.3 Hospitals and Specialised Services under NHI

189. NHI will cover a range of hospital health services and the population will access these services through referral from PHC level providers to these higher levels of care. Certified and accredited hospitals and specialised services in the private sector will be contracted to address the health needs of the population in line with the requirements of NHI.
190. One of the most identifiable factors that contribute to poor quality of health care in our public institutions is inappropriate, weak or poor management. Management of public hospitals has been characterised by over-centralisation, with hospital managers having almost no authority to manage their own institutions. Instead, hospitals are simply administered by provincial health department head offices, rather than being actively managed at facility level. This has led to under-development of management systems and capacity at hospital level and demoralisation of hospital managers, exacerbated by poor remuneration, limited training and support and inadequate career paths for managers. This makes it difficult for the public system to attract and retain skilled managers. Over-centralisation has also undermined the legitimacy and functioning of Hospital Boards, diminishing public accountability and trust in the hospital system.
191. The NDP recognises these weaknesses and endorsed the need for increased management autonomy for public hospitals. The NDP noted that: *“The centralisation of hospital budgets and key functions such as supply chain management at provincial level has been detrimental. The delivery of health services and care of patients takes place at health facilities yet managers lack the power to manage effectively”*.
192. In line with the Regulations for the Designation of Public Hospitals, public hospitals are categorised into the following five categories:
- a) district hospital;
 - b) regional hospital;
 - c) tertiary hospital;
 - d) central hospital; and
 - e) specialised hospital

6.3.1 Definitions of services to be delivered in reorganised hospitals

193. The district hospital is the smallest type of hospital which provides generalists medical services and the services delivered will be limited to four areas namely Obstetrics and Gynaecology, Paediatrics and Child Health, General Surgery and Family Medicine.
194. Regional hospitals receive referrals from district hospitals and provide specialist services to a number of district hospitals. They also serve as a platform for training of health professionals and to undertake research. Regional services are more specialised than those services generally available at District hospitals and may also be provided at provincial tertiary and central hospitals. These services require the permanent presence and input of a general specialist in each of the eight core specialties namely: Medicine; Surgery; Psychiatry; Obstetrics & Gynaecology; Orthopaedic Surgery; Paediatrics; Anaesthetics; Diagnostic Radiology; and Emergency Medicine that has now been established as a core specialty.
195. The Regional/Secondary service package will provide access to high care, short term ventilation and limited CT scanning. The package aims to have at least two full-time specialists per core specialty. Access will also be provided to basic services for ear, nose and throat (ENT), Ophthalmology and Urology. Regional/Secondary hospitals should provide this set of services to a defined, regional drainage population (in general serving more than one district in non-metro areas and more than one sub-district in metro areas), limited within provincial boundaries and should receive referrals from and provide clinical support to several district hospitals.
196. Provincial Tertiary Services (T1) represent services that are rendered by more specialists than is generally available at Regional hospitals and which are provided in Tertiary and Central hospitals. Some large regional hospitals, due to distance and burden of disease might render components of T1. T1 services are centred on a strong core of specialists in the main specialties, supported by other specialist and sub-specialist services. T1 services receive referrals according to a nationally agreed referral plan, mostly confined to provincial boundaries but which may also serve patients from areas beyond provincial boundaries, and tertiary hospitals must aim to provide these services.
197. Central Referral Services (T2) are provided by Central Hospitals and represent a set of highly specialised services, delivered in sub-specialties that require unique, highly skilled and scarce personnel who may require unique and expensive technologies. These services may be provided at Tertiary Hospitals or by means of outreach/telemedicine programmes from the central hospital to tertiary and/or regional hospitals and are invariably linked to a Health Sciences Faculty. They are provided at a small number of sites nationwide according to a nationally agreed referral plan. The population accesses services purely based on need and the services will therefore extend beyond the boundaries of the province within which they are located.
198. National Referral Services (T3) are services that will be provided in super-specialist national referral units only, each linked to a Central Hospital according to a nationally agreed referral plan. This limited number of services represents the final link in the referral chain. These services will be provided at a few carefully selected national locations,

where the personnel and technology required for the extremely specialised and expensive services can be optimally concentrated.

199. Specialised Psychiatric Services are services that may be provided in general hospitals (usually acute psychiatric wards only) but are mostly provided at specialised facilities designed for care of mentally ill patients. These services may be Regional, T1, T2 or T3 depending on complexity of care, multi-disciplinary nature and/or the supporting infrastructure and services required.
200. Each service level (and corresponding category of facility) in the referral chain will deliver the full package of care, ensuring that patients have access to a continuum of care through compliance to referral protocols and treatment guidelines.

6.3.2 Role, functions, management and governance of Central Hospitals

201. 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.
202. Central hospitals will be reformed to be semi-autonomous. Full decentralisation of their management functions and responsibilities will be prioritized 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 health care.
203. 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 be funded through a transitional funding mechanism before NHI is fully functional.
204. 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.
205. 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 tenth edition³⁵ (ICD-10), the use of Diagnosis Related Groupers (DRGs)³⁶ 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

³⁵ ICD as developed by the World Health Organisation is 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. 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.

³⁶ *ibid*

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.

206. 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.
207. 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 to the national health system. This organisational change will also ensure that the expertise within these institutions benefits the entire health system.

6.3.3 Role and management of other levels of public hospitals

208. 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 benefits as determined by the NHI Benefits Advisory Committee.
209. 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.
210. This will be achieved through a process of enhancing 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 qualification.
211. The delegated authority assigned to each category of hospital will be commensurate with the capacity to exercise the appropriate responsibilities and functions that can be delegated. In the initial phases of implementation of NHI, apart from central hospitals, these hospitals will be afforded semi-autonomy. The delegations afforded to these hospitals will be in line with the Public Finance Management Act, 1999 (Act No. 1 of 1999) and Public Service Act, 1994 (Act No.103 of 1994).
212. As the NHI matures, hospitals will be authorised as semi-autonomous entities to provide services funded by the NHI Fund. They should be capable of providing quality services, operating as viable units with capacity to utilise their available resources. Hospitals will be required to assume increasing degrees of managerial autonomy in preparation for NHI but also to improve the efficiency and effectiveness of public hospital services in general.

6.3.4 Governance of public hospitals

213. 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.
214. 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.

6.4 Establishment of the Office of Health Standards Compliance (OHSC)

215. 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 norms and standards for quality by all health establishments.
216. 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. The National Core Standards include 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.
217. Health facilities that meet nationally approved standards will be certified by the OHSC to render health services, and will be eligible for accreditation and contracting by the NHI Fund.
218. The role of the Inspectorate within the OHSC is to enforce compliance with norms and standards. The Ombud function will ensure that complaints lodged by users of health services are appropriately and speedily investigated.

6.5 Implementation of National Quality Standards for Health

219. NHI will provide coverage to quality health services for all South Africans. Therefore, all health facilities must comply with national norms and standards for quality. It is expected that all facilities must be fully compliant with the core standards of quality at all times.
220. 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 should be provided in-house within the public health system.
221. All pilot districts have been implementing quality improvement interventions in the public health facilities to meet these 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.

- 222. 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.
- 223. The health facilities in the pilot districts 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.
- 224. The implementation of the Patients' Rights Charter will be strengthened to ensure a patient-centred approach where the principles of patient's rights, choice, empowerment, participation and access to safe quality and appropriate services and information are recognised.

6.6 Enhancing human resources for health

- 225. Human resources for health are a key component of the pillars of a health system. The 2012 National Human Resources for Health Strategy outlines the roadmap for the planning, development, provisioning, distribution and management of human resources to meet the needs of the population.
- 226. To address efficiency in staffing levels in public health facilities, the WISN tool will be used to determine staffing requirements necessary for accomplishing defined tasks and ensuring a fair distribution of workload.
- 227. Incentives for attracting health professionals to work in rural and hard-to-reach areas are necessary as part of broadening access to quality services in these areas. This will also require concerted efforts for the rapid production of specific categories of health professionals.
- 228. A number of strategies will be implemented, 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.
- 229. 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. Additional nursing colleges will be opened to increase the training numbers for nurses and related professionals. 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.

230. 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.

6.7 Improving access to pharmaceuticals services

231. Another 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.
232. 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.
233. 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)³⁷ and Pick-up Points (PuPs)³⁸.
234. 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. Over 260,000 patients have been registered on the programme and this has helped to improve access to chronic medications.

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

235. 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.

³⁷Relates to individual patients' medicines being centrally dispensed and distributed to the point of service delivery

³⁸Relates to the provision of pre-dispensed medicines at private sector pharmacies, or 'Pick-Up-Points' (PuP), that is conveniently located for patients.

236. 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.
237. 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.
238. 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.
239. 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:
 - i. 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 health care needs that are linked to specific disease incidence at a provincial level
 - ii. This will include developing disease based volume specifications.
 - b. Using clinical governance rules to manage demand and/or utilisation:
 - i. 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 monthly or quarterly, fee-for-service will apply.
 - ii. 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 a certain 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
 - iii. 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:
 - i. This requires a cost-based tariff schedule.
 - ii. Cost per test will be adjusted against the demographic (or disease) profile of the specific province, giving a cost per person for laboratory services.

240. The laboratory investigations to be covered by NHI would be requisitioned for a specified clinical indication and not merely as a routine procedure. The authorized requisitioning health care professional will be required to decide on and define the purpose or reason for each laboratory investigation taking into account the following factors:
- i. If the investigation is clinically justifiable
 - ii. Whether the previous results still have clinical relevance
 - iii. If the investigation is required to ensure patient safety
 - iv. If the investigation is required for quality assurance purposes

6.9 Improving access to Emergency Medical Services

241. 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.
242. 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.
243. Emergency care delivery will be multi-disciplinary and team-based. The clinical teams need to have the competencies to assess, stabilize and provide essential emergency clinical interventions for all presenting clients. Further care or referral will be guided by the clinical condition of the patient.
244. 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.
245. 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.
246. The planned interventions outlined in the foregoing will be undertaken throughout the 14 year phased implementation of NHI.
247. The Department of Health has prepared a number of documents providing further details on the various aspects of reorganising the health care system. These documents, which can be accessed on the Departmental website, are as follows:
- a) Primary health care package of care;
 - b) Operation Phakisa's Ideal Clinic Realisation programme;
 - c) Definition of the hospital packages of care;
 - d) Policy on the governance of hospitals;
 - e) Definition of Pathology, Radiology and Emergency Medical Services under NHI

CHAPTER 7: FINANCING OF NHI

7.1 Expenditure Projections and Cost Estimates for NHI

249. In its research brief on the Costing of Health Care Reforms to Move towards Universal Health Coverage (UHC)³⁹, 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.
250. The World Health Organisation goes on further to caution 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 implementing reforms towards achieving UHC.
251. In this White Paper, after considering several scenarios the following preferred option was arrived at, which is a modified costing from the Green Paper on NHI.

