planning, monitoring & evaluation
Department:
Planning, Monitoring and Evaluation
REPUBLIC OF SOUTH AFRICA

2030 NDP

Socio-Economic Impact Assessment System (SEIAS)

Final Impact Assessment (Phase 2):

White Paper on National Health Insurance

11 May 2017

Final impact assessment: White Paper on National Health Insurance for South Africa

1. THE PROBLEM STATEMENT/ THEORY OF CHANGE

1.1 Give summary of the proposal, identifying the problem to be addressed and the root (causes) of the problem that will be addressed by the new rule.

(a) Summary of the proposal (Summary Background of the proposed policy)

The National Department of Health proposes to publish the revised White Paper on National Health Insurance (NHI) as a final Policy on NHI. The finalisation and publication of the White Paper on NHIfollows the publication on 11 December 2015 of the draft White Paper on NHIand receipt of more than 160 written comments from various stakeholders.These comments were evaluated and considered when the draft White Paper was revised.

The White Paper on NHI is aimed at providing a policy framework for transforming health system in the manner in which health care services are financed and purchased, as well as how these services are provided. NHI is aimed at transforming the fragmented two-tiered health system, the public and private, into a unified health system as envisaged by the 1997 White Paper on the Transformation of the Health System in South Africa.

NHI is aimed at moving South Africa towards universal health coverage (UHC) underpinned by the Constitutional mandate for the State to achieve the progressive realisation of the right to health care services as contained in Section 27 of the Bill of Rights. NHI is about equity and providing social protection and is a reflection of the kind of society that South Africa should become: a society that based on the values of justice, fairness and social solidarity.

The implementation of NHI is consistent with the global vision that health care should be a social investment and therefore should not be subjected to market forces where it is treated as a normal tradable commodity.This is underpinned by the United Nations (UN) Declaration on Human Rights, the UN Office of the High Commissioner on Human Rights in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and Goal 3 of Sustainable Development Goals (SDGs) on Universal Health Coverage (UHC).

NHI is premised on the principle that all South Africans, irrespective of their socio-economic status will have access to needed quality health care servicesthat are free at the point of care. This would ensure that the population and households are protected from financial hardships that emanate from accessing health care services.Vulnerable populations would be prioritised.

The South African health system is historically inequitable and fragmented and has been described as a two tiered system consisting of the public and private health sectors. South Africa spends almost 8.6% of gross domestic product (GDP) on health care, which is comparable to other middle income countries. However, 4.1% of health expenditure as a percentage of GDP is spent on 84% of the uninsured population served in an over-burdened public health sector whilst 4.4% isspent on 16% of the population covered by private medical schemes and who in the main access their health care services in a costly private sector.

In addition to financial resource misalignment, the health system is characterised by the mal-distribution of human resources with a high proportion of health care professionals relative to the population located within the private sector. This occurs in the contextof anescalating burden of disease as a result of communicable diseases, non-communicable diseases, relatively high maternal and child mortality and trauma and injuries that are managed

predominantly in the public health sector. Additionally, human resource mal-distribution is exacerbated by poor implementation of policies such as remunerated work outside of the public service (RWOPS), where a significant proportion of full-time public service professionals perform work in the private sector even during hours designated for public service.

The increasing burden of disease;financial resource misalignment;and challenges in the health work-force and human resource planning and management exacerbated by poor leadership and governance, shortages in pharmaceuticals and technology;as well as challenges in using data and information for decision-makingin the sector. This has contributed to poor delivery of services that has impacted negatively on quality of health careas well as poor quality of health care services in the public health sector.

NHI is aimed at moving South Africa closer to universal health coverage where: the entire population especially vulnerable populations are covered; coverage to needed quality health services is available for all; whilst protecting households from financial risks and reducing user and out-of-pocket payments when accessing health care servicesthus creating a unified health system. NHI will transform the financing, purchasing and provision of health care services underpinned by the provisions of Section 27 of the Bill of Rights on progressive realisation of the right to health carethrough:

- transforming mechanisms of generating revenue throughmandatory prepayment taxes that consist of a combination of taxes mainly general tax revenue augmented by NHI-specific taxes such as employer and employee payroll taxes, surcharge on taxable income and other transactional and excise taxes will be used to cover all in the population to achieve the principle of financial risk protection. Furthermore, other health care related revenues from social security funds such as RAF and COIDA will also be sources of revenue;
- Tax rebates from medical schemes will be phased out as the NHI evolves, the tax treatment of medical expenses and medical scheme contributions will be reviewed and this will contribute to a reduction in the need for medical scheme contributions and/or the level of private health insurance coverage required. The resulting saving in tax expenditure could help to reduce proposed tax increases. As the tax-rebates are reviewed, 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;
- pooling of the generated revenue and risks into a single pool underpinned by the principle of social solidarity and cross-subsidisation through the NHI Fund;
- Strategic purchasing of health care services through a single monopsony purchaser, the NHI Fund,to improve the efficiency and performance of the health system whilst using economies of scale, alternative reimbursement strategies and pricing to contract certified and accredited public and private health care providers and to make health care delivery affordable and sustainable; and
- covering comprehensive quality health care benefits delivered by contracted public and private providers at appropriate levels of care through a motivated, capacitated and competent health workforce. Comprehensive services will have a focus on disease prevention and health promotion using a primary health care (PHC) approach, and a continuum of other services from other community based services, rehabilitative, curative, and palliative to ensure sustainability whilst also addressing.

NHI will be implemented over fourteen (14) years in three phases. The first phase of implementation has taken place over five (5) years starting in 2012/13 and would end in 2016/17. During the first phase, health systems strengthening initiatives within the 11 NHI Pilot districts and in the areas of:

- Improving quality in health facilities such as with Operation Phakisa-Ideal Clinic initiative, the implementation of the Quality Standards for Health and the establishment of the

Office of Health Standards Compliance (OHSC)to inspect and certify health establishments against prescribed norms and standards for quality as well as the appointment of the Health Ombudsman;
- Improving governance and management of health establishments through strengthening hospital boards, clinic committees and management of the different levels of hospitals and clinics;
- PHC Re-engineering through municipal Ward-Based PHC Outreach Teams (WBPHCOTs), integrated school health programme, District Clinical Specialist Teams and contracting-in of PHC providers such as general practitioners (GPs);
- Improving health workforce planning and management especially for the nursing and medical professions by strengthening and expanding the training platform;
- Implementing the e-Health Strategy to strengthen information management;
- Improving availability of medicines and technology in health facilities in readiness for full implementation the implementation of the Direct Delivery Strategy (DDS), Central Chronic Medicine Dispensing and Distribution Programme (CCMDD), the operationalisation of the Control Tower and Provincial Medicine Procurement Units (PMPU), end-to-end visibility in the supply chain and electronic data interchanges and direct purchasing;
- Health Patient Registration linked to the Department of Home Affairs Identification mechanisms in public PHC facilities in the NHI Pilot districts; and
  Strengthening the provision of laboratory services through reforms to the National Laboratory Services (NHLS)

The second phase of implementation will commence in the 2017/18 and end in 2020/21 and will focus finalising the legislation for NHI and establishing the NHI Fund. Some of the specific activities during the second phase include:

- Legislative process to establish the NHI Fund;
- Amendments to other legislations that will be impacted by NHI such as the Chapters 3; 4 & 5 of the National Health Act servicesto redefine the new roles and functions that will be assigned to the different spheres of government in the delivery of health care care; and the Road Accident Fund (RAF) and the Compensation for Occupational Injuries and Diseases Act (COIDA) in anticipation of broader Comprehensive Social Security Reform to align the funding of personal health care services allocated to compensation funds to avoid double dipping and fragmented funding. Legislative amendments will accommodate these changes;
- Amendments to the Medical Schemes Act as the role of medical schemes will evolve to provide complementary cover in an NHI environment;
- Establishment of institutional structures and governance mechanisms for the NHI Fund for strategic purchasing;
- Population registration processes using the Health Patient Registration system linked to the Department of Home Affairs smart identification system prioritising vulnerable populations;
- Certification of health establishments by the OHSC;
- Accreditation of providers that have been certified by the OHSC
- Contracting with accredited PHCproviders (public and private) based on needs in the population through the Contracting Unit for PHC (CUP) located at a sub-district level and that will include the district hospitals;
- Contracting with public hospitals starting with central hospitals and progressively moving to other levels of care;
- Mobilisation of additional financial resources to establish the NHI Fund; and
- Ongoing health system strengthening initiativesundertaken in phase one will continue to be implemented.

The third phase will commence in 2021/22 and extend to 2025/26 and beyond. Some of the specific activities that will be undertaken during this phase will include:

- Ongoing health system strengthening initiatives undertaken in phase one and two will continue to be implemented;
- The introduction of NHI-specific taxes from eligible tax-payers as determined by National Treasury;
- Consideration for contracting with private providers at higher levels of care informed by the need in the population as well as gaps in provision of servicesfrom contracted providers.

(b) Problem/s and root causes that the proposal is trying to address

Identified Problem	Root causes
1. High Burden of Disease that are managed predominantly in the public health sector namely: – High levels of communicable diseases – Increasing levels of non-communicable diseases – Relatively high maternal and child mortality rates and – Increasing levels of trauma and injuries	**1. Burden of Disease** a) South Africa is confronted with a high burden of disease because of HIV and AIDS and Tuberculosis and non-communicable disease such as hyperrtension, diabetes mellitus, asthma, cancers, cardiac diseases, mental health problems and other lifestyle related diseases. b) The high levels of maternal neonatal and child morbidity and mortality are as a result of poor antenatal and perinatal care as well as social determinants of health including availability of water and sanitation. c) There are increasing high levels of violence and trauma as a result of consumption of alcohol and drugs, and increasing levels of stress in society. d) All these factors place an excessive burden on the public health system that is under-resourced and overburdened in the face of the growth of the population that is dependent on public health care services, and the increasing burden of disease. **2. Structural Problems** **a) Poor leadership and governance, shortages** – Fragmentation and poor leadership at the different levels of care that has resulted in suboptimum conditions of delivering quality health services – Inadequate knowledge and skills amongst public sector managers – Weak accountability mechanisms are linked to inadequate, disparate measures and standards for managing performance (good or poor) that is exacerbated by a semi-federal public sector. – Weak systems of governance and leadership due to poor regulation and less accountability in terms of quality and costs – Poor clinical governance in the private sector **b) Shortages and poor management of the health workforce** – The shortage of key health professionals is being experienced in the face of the growth of the population that is dependent on public health care services, and the increasing burden of disease – Skewed distribution of key health professionals between the public and private sectors – Mismatch between urban and rural areas – Financial resource constraints for HR in the face of a bloated management and adminstration component – Poor job design, performance management systems, remuneration policies, employment relationships, in hospitable physical work environment, shortages of equipment and other tools of trade, workplace cultures and human resource practices, facility workforce planning and career-pathing – Poor implementation of policies such asRemunerative Work Outside of Public Service / moonlighting during working hours that compromises patient care and training of health professionals **c) Weak service delivery platform** – Quality especially in the public sector, delivery of health care services has been associated with dissatisfaction amongst the users with