7.1.1 NHI Expenditure Projections: Modified costing from Green Paper

252. 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 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

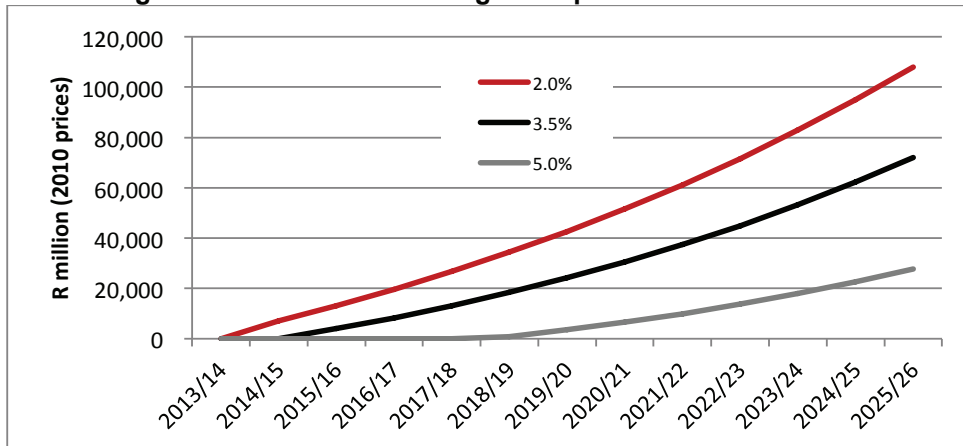
Source: National Treasury projection (2012)

253. 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

³⁹ WHO (2015) Costing health care reforms to move towards Universal Health Coverage (UHC): Considerations for National Health Insurance in South Africa.

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.

254. 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 supporting 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.
255. 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 health care. Total health expenditure growth will be influenced by the extent to which users come to trust the health services covered by the NHI Fund and choose to reduce voluntary health cover.
256. 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.
257. **Figure 3** illustrates the funding shortfall for alternative baseline resource growth projections. 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.

Figure 3: Funding shortfall under different growth paths

258. 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.

7.1.2 Estimates of Public and Private Health Expenditure

259. 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, 2011/12 – 2017/18

Rand million	11/12	12/13	13/14	14/15	15/16	16/17	17/18	Annual nominal change
Public sector								
National Department of health core	1,772	1,926	2,243	3,955	4,610	4,585	4,842	18.2%
Provincial Departments of Health	111,324	122,492	130,690	140,889	150,869	159,540	169,350	7.2%
Defence	3,400	3,460	3,734	3,849	3,933	4,225	4,536	4.9%
Correctional services	519	584	628	692	734	759	825	8.0%
Local government (own revenue)	1,977	2,096	2,221	2,355	2,496	2,628	2,768	5.8%
Workmens Compensation	3,369	3,000	2,713	2,821	2,934	3,090	3,253	-0.6%
Road Accident Fund	785	1,138	1,204	1,279	1,352	1,424	1,499	11.4%
Education	4,929	5,274	5,561	5,875	6,133	6,458	6,781	5.5%
Total public sector health	128,075	139,971	148,994	161,715	173,062	182,710	193,854	7.2%
Private sector								
Medical schemes	107,383	117,528	129,789	139,134	148,456	158,105	167,591	7.7%
Out of pocket	18,202	19,294	20,452	21,679	22,980	24,198	25,480	5.8%
Medical insurance	3,120	3,392	3,687	4,007	4,356	4,587	4,830	7.6%
Employer private	1,491	1,621	1,762	1,915	2,081	2,192	2,308	7.6%
Total private sector health	130,196	141,835	155,689	166,735	177,873	189,082	200,210	7.4%
Donors or NGOs	5,308	5,574	5,852	6,145	6,097	5,876	5,642	1.0%
Total	263,579	287,379	310,536	334,595	357,033	377,668	399,706	7.2%
Total as % of GDP	8.6%	8.6%	8.6%	8.6%	8.5%	8.3%	8.1%	
Public as % of GDP	4.2%	4.2%	4.1%	4.2%	4.1%	4.0%	3.9%	
Public as % of total government expenditure (non-interest, main budget)	15.0%	15.2%	15.1%	15.2%	15.2%	15.2%	15.2%	
Private financing as % of total	49.4%	49.4%	50.1%	49.8%	49.8%	50.1%	50.1%	

Source: National Treasury, 2015

260. Within the estimated health expenditure total for 2013/14, 4.1 per cent of GDP (R148.9 billion) was accounted for in the public sector, 4.5 per cent of GDP through private financing streams (R155.7 billion) and 0.2 per cent through donors. The largest public spending is by provincial Departments of Health at 3.6 per cent of GDP and the largest private spending channel is through medical schemes (3.6 per cent of GDP).
261. The table above shows the total spending in the health system (public and private). The private sector health expenditure by medical schemes in 2014/15 was estimated at R139.1 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). There is also an additional R16 billion in tax credits provided by the state to members of medical schemes, whether employed in the public or private sector. These amounts are not available for the uninsured population.

7.2 Raising Revenue to Finance NHI

7.2.1 Economic growth and financing public health expenditure

262. The implementation of NHI will result in growth in public 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.
263. 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 growth is more rapid, so that tax changes can be introduced without unduly impacting on household's disposable income.
264. The section below explores options for raising tax revenue to meet the health expenditure requirements as the phased implementation of NHI progresses.

7.2.2 Principles of tax design

265. The following principles of tax design serve as a guide in considering funding options for public services.
- a) **Equity:** The tax system should impose obligations on all residents or qualifying taxpayers in proportion to their ability to contribute, with tax rates set after taking into account the economic burden or potential welfare losses associated with alternative tax bases and rate structures. A tax system should incorporate both elements of equity: horizontal (people with equivalent incomes pay comparable amounts of tax)

and vertical (those with higher incomes pay more, according to their ability to do so). The high levels of income inequalities in South Africa require that a progressive tax system be maintained.

- b) **Efficiency:** The tax system should minimise economic distortions, i.e. have a limited unintended burden on the productive economy and consumption patterns. It must produce sufficient income for the state to meet its spending needs, collected in a manner that interferes as little as possible with allocation choices. The tax system should not unduly distort the allocation of resources in the economy, resulting in production or welfare losses. In general, this argues for broadly-defined tax bases and relatively low tax rates. The costs of administration, collection and compliance should also be taken into account in assessing the efficiency of the tax system.
 - c) **Simplicity:** Tax administration should be designed to collect revenue in a manner that is timely and convenient to taxpayers, as well as simple to understand.
 - d) **Transparency and certainty:** The timing of tax collection and calculation of tax liability should be known and certain to allow for proper planning. Transparency implies that a well-reasoned rationale exists for the imposition of taxes and that tax legislation is accessible and comprehensible.
 - e) **Tax buoyancy:** Changes in national income and discretionary changes to the tax system affect tax revenue. Tax buoyancy measures the ratio of change in tax revenue relative to the change in the tax base. In practical terms this refers to the ability of the tax system to raise revenue during all phases of the business cycle. It is important to ensure that the tax system raises sufficient revenue, while contributing to a counter-cyclical fiscal framework. Automatic stabilisers that operate through the tax system include lower income tax liability during periods of economic decline (through assessed losses for businesses, for example), and increased collection during periods of strong growth through a progressive rate structure.
266. The principles stated above are often aligned, but sometimes trade-offs have to be made between them. A balance between the different principles must be found, so as to avoid economic disruption or a breakdown in solidarity. 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.
267. 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. In addition, the special character of health expenditure is taken into account in the design of the personal income tax, which provides relief for medical scheme membership contributions and for

health expenses that exceed prescribed thresholds of income. Recent reforms to these provisions have made the relief more equitable.⁴⁰

268. 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.

7.2.2.1 Efficiency and Equity

269. A narrow tax base requires higher tax rates while a relatively broad tax base requires lower tax rates to generate the same amount of tax revenue. To the extent that high tax rates tend to cause distortions, lower rates and a broad tax base should be preferred. A broad tax base also promotes a greater degree of solidarity.
270. 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.
271. 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.

7.2.2.2 Tax Mix

272. 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.
273. 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.
274. Personal income tax is more effective from a redistribution and vertical equity perspective, but high marginal rates might have distortionary economic impacts. Payroll

⁴⁰See "Conversion of Medical Deductions to Medical Tax Credits – Tax Policy Discussion Document for Public Comment", National Treasury, 17 June 2011.

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.

7.2.2.3 Progressivity

275. 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.
276. 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.

7.3 Options for expanding public funding of health services

277. There are several options for raising revenue to fund an NHI system. Different countries adopt approaches appropriate to their specific circumstances. Building on the discussion of revenue sources and tax principles set out above, the main options for broadening national health funding in South Africa are summarised in Table 3 below.

Table 3: Potential revenue sources for NHI

Revenue Source	Definition	Examples
Direct Taxation	Taxes imposed on individuals or entities in relation to their income, earnings or wealth.	Personal or corporate income tax, surcharge on income, inheritance tax
Indirect Taxation	Taxes levied on transactions or goods and services, irrespective of circumstances of buyer or seller.	Value-added tax, national health insurance levy, financial transactions, fuel levy, taxes on alcohol and tobacco
Payroll Taxation	Taxes calculated on payroll, as either employer or employee contributions, or both.	Contribution to National Health Insurance deducted from pay check
Premiums	Collection of premiums or membership contributions from employee or informal sector.	Ghana NHI for informal sector workers

278. General taxation consists of direct taxes on income and wealth and indirect taxes on goods and services – the former mainly collected from the formal sector while indirect taxes reach more broadly across the economy. Payroll taxes are typically collected from employers and employees (either in the private sector only, or both government and the business sector).

279. The three main sources of 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.
280. South Africa's tax revenue as a share of GDP increased from 22.8 per cent in 1994/95 to 26.4 per cent in 2007/08 during a cyclical period of strong revenue growth. Following the financial and economic crises of 2008, the tax/GDP ratio declined to 23.5 per cent in 2009/10 before recovering to 24.9 per cent in 2013/14.
281. By international comparison, South Africa has a broad-based and well-developed tax structure. The income tax base has been expanded by introducing a capital gains tax and phasing out various incentives and exemptions. Taxes on consumption include a value-added tax at a standard rate of 14 per cent, with a limited number of zero-rated basic foodstuffs, and a range of ad valorem excises and specific duties on alcohol and tobacco products. South Africa makes limited use of payroll taxes, which finance unemployment insurance and skills training at present.
282. Options for further expansion of tax funding are discussed below, with particular emphasis on relevant tax-design considerations.