Identified Problem	Root causes
	respect to acceptability of the health care services and patient experience. - Public sector facilities that when assessed against core quality standards indicatepersistent problems in the areas of staff attitudes, waiting times, cleanliness, drug stock outs, infection control, and safety and security of staff and patients - The service delivery platform still leans heavily towards curative, hospital-centred, unsustainable, and high cost care, with limited adherence to any referral system **d) Lack of or poor supply of medical products and health technologies** Availability of medicines as a result of inefficiencies in pharmaceutical supply chain, inventory procurement costs, medicine stock-outs, trade-deficits on unaccounted stock, and expired medication **e) Poor information management and ability to use research for decision making** The lack of a coherent unified health information management system **f) Inequitable and fragmented health care financing** - Inequitable health care financing where whilst spending 8.5% of GDP on health, 4.1% of the GDP is spent on 84% of the population, the majority utilising the public health sector whilst 4.4 % of its GDP is spent on only 16% of the population; - 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%. Health care benefits are not distributed in line with the need for health care services; - 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 or where scheme benefits have run out; - Unsustainable prescribed minimal benefits (PMBs) that are based on a positive list of medical conditions and where medical schemes are mandated to cover the costs related to the diagnosis, treatment and care; - Fragmentation of funding and risk pools within and between public and private health sectors, which limits the potential for income and risk cross-subsidisation. - Challenges in the inter-governmental fiscal arrangements (IGFR)that relates to striking a balance between the need to provide constitutionally mandated basic services (CMBS) within macroeconomic constraints that limit the available resources and a fiscal federal structure that has its own defined priorities - Escalating costs of private medical schemes is unaffordable for the majority of South Africans with spending through medical schemes in South Africa is the highest in the world and is six times higher than in any OECD country and represents more than 6 times the 2013 OECD average of 6.3%. - Financing through medical schemes and out-of-pocket payments account for a significant proportion of private health care financing. There are three forms of out-of-pocket payments (OOPs) disadvantages the poor and leaves many citizens at a high risk of financial ruin due to catastrophic health expenditure - Misalignment of legislation e.g. RABSA, COIDA

1.2 Describe the intended outcomes of the proposal

NHI is intended to ensure that South Africans live long, healthy and economically productive lives by making health care services to be delivered equitably and in an accessible and affordable manner especially for vulnerable members of the population including the unemployed, by moving towards universal health coverage (UHC). The enables for this intended output enables for this outcome include:

a) The intermediate objectives of NHI in moving South Africa towards UHC include:

- **Equity** in resource distribution to address fragmentation, underfunding and misalignment of resource between public and private; urban and rural and within and as imposed by a fiscally federal system underpinned by principles of progressive universalism, the right to health, social solidarity and cross-subsidisation, justice and fairness within a unified and integrated health system;
- **Efficiency** in the areas of productive and allocative efficiency to improve the performance of the health system and to contribute to affordability and sustainability of delivery of health care services;
- **Transparency and accountability** through improved leadership, governance and management for services provided and how the health system is financed, thus contributing to a responsive health system.

b) The final coverage objectives of NHI in moving South Africa towards UHC include:

- **Utilisation of health care services aligned to need:** implies providing health care coverage to all population groups and that all groups with a need in the population have access to these needed services and that the poorest and vulnerable populations that usually face the highest health risks and need more health services have unhindered access to quality services and are able to use the health system to access these services;
- **Universal financial protection:** implies providingsocial protection to all people by ensuring that access to needed health services by the population and households to the use of health care services does not expose the user to financial hardship. A key element of financing for UHC is that the health costs for the poor and vulnerable are shared by the whole of society. Furthermore, the health care financing system should aim to spread the financial risks of illness across a wide population, by collecting large pools of prepaid funds that people can draw on to cover their health care costs at times of need, regardless of their ability to pay;
- **Quality:** implies that all needed health services (including prevention, promotion, treatment and rehabilitation) are of sufficient quality to be effective and ensurepatient safety whilst also reducing dissatisfaction amongst the users of health services with respect to acceptability of the health care services and patient experience.

1.3 Describe the groups that will benefit from the proposal, and the groups that will face the cost. These groups could be described by their role in the economy or in society. As a minimum, consider if there will be specific benefits or costs for the poorest households (earning R 7000 a month or less); for black people, youth or women; for small and emerging enterprise; and /or for rural development. Add more rows if required

Beneficiaries

The benefits of NHI are multiple and include: improved financial risk protection through prepayment funding and reducing out-of-pocket payments; reduced inequities and fragmentation in both funding and provision of health services in both the public and private health sectors; improved access to quality health care; improved efficiency and cost containment through streamlined strategic purchasing; improved accountability on the use of

public funds through appropriate governance mechanisms and transparency in performance reporting; and better health outcomes across all socio-economic groups through improved coverage.

Therefore, all South African will benefit from the implementation of NHI. The population that will benefit most is the current 84% of the population that is not covered by medical schemes as NHI will cover quality health care for all irrespective of socio-economic status whilst also covering for financial hardships as healthcare services will be delivered free at the point of care. The most vulnerable populations as described in Chapter 1, Section 4 (2) (d) of the National Health Act, 61 of 2003)and the various subsequent sections of the NHAi.e. women, children, older persons and people with disabilities will benefit most and early as the second phase of implementation will prioritise this group. According to the section on sources of revenue for NHI, only household earning above R70000.00 may be required to pay NHI-specific taxes at a rate of between 0.1% and 3.1% depending on the funding scenario used.

Furthermore, the 16% of the population that is currently on medical scheme's coverage will benefit from NHI as they will also be entitled to comprehensive healthcare benefits instead of fragmented benefits that are currently underpinned inadequate prescribed minimum benefits and very little on PHC services. This section of the population will also enjoy financial risk protection as the uncertainty arising out of escalating cost of medical schemes premiums and out-of-pocket payments from levies, co-payments and other payments as a result of benefits that have been exhausted will no longer be the case.Households will benefit from increased disposable income because of a significantly lower mandatory prepayment level than current medical scheme contributions, savings that will be made due to economies of scale, efficiency gains because of reductions in non-health care costs, and affordability of health care as a result of active and strategic, monopsony purchasing arrangements.

Healthcare providers in the public sector will benefit from a better resourced and more accountable and responsive health system. Health care providers in the private sector will also benefit financially as the patient base will be expanded whilst there will be more certainty on their potential income especially for PHC providers.

The implementation of NHI will provide an opportunity for significant economic and social benefits to South Africa. A well implemented NHI could contribute significantly to improved life expectancy. Economic impact assessments also 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 run. This will also translate to increased happiness of the population as it ensures improved quality of life and increased longevity.

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 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 term. Other benefits are increases in labour participation rates and reduced absenteeism.

Cost bearers

NHI will be funded through a combination of general taxes augmented by NHI-specific taxes from employers and employees earning above a certain income threshold, a surcharge on taxable income as well as transactional taxes such as duties and excise taxes as well as taxes on carbon emission. This implies that the costs of NHI will be borne by a broad tax base including sources such as VAT that contribute to the general tax revenue.

Groups that will benefit	How will they benefit?
a) All South Africans	UHC is aimed at ensuring that all in the population have access to quality health services without exposure to financial hardship
b) Vulnerable populations	– Vulnerable populations such as women, children, people with disability, rural populations and the elderly will be prioritised to benefit from NHI at the early stages of implementation. Services will be delivered closest to where these communities are domiciled. – Economically and socially from the greater productivity and participation in the economy and society of a healthier population
c) The 84% of the population currently not covered by medical schemes	Will benefit from a better resourced and better organised health system where the quality of services will improve and they will not be required to pay user fees
d) Households	Households will benefit from increased disposable income because of a significantly lower mandatory prepayment level than current medical scheme contributions, savings that will be made due to economies of scale, efficiency gains because of reductions in non-health care costs, and affordability of health care as a result of active and strategic, monopsony purchasing arrangements.
e) Current medical scheme beneficiaries	The 16% of the population that is currently on medical scheme's coverage will benefit from NHI as they will also be entitled to comprehensive healthcare benefits instead of fragmented benefits that are currently underpinned inadequate prescribed minimum benefits and very little on PHC services. They will also enjoy financial risk protection as the uncertainty arising out of escalating cost of medical schemes premiums and out-of-pocket payments from levies, co-payments and other payments as a result of benefits that have been exhausted will no longer be the case.
f) Public sector facilities and providers	Through the requirements of NHI for facilities to be certified by the Office of Health Standards Compliance (OHSC) before they are accredited by NHI, public sector facilities will be compelled to improve health services based on the norms and standard for quality. This will force them indirectly to be more accountable and responsive to the needs of communities.
g) Private sector healthcare providers	Private health care providers will benefit from increased number of patients that they can see as well as certainty of reimbursement especially for PHC providers Improvements in
h) All Employees	Delinking health insurance as an employment benefit, where people rely on their employers for insurance especially in situations of members having pre-existing medical conditions that confine them to a particular job, and instead making financial protection and access to quality care a universal entitlement.
i) All Employers	– NHI 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. The increase in labour productivity can vary from 20% to 47.5% in the medium to long term. – Other benefits are increases in labour participation rates and reduced absenteeism.

Groups that will bear the cost or lose	How will they bear the cost or lose
a) All South Africans	– All South African pay taxes that goes into the general tax revenue such as from Personal income tax, excise duties, transactional taxes, VAT and capital gains taxes
b) Employers and Employees	NHI Specific taxes
c) High income earners not on payroll d) Capital income earners e) Unincorporated businesses f) Corporates	– Corporate income tax, surcharge on taxable income and inheritance taxes – Gross income from employment from high income earners not on payroll and capital income (interest and profits in the case of unincorporated businesses).
g) Private Sector Health Care Providers	Selective contracting and regulation of prices in the private sector will reduce the high profits that are currently experienced in this sector and that have contributed to high costs in this sector
h) Private Medical Schemes and Administrators	Under NHI, the role of medical schemes will changeand they will offer complementary cover. There will be consolidation in the sector and the number of schemes will reduce. The challenge that may emerge out of loss of jobs in this sector is that where relevant, skills residing in medical schemes may be used in a single payer, publicly administered NHI

1.4 Describe the behaviour that must be changed, main mechanisms to achieve the necessary changes. These mechanisms may include modifications in decision making process systems; changes in procedures; educational work; sanctions; and or incentives. Also identify groups inside or outside government whose behaviour will have to change to implement the proposal. Add more rows if required.

Groups inside Government	Behaviour that must be changed (Current Behaviour)	Main mechanism to achieve the necessary changes
The public sector management	- Lack of accountability resulting in poor quality and poor leadership and governance - Poor planning and management of human resource, medicines and technology resulting in shortages and inappropriate utilisation of resources - Inability to generate or use data and information for decision-making and planning - Non-observance of the Patients' Rights Charter is at the core of what is regarded as an unaccountable and non-responsive public health system.	- Implementation of the health system strengthening (HSS) initiatives that have been identified in Phase 1 of NHI - Strengthening the role of OHSC - Expediting the full implementation of the Ideal Clinic - Implementation of alternative reimbursement strategies such as hospital-based DRGs and capitation model for PHC services - Performance-based reimbursement strategies
Public health employees	- RWOPs and moonlighting in the private sector - Non-observance of Patients' Rights Charter and Batho-pele Principles	- Review of RWOPs policy - Strengthening of leadership, governance and management of public sector for effective Human Resources for Health management and as a way of enforcing accountability
Provincial Treasuries	- Allocations of funds through a fiscally federal system that exacerbates inequitable distribution across provinces and districts - Fragmented funding pools and an inefficient and inequitable mechanism of allocating budgets for personal health care services not based on needs or national priorities	- Introduction of a strategic purchaser that will pool funds and risks for personal health services is introduced based on need - Amendments to the National Health Act to define the new role of Provinces as well as review new functions and funds. This would require changes to the IGFR framework and relevant legislation
Provincial Department of Health	- PDoH are purchasers and providers of health care and with very little incentives to improve efficiency and accountability - Lack of delegations for functions such as supply-chain management to lower levels such as districts, sub-districts and facilities	- The role of PDOH will have to change as the NHIF will in a progressive manner with the introduction of a purchaser-provider split and a central NHI Fund. The Fund will be purchasing health care services directly from hospitals and Contracting Units for PHC (CUPs) - The PDOH will no longer be budget holders for personal health care services. - Amendments to NHA and the IGFR Framework - PDOH will be responsible for non-personal health services and planning
National Department of Health	- Ineffective coordination and stewardship over the entire health system - Lack of effective implementation of national policies - Poor alignment of national health priorities	- Using the concept of a unified health system for integrated policy and planning as well as governance over the entire health system - Implementation of various sections of the NHA including on Section 36 of NHA - Legislative changes to NHA to redefine the roles and functions of