Table 4: Relative contribution of different taxes

% of Budget Revenue	1993/94	1999/00	2006/07	2011/12	2013/14
Individuals	39.1%	43.3%	29.2%	33.9%	34.5%
Companies	11.9%	10.6%	24.7%	20.5%	19.9%
GST / VAT	26.3%	24.4%	27.9%	25.9%	26.4%
Security transfer tax	0.3%	0.6%	0.6%	0.4%	0.4%
Specific excises	4.8%	4.5%	3.4%	3.4%	3.2%
Fuel levy	8.1%	7.2%	4.5%	5.0%	4.9%
Customs duties	3.5%	3.3%	4.9%	4.6%	4.9%
Sub Total	94.0%	93.9%	95.3%	93.7%	94.2%

Source: 2014 Tax Statistics

7.3.1 Payroll taxes

283. 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.
284. Internationally, payroll taxes, among others, are used to finance various social security programmes (i.e. retirement benefits, income replacement in the event of unemployment, death or disability and health benefits).
285. However, payroll taxes can have unintended negative distributional consequences. A flat rate would be regressive whilst a sliding scale is progressive. In addition, they add to the

costs of employment, the impact of higher payroll taxes on overall employment and job creation has to be considered carefully. High payroll taxes can lead to a bias against formal sector employment, and an increase in informal and unprotected work. In some countries, the social security contribution is subsidised for low-wage employees to offset the potential impact on employment and earnings.

286. In summary, 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. 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.

7.3.2 Surcharge on taxable income

287. 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 41 per cent with effect from the 2015/16 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).
288. A higher overall personal income tax burden would impact on the disposable income of households and could only be phased in with due regard to its impact on consumption expenditure and economic activity. A further concern with this option is the potential negative impact on savings.
289. 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 health care to groups with low incomes. However, the general tax revenue remains as the main source of funding for publicly funded health services in Australia.
290. A personal income tax surcharge would be administratively feasible in South Africa as it would be based on a well-established system.

7.3.3 Increase in value-added tax

291. 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.

292. 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.

7.3.4 Tax rate scenarios

293. 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).
294. 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 percentage points of GDP, thereby raising an additional R71.9 billion in 2010 prices by 2025/26.
295. Table 5 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).
296. A payroll tax in this case would work in the same manner as the current skills development levy, where a percentage of the total amount paid in salaries to employees would be taxable. In these scenarios there is no lower or upper threshold. Introducing a lower or upper threshold would decrease tax revenues and require a higher percentage of salaries to be taxable. The surcharge on taxable income is identical to an increase in marginal personal income tax rates. The scenarios assume that a percentage point increase would apply across all the personal income tax brackets. If the marginal tax rate on the bottom bracket is left unchanged (to avoid changing the tax free threshold), in general the percentage point increase for the remaining brackets would need to be doubled. For the value-added tax scenarios it is assumed that there is no change in the number of zero-rated items.

Table 5: Alternative tax scenarios to fund a R71.9 billion (2010 prices) NHI funding shortfall by 2025/26

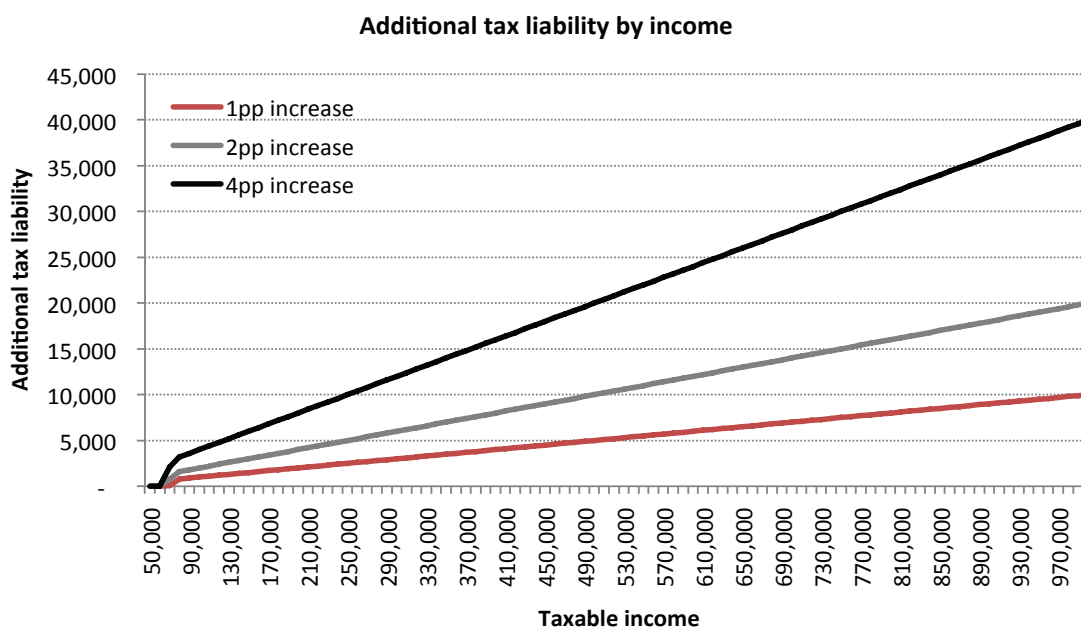
		Payroll tax	Surcharge on taxable income	Increase in value-added tax
Scenario A: Surcharge on taxable income, VAT increase and payroll tax	2016/17	0.5%	0.5%	0.0%
	2018/19	0.5%	0.5%	0.5%
	2022/23	1.0%	1.0%	0.5%
	2023/24	1.0%	1.0%	1.0%
	2024/25	1.0%	1.0%	1.0%
Scenario B: Payroll tax and surcharge on taxable income	2016/17	0.5%	0.5%	
	2019/20	1.0%	1.0%	
	2022/23	1.5%	1.5%	
	2025/26	2.0%	2.0%	
Scenario C: Surcharge on taxable income and VAT increase	2016/17		0.5%	
	2018/19		0.5%	0.5%
	2019/20		1.0%	0.5%
	2020/21		1.0%	1.0%
	2022/23		1.5%	1.0%
	2024/25		1.5%	1.5%
	2025/26		2.0%	1.5%
Scenario D: Payroll tax and VAT increase	2016/17	0.5%		
	2017/18	0.5%		0.5%
	2019/20	1.0%		0.5%
	2022/23	1.5%		1.0%
	2024/25	1.5%		1.5%
	2025/26	2.0%		1.5%
Scenario E: Surcharge on taxable income	2016/17		0.5%	
	2017/18		1.0%	
	2019/20		1.5%	
	2021/22		2.0%	
	2022/23		2.5%	
	2023/24		3.0%	
	2024/25		3.5%	
	2025/26		4.0%	

297. Scenario A would include the introduction of a 1 percent payroll tax, a 1 percentage point increase in marginal personal income tax rates and a 1 percentage point increase in the value-added tax rate. Scenario B would allow for a 2 percent payroll tax and a 2 percentage point increase in marginal personal income tax rates. The same 2 percentage point increase in marginal rates would be applicable in Scenario C, accompanied with a 1.5 percentage point increase in the value-added tax rate. Scenario D would entail a 2 percent payroll tax and a 1.5 percentage point increase in the value-added tax rate and Scenario E would increase the marginal personal income tax rates by 4 percentage points. Table 6 indicates the average tax rate changes under the current system and with a 4 percentage point increase in marginal rates and the change in tax liability given a 1 percentage point, 2 percentage point and 4 percentage points increase in marginal tax rates by income category.

Table 6: Average Tax rate changes and changes in tax liability

Taxable income	Average tax rate				Change in tax liability		
	Current	1pp increase	2pp increase	4pp increase	1pp increase	2pp increase	4pp increase
70,000	0.0%	0.1%	1.1%	3.1%	43	743	2,143
100,000	4.7%	5.7%	6.7%	8.7%	1,000	2,000	4,000
150,000	9.2%	10.2%	11.2%	13.2%	1,500	3,000	6,000
250,000	14.9%	15.9%	16.9%	18.9%	2,500	5,000	10,000
500,000	23.7%	24.7%	25.7%	27.7%	5,000	10,000	20,000
750,000	28.7%	29.7%	30.7%	32.7%	7,500	15,000	30,000
1,000,000	31.8%	32.8%	33.8%	35.8%	10,000	20,000	40,000

298. This information is depicted in the figure 4 below:

Figure 4: Average Tax rate changes and changes in tax liability

299. The tax scenarios illustrated are broad indications only. In practice, revenues will depend on details such as variations in real GDP growth, the targeted tax base, exemptions, the rate structure and the specific combinations of tax adjustments that are chosen in order to increase revenues.

300. Table 7 shows possible changes in personal income tax rates under scenario B; scenario C and D; and scenario E respectively. The table further illustrates the possible impact on tax rebates and tax-free thresholds.

Table 7: Personal income tax structure in 2014/15 and under different scenarios for a surcharge on taxable income in 2025/26 (in 2014 prices)

Taxable Income	Current tax rates	Scenario B tax rates	Scenario C and D tax rates	Scenario E tax rates
R0 - R181 900	18.0%	19.0%	20.0%	22.0%
R181 901 - R284 100	26.0%	27.0%	28.0%	30.0%
R284 101 - R393 200	31.0%	32.0%	33.0%	35.0%
R393 201 - R550 100	36.0%	37.0%	38.0%	40.0%
R550 101 - R701 300	39.0%	40.0%	41.0%	43.0%
R701 301	41.0%	42.0%	43.0%	45.0%
Rebates				
Primary	R13 257	R13 257	R13 257	R13 257
Secondary	R7 407	R7 407	R7 407	R7 407
Tertiary	R2 466	R2 466	R2 466	R2 466
Tax free thresholds				
Below age 65	R73 650	R69 774	R66 285	R60 259
Age 65 and over	R114 800	R108 758	R103 320	R93 927
Age 75 and over	R128 500	R121 737	R115 650	R105 136

301. 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 as per the above scenarios. Attention will have to be given to the distributional impact of such reforms especially on those with special health care needs such as the disabled and the elderly.

7.3.5 Other possible tax instruments

302. 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.

303. 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.

304. For the 2012/13 tax year, about R11.7 billion in revenue was raised from cigarette sales and R14.8 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 3.3 billion to the fiscus in 2012/13. The Estate Duty is a form of wealth tax, which yielded R1 billion in 2012/13.
305. 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.
306. 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.
307. 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.

7.4 Other sources of revenue

308. Additional revenue could potentially be mobilised from the current employer contributions (subsidies) to 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 fund towards the funding requirements for NHI.
309. In addition, over the medium term, the tax credit for membership to medical schemes and for some medical expenses will be reviewed. The scale down of this tax expenditure

could augment the funds available for the NHI and thereby limit the need for additional tax increases. However, the phasing-out of the medical tax credits can only happen once the NHI is fully operational. In addition the needs of people with disabilities and the aged and the financial implications for such taxpayers would require special attention.

310. 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), Unemployment Insurance Fund (UIF) and the Roads Accident Fund (RAF).
311. 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. 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.