Groups inside Government	Behaviour that must be changed (Current Behaviour)	Main mechanism to achieve the necessary changes
		the three spheres of government in delivery of health care services - Amendments to other relevant health legislations as part of NHI Bill development
Health districts	- The geographic and populations sizes of the health districts in most parts of the country does not allow for effective planning and management - Lack of understanding the needs of the population - Inappropriate or inadequate skills in the areas such as financial and human resource management	- NHIF will purchase personal health care services from CUPs located in sub-districts or district hospitals. - Health Districts will play the role of coordination, planning and management of non-personal health services and public health programmes

Groups outside Government	Behaviour that must be changed (Current Behaviour)	Main mechanism to achieve the necessary changes
a) Private sector health care providers	- Cost-drivers of health care due to fee-for-service environment that encourages over-servicing - Over-supply of hospitals and market concentration resulting in lack of competition and price-fixing with no prospects for data-sharing - No mechanisms for measuring quality and outcomes	- Alternative reimbursement strategies such as capitation or DRGs through the implementation of a strategic purchaser - introduction of Certificate of Need / regulated issuance of Licences - Certification by OHSC for norms and standards for quality - Accreditation by NHI Fund for performance management including mandatory reporting - Price determination by NHI Fund - Central procurement and HTA based on cost-effective interventions
b) Private Medical Schemes	- High premiums that are unaffordable for members of schemes - Reducing benefits, poor benefit designs including PMBs and very little coverage for PHC services - Out-of-payments and levies that expose households to catastrophic health expenditure - High non-health care costs such as for brokers, administrators and marketing costing between 10-15% of the total costs	- The introduction of a prepayment NHI-specific taxes accompanied by a broad tax base will reduce costs for households and individuals - NHI will provide comprehensive health care service that are evidence-based and cost-effective using a PHC approach - Health care under NHI will be free at the point of care - As NHI will be publicly administered and covering the entire population, there is no need for intermediaries such as brokers and administrators. Administration costs for NHI will be at less than 3%

1.5 Report on consultations on the proposal with the affected government agencies, business and other groupings. What do they see as the main benefits, costs and risks? Do they support or oppose the proposal? What amendments do they propose? And have these amendments been incorporated in your proposal?

The draft White Paper on NHI was published on the 11 December 2015 followed by a period for public comment. There were 162 written comments received:

Stakeholder category	Number received
1. Academic Institutions	5
2. Big business entities including: Chambers of Commerce; Banks; other Financial Institutions; Auditing Firms; Mining Houses and Insurance companies	15
3. Government sector; Statutory and Regulatory Bodies, Multilateral Institutions and public entities	16
4. Individuals	30
5. Labour	8
6. Medical Schemes Industry	9
7. Civil Rights and Patient Advocacy	31
8. Political Entities and Think Tanks	5
9. Hospitals	4
10. Big Pharma	6
11. Providers	33
TOTAL	**162**

Furthermore, the National Department of Health had consultation sessions with health care professionals such as medical practitioners, pharmacists, nursing professions, dentists, allied health professionals, labour unions, bargainingcouncils, academic entities through the deans of health sciences faculties, civil society and patient advocacy groups including people with disabilities, mental health advocacy groupsas the changes most directly impact on them. The NHI Workstreams consulted with medical schemes and their administrators, private hospital groups and faith-based health care providers.

The following key stakeholder groups in government and regulatory authorities were consulted :

- National Treasuryand Provincial Treasuries
- National Department of Health
- Provincial Departments of Health
- Other government Departments such as SAPS, Correctional Services, Public Service and Administration, Labour, Transport and the Road Accident Fund, and the South African Military Health Services, Statutory Councils such as the HPCSA, Pharmacy Council, SANC and Allied Health Professions Council, Council for Medical Schemes
- Fiscal and Financial Commission

The majority of the stakeholder groups and government entities were supportive of the NHI Policy. Some Provincial Treasuries, medical schemes and administrators, private hospital groups and medical specialists and some think tanks were not supportive of the NHI Policy. Where there has been disagreement, the NDOH has responded providing reasons and explanations.

Table on Consultations:

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
1. Government Departments and Agencies (Name them)				
a) National Treasury	- Benefits: View NHI as a potential mechanism for improving efficiencies - Costs: Cost and price escalation and impact on tax-payers - Risks: Fiscal space and sustainability issues	- Conditional support - Support limited benefit package - Want to retain a multi-payer environment	- The implementation of NHI must be done by both Health and National Treasury - VAT to be increased to fund NHI as part	- No, a multi-payer environment would undermine the role of a single strategic purchaser especially for economies of scale - No, VAT has been described by many stakeholders and civil society in particular as a regressive tax that will adversely affect the poor
b) Provincial DoH	- Risks: Loss of power and autonomy over health care budgets - Concern that NHI contradicts Chapter 3 and Schedule 4 of the Constitution on concurrent functions	- Conditional support from other provinces other than W. Cape	- Would like to still play a role as purchasers and providers for personal health services - W. Cape does not support NHI and have the alternative plan called "Our Health Plan"	- No, the proposals are in direct contradiction to a single payer, strategic purchaser and are not based on principles that have been outlined - Legal opinion has been sought and assurance given that there is no section in the NHI Policy that contradict the Constitution. The National Health Act will be amended where appropriate to bring to effect a new definition of the roles of Provinces
c) Provincial Treasuries	- Risk: Concern that NHI contradicts Chapter 3 and Schedule 4 of the Constitution - Risk: Centralisation of	- No. Not Supported	- Would like to still play a role as budget holders for personal health services -	- NO. The National Health Act will be amended where appropriate to bring to effect a new definition of