7.5 Changing landscape of intergovernmental arrangements

312. NHI will cover personal health care 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.
313. It is likely that NHI will progressively imply major 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 extent to which funds are pooled in a central NHI Fund.
314. The functional assignment of health services is governed through Schedule 4A of the Constitution, the National Health Act and the Municipal Systems Act. The Constitution assigns health services as a functional area of concurrent national and provincial legislative competence. The introduction of NHI will further require restructuring of intergovernmental functions and fiscal relations in the health sector.
315. As service provision management authority is increasingly delegated to individual hospitals and District Management Offices, the Department of Health must play a key role in supporting managers at these levels and monitoring and evaluating service provision.
316. In moving towards the implementation of NHI, it is necessary to revisit these arrangements. There will be major reorganisation of functions and responsibilities with regards to funding and service provision. The reorganisation will require changes to legislations such as the National Health Act and other relevant legislations.
317. As part of the process for the establishment of the NHI Fund and its functions, the State will explore legally whether some form of sharing of powers and functions across the

spheres might be possible. For example provinces might be responsible to ensure that the basic elements of the service are in place using part of the existing PES formula (supply side funding) while the NHI Fund reimburses for services delivered (demand side funding).

318. These proposed changes will be tabled for consideration by the Presidential Coordination Committee (PCC) on Intergovernmental Relations and Fiscal Arrangements (IGFR). The Financial and Fiscal Commission will be consulted once the PCC on IGFR has made the decision on the above recommendations. The Department of Health will also remain a major provider of services.

7.6 Pooling of revenue

319. NHI will pool funds for personal health services. 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 on behalf of the entire population. The pooled funds will initially purchase personal PHC services in both public and private health sectors using a Transitional Fund. Furthermore, in this first phase of implementation, funding for central hospitals will be reconfigured into a central funding mechanism.
320. The NHI Fund will be publicly administered and the administration costs will be kept to a minimum. During the initial phase of implementation, additional resources will be required for the setting up of the administrative structures and supporting operational systems.
321. The NHI Fund will leverage its monopsony power to strategically purchase services that will benefit the entire population entitled to benefit from NHI. Acting as a single-payer, the NHI Fund will be able to yield the efficiency benefits of economies of scale and ensure that incentive structures for health care 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 health care services and expansion of the scope of personal health care services offered to the entire population.

7.6.1 Establishment of the NHI Fund

322. 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. 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. The funding for NHI will be through a combination of various mandatory pre-payment sources.
323. The NHI Fund will be established through the NHI Act. Establishing the Fund and accompanying public entity will be a straight process legislatively.
324. The introduction of the NHI Act and amendments to the National Health Act and relevant municipal legislations will be required to establish the NHI Fund. The NHI Act will also outline the relationship between the NHI Fund and the different spheres of government in respect of how personal health services will be funded.

7.6.2 Organisation of the NHI Fund

325. 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:

- i. Pooling of all the financial resources allocated for purchasing personal health services for the entire population;
- ii. Strategic purchasing of personal health services on behalf of the entire population;
- iii. Contracting with all accredited NHI public providers and identified accredited private service providers (based on need);
- iv. Facilitating the procurement of goods and services for all NHI accredited and contracted facilities, whether in the public or private sector, in order to increase the buying power of the Fund at an affordable cost;
- v. Administering the funding and purchasing of all personal health services that are provided through accredited and contracted providers;
- vi. Developing and implementing strategic mechanisms for procuring of goods including drugs, medical equipment and technology on behalf of providers that will be contracted;
- vii. Developing contracting and reimbursement strategies for contracted providers at various levels of care;
- viii. Undertaking audit and risk management to mitigate moral hazard, collate utilisation data and implement information management systems;
- ix. Maintaining the national database on the demographic and epidemiological profile of the population;
- x. Undertaking health economic analysis, pharmaco-economic analysis, cost-benefit analysis and actuarial research and analysis to ensure sustainability of the National Health Insurance Fund; and
- xi. Undertaking ongoing research, monitoring and evaluation of the impact of National Health Insurance on health outcomes.

326. The NHI Fund will have specific units, namely:

- a) Planning and Benefits Design Unit
- b) Price Determination Unit
- c) Accreditation Unit
- d) Purchasing and Contracting Unit
- e) Procurement Unit
- f) Provider Payment Unit
- g) Performance Monitoring Unit
- h) Risk and Fraud Prevention Unit.

7.6.3 Governance of the NHI Fund

327. To ensure that a single-payer system achieves the intended benefits, there will be appropriate governance mechanisms put into place for the NHI Fund. In this regard, the NHI Fund will be governed by the NHI Commission which will exercise oversight over the entity. This will be an external oversight mechanism that will ensure that the NHI Fund is accountable and that the interests of the general public are taken into account.
328. The composition of the NHI Commission will be based on experts in relevant fields which may include: 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. The Commission 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 Commission.
329. The NHI Fund will report on at least a quarterly basis to the NHI Commission 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.

7.7 Linkages to Broader Social Security Reforms

330. 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 have taken pivotal importance in the developmental programme of the State, this has played a significant role in reducing high poverty levels and improving overall population health.
331. 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 recognizes 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 also 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.
332. In recognition of the proposals outlined in the draft Comprehensive Social Security Reform discussion paper, there will be 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), Unemployment Insurance Fund (UIF) and the Road Accident Fund (RAF).

333. During the transitional phase, alignment of the benefits covered through the COIDA, ODMWA, UIF and the RAF as well as the reimbursement strategies for contracted providers will be aligned with those of NHI institutional and organisational reforms.
334. 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. This will ensure the minimisation/elimination of duplicate administrative and benefit disbursement systems, thus eliminating the problem of inefficiency, double dipping and duplication of social protection cover.
335. 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

327. A key element of the NHI reforms is to create a purchaser-provider split by creating an institution that will purchase health care services. Currently personal services are purchased passively in the health sector but under NHI, the NHI 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 population⁴¹.
328. As an active purchaser⁴², 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 health care providers are integrated and coherent.

8.1 Purchaser-Provider Split

329. A purchaser-provider split refers to the separation of institutional and organisational components that are responsible for the purchasing and provision of health services. Purchasing 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.
330. The NHI Fund will be the single, strategic purchaser of personal health services for the population. The Fund will contract directly with accredited public and private facilities at the relevant level of care, including accredited private hospitals and emergency medical services through strategic purchasing arrangements. The contracting will be based on pre-determined criteria to realise value for money, accountability and equity among others. **Box 1** provides a summary of key elements that need to be in place to ensure that the NHI Fund is a strategic purchaser:

⁴¹ibid

⁴² An active purchaser is an entity that pools funds on behalf of a population and purchases health services from accredited and contracted providers. Part 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.

Box: RESYST (2014)⁴³**Key strategic purchasing actions in relation to providers**

- Select (accredit) providers – range and quality of services, location
- Establish service agreements/contracts
- Develop formulary (of generic drugs, surgical supplies, prostheses etc.) and standard treatment guidelines
- Design, implement and modify provider payment methods to encourage efficiency and service quality
- Establish provider payment rates
- Secure information on services provided
- Monitor provider performance and act on poor performance
- Audit provider claims
- Protect against fraud and corruption
- Pay providers regularly and timeously
- Allocate resources equitably across areas
- Implement other strategies to promote equitable access to services
- Establish and monitor user payment policies
- Develop, manage and use information systems

Key strategic purchasing actions in relation to citizens / population served

- Assess the service needs, preferences and values of the population and use to specify service entitlements/benefits
- Inform the population of their entitlements and obligations
- Ensure population can access their entitlements
- Establish effective mechanisms for complaints and other feedback from the population and respond
- Publicly report on use of resources and other measures of performance

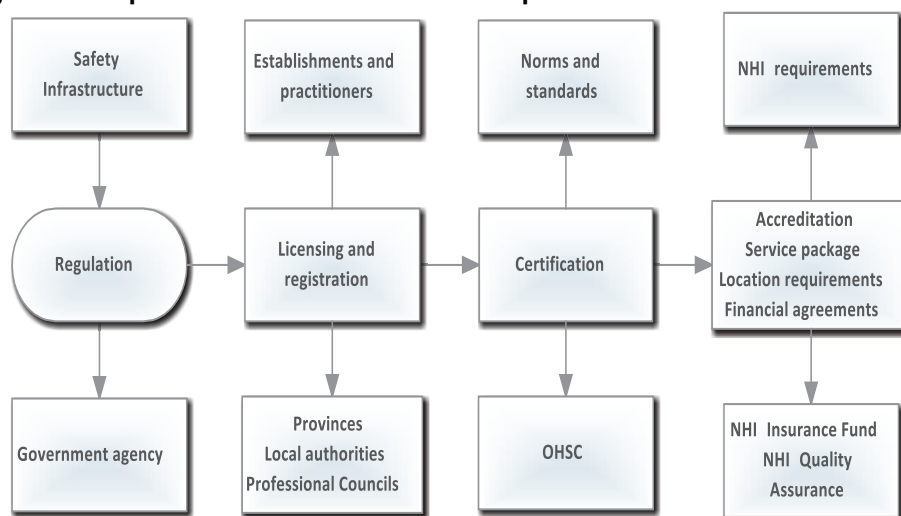
Key actions by government to promote strategic purchasing

- Establish clear frameworks for purchaser and providers
- Fill service delivery infrastructure gaps
- Ensure adequate resources mobilised to meet service entitlements
- Ensure accountability of purchaser

8.2 Accreditation of Providers by NHI Fund

331. Health service benefits to which the population is entitled will be delivered by public and private providers that have been accredited and contracted by the NHI Fund. 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 as shown **Figure 5**.

⁴³Resilient and Responsive Health Systems (2014) *What is strategic purchasing for health*. <http://resyst.lshtm.ac.uk/researchprojects/multi-country-purchasingstudy>

Figure 5: Sequential external evaluation requirements for NHI

332. 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 purchasing of services by the NHI Fund will be the routine submission of specified information. This will include the following information for each patient:

- a) Identity number (which will not only confirm benefit entitlements, but also indicate the age and sex of the patient);
- b) ICD-10 diagnostic codes, including complications;
- c) Procedure codes using the prescribed coding system;
- d) Drugs dispensed (using pharmaceutical product codes);
- e) Diagnostic tests ordered;
- f) Length of stay;
- g) Level of care to which referred; and
- h) Discharge/Separation information.

333. 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 will become available, and can be used to determine the global budget on a risk-adjusted capitation⁴⁴ basis. Providers, both the public and private, will be assessed against indicators of clinical care, health outcomes⁴⁵ and clinical governance⁴⁶ rather than simply on perceived quality of services.

⁴⁴ 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

⁴⁵ 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.

⁴⁶ Described as a system through which healthcare teams are accountable for the quality, safety and experience of patients in the care they have 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

8.3 Contracting of health service providers

334. Providers who satisfy accreditation requirements will be considered for contracting with the NHI Fund. The contracts will contain a clear statement of performance expectations in respect of: patient management; patient volumes; quality of services delivered; adherence to clinical protocols and treatment guidelines⁴⁷; and improved access to health services.
335. The NHI Fund in consultation with the Minister will determine its own pricing and reimbursement mechanisms. Providers who wish to contract with the NHI Fund must comply with the stipulated pricing and reimbursement mechanisms.
336. 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.

8.4 Treatment guidelines

337. An extensive set of treatment guidelines⁴⁸ already exists within the public health sector, in the form of the 'Standard Treatment Guidelines' associated with the Essential Drug List (EDL). There are three main sets of EDL guidelines:
- i. Guidelines for primary health care services, which are targeted mainly at nurse prescribers but also medical officers;
 - ii. Guidelines for adult care at district and regional hospitals (combined), which are targeted at medical officers and specialists (excluding sub-specialties and oncology); and
 - iii. Guidelines for paediatric care at district and regional hospitals, targeted at medical officers and specialists (excluding sub-specialties and oncology). There are also 'guidelines' for highly specialised services, but these are simply brief reviews of the international evidence with some guidance (less so than with the other guidelines).
338. Each guideline generally includes a definition of the condition and its cause, and a description of the complete approach to treatment, including some diagnostic measures (e.g. tests, procedures), non-medical treatment (e.g. diet, counselling etc.), some instances of surgical treatment, use of medicines and the need for referral upwards to higher levels of care (and sometimes when patients can be referred downwards). The description of medicines use is the most detailed and specific and includes the types and doses of drugs and variation in the use of drugs according to the severity of condition, stage of condition, age of patient, complications etc. While the guidelines for

⁴⁷Good guidelines can change clinical practice and influence patient outcome

⁴⁸ The 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.

each condition are very specific (and could be termed protocols), in the main they are not in the form of algorithms (i.e. decision-making flow-charts), although there are some instances of this.

339. The EDL guidelines are the most extensive treatment guidelines available in South Africa, and have been developed through a process of evidence review and consultation. The overall approach guiding choices of what is included in the guidelines is evidence-based with extensive peer review. In making these choices, principles that are considered include:

- i. Efficacy;
- ii. Effectiveness – this often has to be extrapolated to the South African situation;
- iii. Safety;
- iv. Cost (total cost of the treatment plus some measure of cost-effectiveness where necessary or available);
- v. Strength of evidence, i.e. the reliability/validity of the data;
- vi. Epidemiological considerations, with priority given to developing guidelines to strengthen priority health interventions; and
- vii. Practical considerations, such as assessing what is feasible in the South African context.

340. The guidelines are reviewed and updated over a three-year cycle to take account of new technology and evidence. These guidelines cover 80 percent of the most prevalent conditions in South Africa. However, they focus on conditions that could require drug therapy at some stage (given that the focus was on drawing up guidelines to accompany the EDL). Thus, conditions that require purely surgical procedures are not included. In addition, anaesthesia, treatment of malignancies, oral health outside of hospitals and optometry represent a gap in the current guidelines. The EDL guidelines will form the basis of the treatment guidelines for the NHI, along with those developed by the Department of Health. The treatment algorithms that have been developed for PMB conditions in terms of the Council for Medical Schemes regulations should be reviewed to assess if they can be used to complement the EDL and Department of Health Treatment Guidelines.

341. There will also be a process of identifying key gaps in the EDL and other guidelines, focusing on areas where clinical practice can vary widely with potentially large resource use implications, as well as interventions where there is currently very limited service provision but where service expansion over time may be desirable (e.g. vision and dental care, mental health services and long-term care). The NHI Benefits Advisory Committee will establish Expert Committees to develop guidelines for the priority areas where there are currently gaps.

342. 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).

8.5 Provider payment mechanisms

343. Cost containment is essential to achieving and sustaining NHI. The implementation of NHI will enable the State to progressively realise the right to access health and for businesses and households to afford better quality health care. Cost containment initiatives will not merely focus on cost-saving innovations but will also improve the affordability and availability of quality health care to the population.
344. In order to ensure effective cost-containment and the future sustainability of NHI, it is critical that the existing provider payment mechanisms function with the budget and associated accountability processes are changed. The provider payments must contribute to a responsive health system by incentivising improved quality in the public sector whilst they also reduce prices in the private health sector. 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.
345. The FFS model has been found not to cost-effective and incentivise for overprovision. The FFS will not be the preferred method of reimbursing providers because it:
- a) Offers substantial financial incentives for providers to see more patients and deliver more services than may be clinically necessary.
 - b) May lead to providers doing more than may be justified by the clinical diagnosis (e.g. extra procedures and tests). These extra services can be big drivers of healthcare cost, an issue that is prevalent in South Africa and must be addressed proactively.
 - c) Perpetuates fragmentation in healthcare. Some have gone so far as to say that FFS has created the fragmentation we all witness throughout healthcare. Services such as collaborating with other healthcare providers and delivering more comprehensive services are not incentivised in a FFS framework.
 - d) Does not really encourage providers to spend more time with patients. Under the premise of FFS, the more patients a provider sees, the more money they make;
 - e) Allows for the provider to receive payment regardless of how successful they were in improving the condition of the patient. The variability that exists between provider outcomes and their cost in the healthcare system is wide ranging. Some providers cost the system substantially more (in their fee for service) while not demonstrating better outcomes.
346. Although FFS is easy to understand conceptually, it can be difficult to understand in practice. Because payment is limited to one provider for one interaction, FFS does little to encourage management of care across settings and among multiple providers.
347. The types of care that may be best suited for FFS payment include complex diagnostic services and treatments that are difficult to categorise in a bundle or episode of care and EMS services.
348. 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. The mechanisms

that will be employed for provider payment will be described below for the different levels of service provision.

8.5.1 Provider Payment at Primary Health Care Level

349. In the initial phases the NHI Fund will pool all available PHC funds allocated for personal health services at the district level. These funds will be used to purchase PHC services from accredited and contracted public and private providers including general practitioners and other categories of health care professionals working in multidisciplinary group practices. The magnitude of the budget will be determined on the basis of the size of the population served, epidemiological profile taking account of target utilisation rates and average costs of providing a comprehensive range of personal health services at the PHC level.
350. At the PHC level, the main mechanism that will be used to pay providers for personal health services 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, taking into account the re-engineered PHC approach that is currently being implemented across the country. 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). There will be a gradual phasing in to the provider payment mechanisms over the implementation period of NHI.
351. 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. Consideration will be directed towards the introduction of complementary payment methods to enhance incentives for providers. These could include performance-related payments linked to immunisation rates (or activity targets such as number of immunisations), TB cure rates and the like.
352. The design of these types of payments will be carefully designed and monitored to mitigate some reported adverse consequences of 'pay-for-performance' initiatives (e.g. facilities and individual providers focusing on services for which performance payments are made and neglect other equally important services). Performance payments could be linked to reaching or exceeding certain targets, a facility's performance relative to other comparable providers or improved performance by that facility over time. Lump sum performance payments could also be made to individual staff and/or clinical and outreach teams as part of a broader incentive regime.
353. The capitation amount will be a uniform amount for the defined levels of providers, regardless of public or private ownership. The capitation amount will be calculated on the basis of a risk-adjusted capitation formula, taking into account key factors such as population size, age and gender and disease/epidemiological profile. The annual capitation amount will be linked to the registered population, target utilization 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. Contracted providers will also be assisted in controlling the expenditure through recommended formula, and adherence to treatment protocols for all conditions covered under the defined package of care. This will be necessary to assure the appropriate level of service provision and avoid under-servicing, which is a common likelihood in a capitation payment environment.

354. To deal with any potential adverse effects of capitation funding⁴⁹, 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. This will include both peer review at the district level and monitoring by the NHI Fund through analysis of diagnosis, treatment and referral information.

8.5.2 Ambulatory private specialist services

355. In relation to services purchased from private specialists, NHI will initially use a capped case-based fee adjusted for complexity where appropriate for reimbursement. This will be continuously reviewed taking into account access and budgets. In terms of purchasing diagnostic services from the private health sector, cost and volume contracts will be implemented. 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 capitation 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.

8.5.3 Provider payment at hospital level

356. Currently public sector hospitals are paid through inflation adjusted line-item budgets and individual staff through salary. Within the private sector, itemised fee-for-service billing is the dominant form of reimbursement used. Internationally, there is an increasing trend to move towards case-mix activity adjusted payments (such as Diagnosis-Related Groups or DRGs) to hospitals, irrespective of whether the hospital is public or private. 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 that are granted greater management autonomy. As more hospitals are given management autonomy, the global budgeting system will be expanded. This requires collecting basic data on hospital activities (outpatient visits, inpatient days and admissions) and average (as opposed to facility-specific) unit costs (for different levels of care).
357. In each phase, there will be a transition period. A key element of the transition process is to progressively develop, implement and improve health information systems so that reliable routine data is available at facilities regarding patient treatment (namely cost, diagnosis and procedures data). This would assist with the improvement of the case-mix adjustments to activity information as the basis of determining and refining global budgets. Once all accredited hospitals have been granted decentralised management

⁴⁹ It 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.

authority as part of the broader hospital management reforms, the NHI Fund will gradually introduce payments fully based on a case-mix reimbursement system (particularly DRGs for inpatient based hospital care).

358. The gradual transition will allow hospitals to adjust their service organisations and provision arrangements in preparation for moving to the next phase. This approach has been used in many other contexts, such as Australia, France, Estonia and Kyrgyzstan during their reform process.
359. The development of a base DRG started in 2014 and more than 25,000 patient files from 8 central hospitals have been analysed. This data has been classified into Major Disease Categories to be used for reimbursement of hospitals, taking into account complexity and severity of a patient's condition. In the next phases of implementation, the full DRG will be implemented in the central hospitals and extended to other tertiary, regional and district hospitals.

8.5.4 Emergency medical services (EMS)

360. 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. 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.

8.6 NHI information systems

361. 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.
362. 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 health care providers. Information system will be crucial for the implementation of the NHI and the portability of services for the population.
363. 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 health care benefits by the NHI members and how this information must be used to support planning and decision making around contracting, purchasing and communication strategies;
 - e) Quality assurance programmes for the health care providers;
 - f) Production of reports for health facilities and health system management; and
 - g) Research and documentation to support changes as the health care needs of the population change.