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
	procurement has resulted in inefficiencies - Risks: Loss of power and autonomy over health care budgets.			the roles of Provinces so that Funds follow Function - Concerns raised perpetuate an inequitable fiscally federally funded health system
d) SAPS	- Risks are that members of the SAPS currently enjoy superior services covered under Polmed - Due to the high risk nature of the job done by members of the SAPS, they are entitled to a special and different dispensation outside NHI that will continue to entitle them to a superior service that compensate in lieu of salary and for staff retention	- NO. Not Supported	- Retention of status quo where they remain covered by POLMED	- NO, other that members of the SANDF, all members of the population will be covered under NHI. International benchmarkinghas also demonstrated that members of the Police are covered through a UHC financing system such as NHI and not through a separate dispensation
e) Correctional Services	- Benefits: Correctional Services will focus on their core business and health will take over what it is Constitutionally mandated to do - Standardisation of services with those of the general population for inmates - Expect that access including to HR and other services will improve - Clarity sought on who will be required to hold budget for State Patients - HRH for Health in Correctional Facilities to be	- YES. Supported	- The health budget for Correctional Services must be incorporated into NHI -	- YES, Health services in Correctional services to be Funded through NHI and benefits to be standardised with those on un-incarcerated populations including for TB

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
	absorbed into public health service			
f) Department of Public Service and Administration	– Under a strategic purchaser, the role of the employer of public servants needs to be clearly defined and where there are envisaged changes such as with pay-for-performance or direct employment by health establishments, the Public Service Act needs to be aligned	– YES, Supported	– Nil	– The implementation plan outlines accountability and delegations within a decentralised employment environment – Negotiations between DPSA and employees in the public sector have to take place at an early stage for the new envisaged roles
g) Department of Labour	– UIF benefits such as maternity and unemployment benefits are not linked to personal health care services – On COIDA, clarity on services such as medical screening and surveillance and whose responsibility will it be	– Yes, supported	– Removal of UIF as an additional source of revenue from Social Security Funds – Medical screening and surveillance remain the responsibility of the employer	– YES, both proposals have been incorporated
h) Department Transport and RAF	– Amendments to RAF to be aligned to NHI Benefits and alternative reimbursement strategies as proposed in White Paper	– Yes, supported	– **Nil**	– **Nil**
i) South African Military Health Services	– Would like to retain a different dispensation for active members of the defence force. – Where appropriate, systems need to be aligned whilst retaining the necessary SECURITY and ACCESS features	– Yes, supported	– **Nil**	– **Nil**

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
	– The platform such as the National Health Council to be used as a general planning and information sharing within the health sector			
j) HPCSA	– NHI should provide a legislative framework that will guide necessary changes required for multi-disciplinary practices	– Yes, support	– Nil	– N/A
k) Pharmacy Council	– Pharmacists are willing to provide diagnostic and curative services for PHC services to increase access – CCMDD must comply with Good Pharmacy Practices	– Yes, support	– Nil	– N/A
l) SANC	– Portability of benefits must not be undermined in migrant communities – NHI must not create an environment where WBPHCOT become a risk because of their skills levels and their non-registerable with statutory body – Currently SANC focuses on Education and Registration and not the Practice of Nursing. With establishment of multi-disciplinary or independent practices, there may be a danger posed on the public – Concerned that number of nurses is not adequate to	– Yes, supported	– Nil	– N/A

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
	address the needs of the country			
m) Allied Health Professions Council	– Risk is that there is no reference to health care providers and services delivered by Allied health professional such as homeopaths, reflexologists, aromatherapy, acupuncture and massage therapists etc	– Yes, supported	– NHI policy must be explicit about the role of Allied Health Professionals in provision of services	– NHI will cover evidence-based health services
n) Council for Medical Schemes	– Support single fund NHI – Risk is that it must not pose disruption of cover during the transition period	– YES, supported	– N/A	– N/A
o) Financial and Fiscal Commission	– Funds must follow function – Provinces need to be consulted when functions change – Have undertaken an Inter-temporal CGE Macro-economic modelling of NHI and it demonstrates that in the long run, NHI will benefit the economy – Risk identified is on Constitutionally mandated powers such as Ambulance Services – Experiences must be learnt on how SASSA and SETAs were established and also how the budget can be carved out by provinces during transitions	– Conditional support	– N/A	– Need to rewrite the National Health Act to ensure that under NHI, funds follow function

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
2. Business (Name them)				
a) Chambers of Commerce including American Chamber of Commerce; **b)** Commercial Banks and other Financial Institutions; **c)** Auditing Firms; **d)** Mining Houses; **e)** General Insurance companies	- Right to choice to be retained - Quality to be improved in public sector otherwise the health system will collapse - If there is certainty created by NHI on affordability, they are willing to pay NHI Taxes - Economic climate poses a risk to sustainability - NHI card will be expensive and should not be used. Instead, use SA smart ID - Mining houses would like NHI to cover occupational health services over the long term period - Use of generics will compromise the viability and economic sustainability of the multi-national originator pharmaceutical industry and access to medicines	- Conditional support of NHI Policy if the concerns raised are addressed except the American Chamber of Commerce	- Instead of implementing NHI, implement a voucher system for the poor - Use of Department of Home Affairs smart ID instead of issuing a new expensive NHI Card	- On vouchers, NO as NHI is intended to establish a single pool of funds and risks and create an integrated unified health system based on solidarity - On issuing of NHI Card, the White paper has been amended accordingly
f) Big Pharmaceutical Industry	- Concern that direct delivery will increase the price of medicine - Want direct participation in the establishment of HTA Capability - Want price of medicines to increase for the survival of the industry - Medical schemes to have a supplementary and substitutive role - Want over the counter	- Conditional support	- Medical schemes to still have a supplementary and substitutive role to ensure survival of the pharmaceutical industry	- No, the schemes will play a complementary role to ensure that the single fund, strategic purchaser can be able to use its power to drive down costs