8.6.1 Health patient registration systems

364. The Green Paper on NHI identified the need for a patient registration system to enable for the planning and provision of health services, as well as to support the tracking of usage of health services. The patient registration system will provide key information on demographic and epidemiological data which is important for determining needed services and refining reimbursement mechanisms.
365. The eHealth Strategy for South Africa outlines a road map for achieving a well-functioning, patient-centred electronic national health information system. The strategy recommends that the integrated national patient-based information system must be based on agreed scientific standards for interoperability, improving the efficiency of clinical care, producing the indicators required by management, and facilitating patient mobility.
366. The realisation of the national health information architecture, or eHealth enterprise architecture proposed in the eHealth Strategy is an iterative process nested within the establishment of key building blocks or technical components. This is to facilitate integration with other information systems in the health sector as it is a critical enabling factor for the implementation of NHI.
367. The Health Patient Registration System (HPRS) will be a component of the NHI Information Systems. The development of HPRS commenced in July 2013 in a partnership the National Department of Health, the Department of Science and Technology and the Council for Scientific and Industrial Research (CSIR). The HPRS has been developed and setup to provide Patient Registry and Master Patient Index (MPI) service using the South African Identification Number and all other legal person identification numbers such as Passport as the primary patient identifier.
368. The HPRS supports the tracking of utilisation and linkage to electronic health records to create a register of patients and to contribute to health sector planning, decision making and improved service delivery. This has made it possible to track patients at all levels of care for improving quality and continuity of care. The system will further track the beneficiaries accessing services at health facilities at different levels of care using the following capabilities:
- a) Barcode Scanning (ID Book and Driver's License) and Biometric reader;
 - b) Patient lookup (patient demographic details, facility linkage, patient file number);
 - c) Generate a patient file number;
 - d) Maintenance of patient details;
 - e) Linkage of patient to PHC facility;
 - f) Record the visit (date, time, facility, purpose); and
 - g) Management information – health service provision.
369. The first phase of implementation has focused on PHC facilities in the Pilot Districts. To date a total of 555,139 patients were registered in 118 facilities. This system would be functional in all PHC Facilities (698) in the NHI Pilot Districts by 31 March 2016. In the next phases of implementation, the HPRS will be implemented in PHC health facilities in all 52 districts as well as in the 400 hospitals in the public sector

8.6.2 Health provider registration system

370. The Health Provider Registration System is another key building block for the development of the enterprise architecture for NHI information systems. In the initial phase of this component providers currently practising in South Africa have been geo-spatially plotted (12,808 general practitioners, 3,085 dental practitioners and 15,717 allied health care professionals). A web based Health Provider Registration System will be deployed for provider registration.
371. In the next phases of implementation, the Health Provider Registration System component will be deployed for the creation of a Health Provider Index. This will allow the linkage between the Master Patient Index and the Health Provider Index through a health information exchange middleware.

8.6.3 National Health Insurance Risk Engine for Fraud Mitigation

372. As the NHI Fund will be managing significant amounts of money, fraud and corruption may thrive particularly where internal control systems are inadequate. In circumstances where public trust is high, such as with the doctor-patient relationship, the public is likely to “take the eye off the ball”. This may lead to abhorrent provider behaviour which may include corrupt activities. The more actors the greater the chances of corruption as it may be difficult to simultaneously monitor their actions manually. There is always a possibility of regulatory capture, where those who write regulations bias them towards specific actors. In a less transparent environment, regulations may be skewed to benefit those who have the means to give perverse incentives. Preventing corruption therefore requires policies, procedures and systems that aim to curb these aberrant practices.
373. Inappropriate use of NHI resources may occur due to fraud, abuse and waste. These will need to be identified and preventive strategies will be developed. Abuse may relate to, for example, patients who when diagnosed decide to seek confirmation by visiting several health providers, or a patient visiting a facility for minor health problems that could rather be managed outside of the health facility. Waste may occur due to inefficiency, such as excessive use of medical equipment or drugs or by not following recommended treatment guidelines.
374. Overprescribing is one example of waste, where patients end up with more medicines than they need. Health service providers may receive perverse incentives for providing inappropriate health service at a higher cost than necessary even in the absence of scientific evidence to support the basis for their provision. Pharmaceutical companies may incentivize doctors to use drugs they produced and marketed even though scientific evidence shows they are less effective than other drugs for the same condition. Because patients are not knowledgeable about which treatment is effective against the condition and are desperate for cure, they will pay for a doctor's prescription that promises to alleviate the health problem. Doctors may not be alone in this; professionals and organizations such as hospitals, clinics, and pharmacies may be given perverse incentives to be corrupt.
375. With respect to patients, they may use fake identity documents to access and use NHI health benefits even though they are not entitled to them. They may also agree to have

the doctor write a wrong procedure in order to get the NHI to pay based on DRGs to avoid the NHI Fund declining payment of a rare condition or a condition not included in the service benefit. Suppliers may also bribe officials to overcharge the services in return for a kickback. The NHI Fund officials may also engage in corruption by benefitting non-qualified suppliers in return for kickbacks. The public may receive poor services relative to the expenditure incurred.

376. Workers, patients and others may also help themselves with medicines, linen and other supplies, creating artificial shortages that cost the state losses.
377. The managers employed by the NHI Fund as well as people in positions of authority may also be involved in activities that are corrupt or fraudulent. This may manifest in the form of awarding contracts to inappropriate/unaccredited providers or issuing fraudulent NHI cards to non-beneficiaries. To deal with this risk, adequately strong governance arrangements will be put into place to proactively ensure continuous oversight. The NHI Fund will also be supported by adequately complex and integrated health information systems to undertake effective risk identification, management and responsiveness. These systems will also be used to prevent fruitless and wasteful expenditure so that all allocated funds are used to meet the needs of the population.
378. These examples show that, although not all of these people may short change the health system, there is a need to develop and implement a proactive risk identification and fraud prevention strategy to capture those who engage in fraudulent activities.
379. Any fraud, corruption, abuse and waste have a potential of jeopardising the functioning and performance of the health system and putting lives at risk. These should not be tolerated by the authorities and the public. Penalties imposed for such transgressions should be particularly severe. Some of these transgressions are criminal in nature and the criminal justice system should deal with them harshly.

8.6.3.1 Creating a Risk Management Framework for NHI

380. In order to adequately identify and manage risks within the phased implementation of NHI, it is necessary that government develops a risk management framework that will utilise the concept of clinical pathways to facilitate automatic and systematic construction of an adaptable and extensive fraud-detection model. Robust systems and processes are required for the NHI Fund to be able to identify and proactively respond to the vast variety of risks in a holistic manner.
381. There is a great recognition that there is an anticipated variety and increasing number of risks that the NHI system will encounter during the preparation and implementation phase. Embarking on establishing a risk management framework will help NHI develop a platform whereby process-mining techniques can be developed to gather clinical-instance data to construct a model that distinguishes fraudulent behaviours from normal.

8.6.3.2 NHI Risk and Management Process

382. The risk and management process outlined below recognises seven risk management steps that form part of the governance process of the NHI Fund. Establishing a robust Risk Management Framework for NHI with all the necessary data, analytics and tools will be key to promoting risk awareness across the organisation and to managing the various threats and opportunities that will be identified at levels of the organisation as a result of this awareness. Ultimately, this work will support the success of NHI business operations.
383. One approach the NHI will have to undertake is to incorporate risk management into operations through the development of a framework for systematically identifying, assessing and managing the risks at all levels of the organisation. During the phased implementation process, it is necessary that the NHI Fund develops, implements and refines a risk management and data-mining framework based on an electronic platform. The Framework will utilise the concept of clinical pathways to facilitate automatic and systematic construction of an adaptable and extensive fraud-detection model. Establishing this risk framework will help the NHI Fund develop a platform whereby process-mining techniques can be developed to gather clinical-instance data to construct a model that distinguishes fraudulent behaviours from the normal. A generic framework will form the basis for NHI Risk and Fraud management platform and will consist of the following seven risk management steps as part of the governance process of the NHI Fund:
- a) Step 1 – Appoint a risk management co-ordinator and a risk management committee.
 - b) Step 2 – Define the context for risk management and this include the mission and main objectives.
 - c) Step 3 – Develop an approach for risk identification (NHI Risk Engine).
 - d) Step 4 – Build a risk assessment matrix.
 - e) Step 5 – Establish a risk register.
 - f) Step 6 – Rollout the risk management framework.
 - g) Step 7 – Incorporate risk management into performance monitoring.

8.7 Health technology assessment

384. In implementing NHI, health technology assessment will inform prioritization, 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 health care interventions are envisaged.

8.8 Procurement of pharmaceuticals and goods

385. The health system faces many challenges in its current procurement system and these must be addressed for NHI to function optimally. NHI will play a role in influencing the procurement of goods. Key components to implementing a successful procurement process include transparency, cost containment, technical capacity, implementation of operational principles, purchasing for safety, adhering to appropriately selected health

products list, timely and accurate information, ensuring quality products, and proper budgeting and financing.

386. As part of the process of moving to NHI, various procurement strategies will be applied to obtain fair prices, access to innovation and a secure supply of medicines. A formulary listing the prices of medicines and health products will be established nationally. A centralised function will be established to assume responsibility for facilitating and co-ordinating all functions related to procurement of health-related products, including medicines, devices, equipment and other products within the NHI environment.
387. The benefits of central procurement derive from leveraging the economies of scale of NHI to obtain the best possible price. The advantages of price determination could save millions of Rands every year. Improving systems and processes within the procurement system will bring greater efficiencies, fewer stock-outs and better access to health products for the patient.
388. The introduction of a national health products list with pre-determined facility or provider levels will greatly streamline the procurement process for facilities. This will also facilitate improved standardisation of prescribing practices and adherence to treatment guidelines.
389. The selection of medicines and other health technologies will be based on burden of disease, efficacy, safety, quality, appropriateness and cost-effectiveness. The list will be reviewed on a regular basis to take account of changes in the burden of disease, product availability, and price changes based on evidence.
390. Pharmaceutical depots are no longer a preferred method for ensuring the sustainable supply of medicines because of the inherent risks of pilferage, expired stocks, lack of security of supply, drug stock outs and inefficient distribution to health care facilities. A mechanism of direct delivery of health commodities from suppliers to facilities shall be implemented.

8.9 Containing cost and improving efficiency in resource use

391. To ensure that the phased implementation of NHI remains sustainable and affordable to the country over the medium to long term, government will have to implement various measures to effectively control costs. The cost containment measures implemented will have to holistically address both supply side and demand side constraints, while ensuring that providers are fairly reimbursed for the health services provided without compromising the quality of care rendered to the population. Table 8 summarises the supply and demand side interventions that have been used to determine the cost-containment measures for the NHI:

Table 8: Summary of supply side and demand side cost containment measures

Supply side	Demand side
Reforms to provider reimbursement methods	Reforms to the voluntary health insurance tax policies (including subsidies)
Promoting greater provider competition	Stronger enforcement of referral systems through gate-keeping function
Selective contracting	Compliance with stipulated treatment protocols and clinical guidelines
Innovative pharmaceutical procurement and distribution policies	
Budget caps	
Workforce and malpractice legislation	

Source: OECD 2015

392. Furthermore, many countries have gone even further to effect public management reforms that support cost containment at the service planning, delivery and provision level. These interventions have included promoting stronger and more direct control of pharmaceutical prices through improving regulatory capacity around determining and capping drug prices accompanied by mandatory generic substitution; stronger decentralisation of health system functions around planning and service delivery to sub-national levels; and health technology assessment being increasingly used as a mechanism to promote efficiency in health system funding allocation and judicious definition of the interventions to be included in the package of health entitlements covered by public health.
393. There is a growing evidence base on how to achieve universal access to quality health services on an affordable and sustainable basis, drawn from the practical experiences of low- and middle-income countries (from as far afield as Thailand and Estonia). The 2000 World Health Report⁵⁰ states that “*strategic purchasing involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom.*” It is internationally accepted that strategic purchasing is required to ensure that the health system operates efficiently, does not experience uncontrolled expenditure increases and maintains quality in health services on an ongoing basis. Affordability and sustainability can be ensured through what is termed ‘strategic or active purchasing’⁵¹, which requires paying attention to key aspects namely:
- The services that will be purchased and how the population will access them. The essential considerations include the following:

⁵⁰World Health Report 2000: Improving health systems performance. WHO, Geneva.

⁵¹Resilient and Responsive Health Systems (2014) *What is strategic purchasing for health.* <http://resyst.lshtm.ac.uk/researchprojects/multi-country-purchasingstudy>

- i. There should be a strong emphasis on disease prevention and health promotion and not only on curative services through a re-engineered Primary Health Care platform. There is a rapidly growing burden of chronic diseases such as diabetes and hypertension in South Africa, much of which could be prevented through a robust prevention, health education and promotion programme;
 - ii. Centralised procurement of pharmaceutical products, medical and surgical consumables and medical equipment;
 - iii. Efficient use of laboratory services, and blood and blood products;
 - iv. The most cost-effective, evidence-based interventions should be provided, which can be ensured by developing an essential list of generic drugs, surgical and other medical supplies and standard treatment guidelines that indicate the appropriate range of diagnostic tests and treatment interventions for all common illnesses. Health technology assessment and economic evaluation should be undertaken for new technologies to assess whether or not they are more cost-effective than existing health service interventions; and
 - v. With the exception of medical emergencies, health services must be accessed at the primary health care level, with referral to specialist services when needed.
- b. The service providers that will be accredited and contracted to provide services that are covered by the NHI Fund. The essential considerations here include the following:
 - i. All public health facilities (clinics, community health centres and hospitals) which provide services at considerably lower cost than private for-profit providers, should be the backbone of the health system
 - ii. Providers that services will be purchased from should be accredited on the basis of their ability to provide a comprehensive range of services (to ensure access for all irrespective of where they live), quality of care, location relative to the population in need of health services and acceptance of the provider reimbursement tools and rates; and
 - iii. Government will put into place the necessary regulatory and policy interventions to determine tariffs for health services (including provider tariffs, and prices for pharmaceuticals and related products). The law will equally apply to public and private providers including suppliers of medicines.
- c. Importantly, it is important that robust systems are put into place to influence how services will be purchased through:
 - i. Creating a purchaser-provider split that will introduce the active purchasing function by strategic engagement with suppliers to ensure value for money
 - ii. Establishing service agreements or contracts with service providers (public and private sectors) to clarify expectations on the range and quality of services to be delivered, requiring adherence to the essential drug list and standard treatment guidelines, and specifying information that providers should submit to the NHI Fund and the methods and rates of payment.
 - iii. Introducing ways of paying providers that create appropriate incentives to promote efficient provision of quality services, such as capitation payment for primary health care services and diagnosis related group payments for hospital

services, with comparable rates being paid to public and private providers. This should be accompanied by global budget caps to ensure that overall expenditure does not exceed available resources.

- iv. Ensuring that the NHI Fund can use its purchasing power (as a single, large fund purchasing personal health services for the entire population) to establish affordable provider payment rates and ensure that they do not increase at an unsustainable pace. Providers will be free not to contract with the NHI Fund if they choose not to. The substantial purchasing power of the NHI Fund can also be used to procure pharmaceuticals, surgical and other medical consumables at the lowest possible cost for distribution to all accredited providers.

394. There are other strategic purchasing actions that can be implemented to further strengthen cost containment interventions as phased implementation progresses. The NHI Fund will have to use strong information systems that will enable routine monitoring of service provision (e.g. clinical quality of services in terms of appropriateness of diagnostic and treatment interventions; evaluating provider payment claims) and to ensure that expenditure is in line with available resources. The information system will also have to support the risk identification and mitigation interventions to ensure all fraudulent activities (on the part of providers and users) are immediately identified and addressed. Further, the creation of the NHI Fund as a strategic purchaser must be accompanied by increased management autonomy in public facilities to enable them to respond to incentives for the efficient provision of quality services (e.g. to make decisions on the appropriate and least costly staff mix). Cost containment will also focus on legislative reforms that create a transparent tariff determination.

8.10 The future role of medical schemes

395. The role that medical schemes will play within NHI must be considered within the current context of the existing two-tiered health system. The establishment of NHI will ensure that the State optimally utilises available resources to the benefit the national population including post-retirement entitlements. This requires that government intervenes strategically and decisively to eliminate fragmentation in funding pools which has been shown to adversely impact on the performance of the current health system. This fragmentation and resulting inequities in access to and use of health services provides the basis upon which NHI is necessary to ensure the progressive realisation of universal health coverage.

396. 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 the benefits covered by the NHI Fund.

397. One of the core objectives of NHI is to optimise the utilisation of available resources, including financial and human resources, and to ensure that people do not insure against the same health care costs twice. To this effect, it is important that mechanisms are put into place so that medical schemes work in tandem with the NHI Fund in streamlining covered health care entitlements to ensure value for money and to

eliminate duplicative cover and double dipping. This requires an alignment of the health benefits offered by the medical schemes industry and those covered by the NHI Fund.

398. Medical schemes currently operate as voluntary prepayment health financing intermediaries, offering private medical insurance cover to those that can afford 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 cover for many individuals and households ends with the termination of a person's employment, for example, upon retirement or retrenchment which means that such individuals and households will then fall back onto the State for the health care they need.
399. In line with international experience, individuals and households will have the opportunity to purchase voluntary private medical scheme membership to complement this universal entitlement if they choose to. Private health insurance coverage, such as that offered by medical schemes can play various roles (see **Table 9**) within South Africa's universal coverage health system. As part of the transition process medical schemes will play a supplementary role. Once NHI is fully implemented medical schemes will offer complementary cover to fill gaps in the universal entitlements offered by the State.

Table 9 : Alternative roles of voluntary health insurance

Role of private health insurance	Driven by	Covers
Substitutive	Breadth of coverage	Provides coverage that would otherwise be available from the state. It is purchased by those who choose to opt out of statutory health insurance or are excluded from participating in some or all aspects of the national health insurance system (such as foreign visitors, professionals involved in extreme sports, etc).
Complementary	Scope of coverage Depth of coverage	Provides coverage for services excluded or not fully covered by statutory health insurance. It sometimes covers whole areas of care, such as dental care in many European systems or outpatient pharmaceuticals in Canada. It can also cover the cost of statutory user charges, where cost sharing exists (e.g. France). Its form is influenced by the nature of the benefits covered by statutory health insurance.
Supplementary	Consumer preference	Usually covers the same range of services as statutory health insurance, aims to increase the choices of provider (e.g. private providers or private facilities in public institutions) and level of inpatient amenities (e.g. a single room). By increasing the choices of provider it may also provide faster access to health care. Often sold in combination with complementary and/or substitutive private health insurance.

400. 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 fund towards the funding required for NHI. However, it is necessary to take into account the reality that irrespective of how comprehensive the NHI entitlements will be, some personal health care 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.

401. In future, all medical schemes will only offer complementary cover for services that are not included in the health service benefits and medicines approved by the NHI Benefits Advisory Committee. The cover provided by medical schemes must only complement (and not duplicate) the NHI service benefits. Part of this work will require a complete overhaul to the existing Prescribed Minimum Benefits regime, taking into account the burden of disease and changing population demographics. This will ensure that the population is granted greatest possible access to health care services by everyone within available resources.
402. When NHI is fully implemented, it is anticipated that the number of medical schemes will reduce from the current 83 to a much smaller number.
403. The transition from the current role to a future evolved role of medical schemes will require changes to the Medical Schemes Act. The amendments will be initiated in the second phase of implementation as part of the broader phased implementation approach.
404. Government recognises that there is existing expertise residing in the medical schemes industry with regards to various areas of the NHI. 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 over the 14-year phased implementation period. The expertise will be drawn upon where necessary to build in-house capacity within the publicly-administered Fund, rather than to outsource any component to a private entity.

CHAPTER 9: PHASED IMPLEMENTATION

405. The transitional process from the current health system to the proposed NHI environment requires a well-articulated implementation plan.
406. A key step in the transition is to strengthen the health system. Pilot districts have been selected on the basis of a detailed facility audit assessing health systems capacity, as well as socio-economic and demographic profiles, burden of disease and selected health indicators to initiate health systems strengthening activities. The specific interventions that have been piloted include: strengthening the service delivery platforms at primary care level including WBPHCOTs, integrated school health programme, district clinical specialist teams, contracting with private providers, strengthening management and governance at facility level and at the district, and improving management of central hospitals as well as improving infrastructure of health facilities.
407. Transition from the current system, including the piloting process starting at PHC level and extending to higher levels of care, phased over a period, will be supported by a detailed risk management plan and a monitoring and evaluation plan that will allow close monitoring of progress. NHI will be implemented in three phases outlined below:

9.1 Phase I of the Implementation

408. This phase extends from 2012/2013 to 2016/2017 financial years. Activities in this phase have been funded through a combination of sources which include NHI Conditional Grants, equitable share allocations and other grants such as the HIV Grant. During this phase, a Transitional Fund will be established to fund contracting of providers at the PHC level.
409. This phase will also include various activities in preparation for the full implementation of NHI. Part of this work includes the strengthening of the health system and the creation of a Project Team through the NHI work-streams which will oversee all phases for the establishment of a functional NHI Fund and other preparatory work. The following activities take place during this phase:

9.1.1 Health System Strengthening Initiatives

- a) Implementation of the four streams of PHC Re-engineering including contracting of general practitioners and other private PHC health professionals into public health facilities
- b) Quality improvement in clinics through the Ideal Clinic Model, public hospitals
- c) Implementation of the Centralised Chronic Medication Dispensing and Distribution (CCMDD) programme
- d) Amendments to the NHLS Act and National Public Health Institute of South Africa (NAPHISA) Bill
- e) Implementation of EMS Regulations
- f) Establishment of Hospital and Clinic Governance Structures
- g) Strengthening financial management and procurement reforms
- h) Implementation of the Human Resources for Health Strategy

- i) Implementation of the eHealth Strategy
- j) Strengthening management and leadership for the overall health system.

9.1.2 Moving central hospitals to the national sphere

410. Central hospitals will be reformed to be semi-autonomous and a national competence. Amendments to the National Health Act and regulations for the governance and management of these hospitals will be promulgated. A Transitional Fund will be established for the funding of functioning of these hospitals.