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
	medicines to be paid for by NHI			
g) Medical Schemes and Administrators	– Concern that a single purchaser NHI will destroy the medical scheme environment – HPCSA rules must change allow them to employ doctors as a Health Management Organisations	– No, do not support the Policy	– Medical schemes to still have a supplementary and substitutive role to ensure survival of the pharmaceutical industry	– No, the schemes will play a complementary role to ensure that the single fund, strategic purchaser can be able to use its power to drive down costs
h) Private Hospital Groups	– They are concerned that they are characterised as the key cost drivers of health and dispute the OECD-WHO findings – Would like to train medical practitioners in the private sector. – HPCSA rules must change allow them to employ doctors to reduce costs of health care – OHSC does not have capacity to certify all existing private providers – Would like to be accredited early by NHI Fund so that a competitive environment with public sector can be established	– No, do not support the Policy	– Medical schemes to still have a supplementary and substitutive role to ensure survival of the pharmaceutical industry	– No, the schemes will play a complementary role to ensure that the single fund, strategic purchaser can be able to use its power to drive down costs
3. Organised Labour				
a) COSATU; PSA, DENOSA, HOSPERSA, IMATU, SACTWU b) National Bargaining Council for the	– Benefits of NHI in establishing a UHC platform fully supported IMATU who would like the status quo to remain – NHI must not create an environment that will	– In general supported except for IMATU	– Employers must be required to also make NHI-specific tax payments that subsitute the current employer portion that is paid to medical schemes	– YES on Employer NHI-specic taxes, exclusion of VAT and coverage of Refugees and undocumented migrants – No, on expanding tax

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
Clothing Manufacturers	prejudice refugees or reduce the benefits that they are entitled to based on domestic and international legal legal instruments - VAT as a source of revenue is not supported by all labour unions - Concern that traditional health practitioners should be engaged to clarify their role under NHI - Concern that Bargaining council benefits must not be undermined and NHI should either contract them for exclusive use by members of unions only		premiums - Do not include VAT as a source of revenue for NHI-Specific taxes - Refugees and undocumented migrants to be covered in line with national and international legal instruments - IMATU would like the subsidy on medical schemes expanded to those that are not covered instead of imposing NHI	subsidies as this is against the principle of creating a single fund that will pool risks and funds for the entire population
4. Civil Society				
a) Section 27 b) Johannesburg Migrant Health Forum c) Movement for Social Justice d) Women's Health Empowerment e) Scalibrini Centre of Cape Town f) Foundation for Human Rights g) SACP	- The policy must take a Human Rights approach that includes UN Declaration on Human Rights, the rights of Children and Migrants and the International Convention on Socio, Economic and Cultural Rights - Social Determinants of Health must be taken into account - Implementation period is too long - NHI must always have equity considerations - On accountability, more needs to be stated about participatory processes	- All support NHI as a strategy of moving SA towards UHC	- Include a Rights based approach in the policy - Include prevention and environmental risk factors - Clear processes of health systems governance, accountability and participatory democracy should be included - There is limitation of rights in the Constitution such as the right to choice and right to economic activity - Change the section on issuing of an NHI Card to using the Department of Home Affairs Smart ID	- Yes, all proposed amendments have been taken into account and revision have been made accordingly

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
	– Vulnerable populations must not be left out such as people with disabilities, rural communities – OHSC is underfunded and under-capacitated and this will hamper its ability to execute its legislative mandate – NHI must ensure that EMS is made available to the entire population including those in rural and disadvantaged settings – Concern that NHI does not address adequately the LGBTI community – Transport is a major inhibitor to access and is also a cost driver especially for poor and rural households – Mental health services are inadequate and stigmatised		Card – Ensure that Children are registered for NHI at birth – Ensure that children of refugees, asylum seekers and undocumented migrants are covered in line with the Constitution and other domestic international legal instruments – Transport must be included as an NHI Benefit especially for vulnerable persons such as those with disability and the elderly	
5. Patient Advocacy Groups				
a) National Council of People with Disability in South Africa b) People living with Cancer c) Soul City d) SA Haemophilia Association	– Concern that NHI Benefits are not sufficiently comprehensive for conditions that these groups advocate for – Transport is a major inhibitor to access and is also a cost driver especially for people with disability – Rare diseases like haemophilia must still enjoy cover under NHI	Fully support NHI	Transport is a major inhibitor to access and is also a cost driver especially for people with disability	Yes, Proposed amendments factored into the revised policy