9.1.3 Establishment of the NHI Fund

411. Establishing the NHI Fund will require the development of systems and processes to ensure its effective functioning and administration. These include the development of a provider payment system (DRG system), health patient registration system, health provider registration system and fraud and risk mitigation system.
412. Providers and patients will be registered. A web based Health Provider Registration System will be deployed for provider registration for all categories of providers. Patients will be registered at designated public facilities using the health patient registration system.
413. The NHI Fund will initiate the process of accrediting Ideal Clinics, private PHC Providers and public hospitals once they have been certified by respective bodies such as the OHSC and respective health professions statutory bodies.
414. Six work streams will be established to support the required activities. These are:
- a) Work Stream 1: Prepare for establishing the NHI Fund including reviewing other relevant legislations and inter-governmental functions and fiscal framework that will be impacted by the implementation of NHI
 - b) Work Stream 2: Clarification of the NHI benefits and services including the PHC 'Lab'⁵²
 - c) Work Stream 3: Preparation for the purchaser-provider split
 - d) Work Stream 4: Review of medical schemes to define their future role
 - e) Work Stream 5: Completion of NHI Policy paper and NHI Bill
 - f) Work Stream 6: Strengthening of the District Health System in preparation for a functional DHMO

9.1.4 Institutions that will be established

415. The following institution will be established during this phase:
- a) The Office of Health Standards Compliance;
 - b) District Health Management Offices (DHMO); and
 - c) National Health Commission.

⁵² Operation Phakisa will focus on the national roll-out of the PHC 'Ideal Clinic' program.

9.2 Phase II of Implementation

416. This phase will extend from 2017/2018 to 2019/2021 financial years. Other health system strengthening activities identified in phase one will continue to be implemented during this phase. Implementation of NHI in Phase 2 will include the following activities:

9.2.1 Purchasing of services to be funded by NHI

417. During this phase, the Transitional Fund will be used to purchase personal health services from contracted public and private providers at the PHC level including general practitioners, audiologists, oral health practitioners, optometrists, speech therapists etc. In the latter stages of this phase the NHI Fund will purchase personal health services from public hospitals (central, tertiary, regional and district hospitals) and EMS. NHLS Services will also be purchased in the latter stages of phase 2 of the implementation of NHI.

9.2.2 Mobilisation of additional resources

418. Mobilisation of funding resources will be undertaken through alignment of the funds directed at medical benefits for Compensation Funds as indicated in the Comprehensive Social Security Review Discussion document.
419. A review of state subsidies to medical schemes (into GEMS, Polmed, Parmed and other private medical schemes to which the state makes contributions as an employer including state-owned entities) will be undertaken. These subsidies will be reallocated into the NHI Fund.

9.2.3 Establishment of a fully functional NHI Fund

420. An NHI Fund with all the identified units will be fully functional. 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.

9.2.4 Establishment of NHI Fund Management and Governance Structures

421. The NHI Fund will be governed by the NHI Commission as an external oversight mechanism. The Commission will also include civil society representatives. In the latter stages of Phase 2 the following structures will be established:
- i. Appointment of the NHI Commission
 - ii. Appointment of Management Team
 - iii. Appointment of a Stakeholder Representative Forum

9.2.5 Population Registration Process

336. The HPRS will be deployed in all public PHC health facilities in all 52 districts as well as in the 400 hospitals in the public sector. 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 NHI. South Africans that have been registered will be issued with an NHI card linked to the Department of Home Affairs' smart identification system. The information on the NHI card will be encrypted and will be utilised to access services at different levels of the health system.

9.2.6 Amendments to the Medical Scheme's Act

422. In latter stages of this phase amendments to the Medical Schemes Act will be initiated as part of the broader phased implementation approach. The activities to be undertaken in this phase will involve consideration for the creation of an interim single 'virtual' pooling arrangement for schemes not funded through the State. Private providers will be required to comply with a uniform information system for registration and reimbursement that comply with the stipulated requirements of the NHI Fund.

9.3 Phase III of Implementation

423. This phase will extend from 2021/2022 to 2024/2025 financial years. The phase will include contracting with accredited providers beyond public sector hospitals and mobilisation of additional financial resources for the NHI Fund. The following activities will be undertaken in the third phase of implementation:

9.3.1 Introduction of mandatory prepayment for the NHI

424. The fully established NHI Fund will require supplementary funding mobilised through mandatory prepayment taxes.

9.3.2 Contracting for accredited private hospital and specialist services

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

9.3.3 Finalisation and implementation of the Medical Scheme's Amendment Act

426. Medical schemes will evolve and consolidate during this phase to provide complementary cover.
427. As the medical scheme industry consolidates, where necessary and relevant, expertise may be drawn upon to support the implementation of a single payer, publicly-administered NHI Fund. The expertise will be drawn upon where necessary to build in-house capacity within the publicly-administered Fund, rather than to outsource any component to a private entity.

CHAPTER 10: CONCLUSION

428. This White Paper lays the foundation for moving South Africa towards universal health coverage through the implementation of NHI. Building on the significant achievements over the last 20 years, the NDP envisions that by 2030 South Africa should have made significant strides in moving towards universal health coverage and that this will be critical to realising the vision of a long and healthy life for South Africans.
429. NHI seeks to transform the financing of the health system in pursuit of the goal of universal health coverage. Implementation of NHI will be based on the principle of the right of all citizens to have access to quality health services that are delivered equitably, affordably, efficiently, effectively and appropriately based on social solidarity and health as a public good.
430. In moving towards universal health coverage, NHI will extend population coverage, improve the quality and quantity of services that the covered population will be entitled to, as well as reducing the direct costs that the population will be exposed to when accessing health care. This will protect individuals and households from out-of-pocket expenses and financial catastrophe related to health care. NHI will provide cover to co health entitlements that are delivered comprehensively and based on scientific evidence.
431. To implement NHI successfully will require the transformation of health service delivery and management, particularly to improve the quality of health services in both the public and private sectors. This will be achieved through re-organisation of the health care system and will be undertaken in the first phase of implementation. Reorganisation of the health care system will include PHC re-engineering the implementation of the Ideal Clinic Model and establishment of the National Health Commission, reforms to the management and governance of hospitals, quality improvement including through the establishment of the Office of Health Standards Compliance and quality improvement initiatives including addressing the seven domains of quality in the areas of 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.
432. The key focus of the NHI transformation is to create a single, publicly owned and administered NHI Fund that purchases health services on behalf of the entire population from suitably accredited providers. Transforming the health care financing system requires changing how revenue is collected to fund health services 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 at the point of use of health care services will be avoided.
433. Equally importantly, 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 requires the establishment of strong governance mechanisms and improved accountability for the use of allocated funds.

434. Implementation of NHI will 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. This will require a review of inter-governmental functions and inter-governmental fiscal relations as they pertain to the health sector. The policy will also be subject to review as implementation happens to ensure that emergent problems that arise out of the implementation of NHI are addressed in time and appropriately.

BIBLIOGRAPHY

Ataguba JE, Akazili J, McIntyre D (2011). Socioeconomic-related health inequality in South Africa: evidence from General Household Surveys. *International Journal for Equity in Health* 10: 48

Ataguba JE, McIntyre D (2012). Who benefits from health services in South Africa? *Health Economics, Policy and Law*. Doi: 10.1017/S1744133112000060

Bobadilla J-L (1994). *Design, Content and Financing of an Essential National Package of Health Services*. Geneva: WHO

Cleary S, Birch S, Chimbindi N, Silal S, McIntyre D (2012). Investigating the affordability of key health services in South Africa. *Social Science and Medicine* (in press)

Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. (2009). The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges. *The Lancet*; 374: 817-34.

Council for Medical Schemes *Annual Report, 2014-15*. Pretoria: Council for Medical Schemes.

Department of Health (1997). The White Paper on the Transformation of the Health System: Towards a National Health System

Department of Health (2003). National Health Act, Act No 61, 2003

Drechsler D, Jutting J (2005). *Is there a role for private health insurance in developing countries?* Berlin: German Institute for Economic Research.

Gilson L, McIntyre D (2005). Removing user fees for primary care in Africa: the need for careful action. *British Medical Journal*; 331: 762-765.

Goudge, J., Gilson, L., Russell, S., Gumede, T., & Mills, A. (2009). The household costs of health care in rural South Africa with free public primary care and hospital exemptions for the poor. *Tropical Medicine and International Health*, 14(4), 458-467

HEU (2012). *Community preferences for improving public sector health services in South Africa. What aspects of public sector health service quality improvements should be prioritised?* HEU Policy Brief. Cape Town: Health Economics Unit (HEU), University of Cape Town.

Hussey P, Anderson GF (2003). A Comparison of Single- and Multi-Payer Health Insurance Systems and Options for Reform. *Health Policy*; 66: 215-228

Kutzin J (2008). *Health financing policy: A guide for decision-makers*. Copenhagen: WHO Regional Office for Europe.

Lagarde M, Powell-Jackson T, Blaauw D (2010). *Managing incentives for health providers and patients in the move towards universal coverage*. Background paper for the global symposium on health systems research. Geneva: World Health Organisation.

McIntyre D (2012). What health care financing changes are needed to reach universal coverage in South Africa? *South African Medical Journal*; 102(6): 489-490

Nkosi M, Govender V, Erasmus E, Gilson L (2007). *Investigating the role of power and institutions in hospital-level implementation of equity-oriented policies*. Johannesburg/Cape Town: Centre for Health Policy/Health Economics Unit. (http://www.crehs.lshtm.ac.uk/downloads/publications/South%20Africa_final.pdf)

OECD (2015). Fiscal Sustainability of Health Systems: Bridging health and finance perspectives. See chapter 5, pp 129 – 158.

RESYST (2014): What is strategic purchasing for health? Resilient and Responsive Health Systems Policy Brief.

Savedoff W, Gottret P (Eds) (2008). *Governing mandatory health insurance: Learning from experience*. Washington D.C.: The World Bank.

Shung-King M (2011). *Dilemmas of co-payment and moral hazard in the context of an NHI*. Cape Town: Health Economics Unit, University of Cape Town. (<http://www.heu-uct.org.za>)

Silal SP, Penn-Kekana L, Harris B, Birch S, McIntyre D (2012). Exploring inequalities in access to and use of maternal health services in South Africa. *BMC Health Services Research*; 12: 120 doi:10.1186/1472-6963-12-120

Statistics South Africa (2008). *Income and expenditure of households 2005/06: Analysis of results*. Pretoria: Statistics South Africa.

Strittmatter A, Sunde U (2011). Health and economic development: Evidence from the introduction of public health care. Discussion Paper No. 2011-32. St. Gallen: Department of Economics, University of St. Gallen.

WHO (2007). *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*. WHO's Framework for Action. Geneva: World Health Organisation

WHO (2010). *Health systems financing: the path to universal coverage*. Geneva: World Health Organization.

WHO CSDH (2008). *Closing the gap in a generation: Health Equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

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