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
6. Academic Sector				
a) Faculty of Medicine and Health Sciences, Stellenbosch University b) School of Public Health (SoPH) of the University of the Western Cape c) Department of Paediatrics and Child Health, University of Cape Town d) School of Public Health and Family Medicine, University of Cape Town e) Priceless SA, School of Public Health, WITS University	– Public health services and quality have to be strengthened for NHI to be successful – Regulatory environment needs to be strengthened especially on pricing of health care services and issuing of hospital licence – Rights of children have not been prioritised in the Policy – HTA is necessary if costs of health care are to be managed	Yes Support	– Include social determinants of health in the problem statement – Enhance rights of children	Proposed amendments factored into the revised policy
7. Other groupings (Think Tanks)				
a) Free Market Foundation b) Helen Suzman Foundation c) South African Institute of Race Relations	– NHi is addressing the wrong problem. – Governments must focus on challenges in the public health system – The private sector is operating perfectly and is addressing a need that is determined by market forces – NHI must use the funds to provide services for the poor and rich will care for themselves – NHI is ultra vires to the	• All do not support NHI	– NHI is unaffordable for South Africa and it must be abolished – Medical schemes to still have a supplementary and substitutive role to ensure survival of the pharmaceutical industry	– NO, None of the proposals have been factored in

Affected Stakeholders	What do they see as main benefits, costs and risks?	Do they support or oppose the proposal?	What amendments do they propose?	Have these amendments been incorporated in your proposal?
	Constitution - NHI is too costly a policy option for SA - Medical schemes must be allowed to coexist with NHI			
8. Other groupings (Health Care Providers)				
a) South African Medical Association b) South Africa Private Specialist Association c) South African Dental Association d) South African Medical and Dental Practitioners e) Dental Practitioners Association f) South African Society of Psychiatry	- Mental health services inadequately provided for, NHI should cover a comprehensive set of benefits - Quality considerations must be used when performance-based payments are made - Specialists are opposed to NHI as it is a wrong solution for a misdiagnosed problem - Corruption is pervasive in South Africa and NHI has to be managed - Corruption by Social Security Funds such as RAF and COIDA does not give specialists confidence in NHI	- Yes, supported except for SAPPF	- Proposal by SAPPF to dispose of the entire NHI Policy and replace it with a National Combined Insurance Plan that combines A mandatory Low Income Medical Schemes, mandatory Gap Cover, the Private Health Access Fund and the introduction of PPPs and Private Sector Reforms - Comprehensive mental health services must be included at community, PHC and district hospital level as well	- No, the proposal has been rejected from SAPPF as it creates fragmentation and is not creating an environment of solidarity and risk pooling - The proposals on mental health services have been factored into the revised policy

1.6 Describe possible disputes arising out of the implementation of the proposal, and system for settling and appealing them. How onerous will it likely be for members of the public to lodge a complaint and how burdensome and expeditious is the proposed dispute-settlement procedure?

There are several disputes that would arise from implementation namely:

a) The future role of Provinces and Municipalities: The disputes will be addressed through amending the National Health Act (NHA) and the Presidential Coordinating Committee on IGFR
b) The future role of National Department of Health will be addressed through amendments to NHA and also through the National Health Council
c) Quality of Health Services will be addressed through inspections, certification based on regulated norms and standards for health establishments; Ombuds function of the OHSC and the National Health Council;
d) Price of health services especially in the private sector will be resolved through the strategic purchasing with budget impact analysis and mechanisms located with the Competition Commission;
e) Licensing of health establishments and providers (Certificate of Need) would be resolved through a joint national and provincial process established by the National Health Act Regulations on Section 36 and selective contracting by the NHI;
f) Certification by OHSC will addressed through regulations and guidelines outline for the National Health Amendment Act of 2013;
g) Health Technology Assessment (HTA) will have a stakeholder forum that will be established to address disputes arising out of the recommendations made
h) Future role of Medical Schemes as complementary and not substitutive or supplementary will be addressed through amendments to the Medical Schemes Act
i) NHI Benefits disputes will be resolved through the NHI Benefits Advisory Committee including the EML committees and an Appeals and Dispute Resolution Committee that will address concerns raised by the public
j) Licensing of health practitioners will be addressed through Statutory bodies such as:
    - The HPCSA
    - SANC
    - SAPC
k) Disputes from Private Sector Health Care Providers will be addressed through the Benefits Advisory Committee, the Pricing Committee, the Health Technology Assessment Committee and the Health Products Procurement Committee of the NHI with the Minister of Health being the final arbiter on matters that have not been resolved. Health care professionals will still have to be subjected to regulatory oversight on professional and licencing issues by the different professional statutory councils.
l) Private Medical Schemes will still be regulated through the Council for Medical Schemes (CMS) with its structure for dispute resolution in the new role of providing complementary cover.

Very clearly articulated standard operating procedures that will support the structures that disputes are referred to, to ensure that the public and those tasked with the responsibility of resolving disputes can follow. The National Department of Health, the National Health Council and Parliament will provide oversight on how NHI is implemented.

2 Impact Assessment

2.1 Describe the costs and benefits of implementing the proposal to the groups identified in point 1.5 above, using the following chart. Add more rows if required

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

There are many factors that influence health expenditure. These include trends in population health service needs and utilisation (e.g. epidemiological trends, rates of hospitalisation and use of outpatient services). It also depends on supply capacity, such as availability of health facilities and professional personnel as well as the prices of supplies and services.

Policy options that will impact on costs include the range of private service providers from whom services are purchased and the reimbursement arrangements. Costs will also depend on the extent to which economies of scale are achieved through active purchasing and the effectiveness of cost controls. 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 insurance cover.

The main cost estimate used by the National Treasury adapted to the Green Paper on NHI for the purposes of modelling revenue raising options are as follows:

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

These cost estimates 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.

NHI will be funded through a pre-payment system from a combination of taxes such as general tax revenue augmented by NHI-specific taxes from employer and employee payroll

taxes, surcharge on taxable income and transactional taxes. Scenario B in the table below is the preferred scenario for NHI-specific taxes.

	Year	Payroll tax	Surcharge on taxable income	Increase in value-added tax
Scenario A: Surcharge on taxable income, VAT increase and payroll tax	2016/17 2018/19 2022/23 2023/24 2024/25	0.5% 0.5% 1.0% 1.0% 1.0%	0.5% 0.5% 1.0% 1.0% 1.0%	0.0% 0.5% 0.5% 1.0% 1.0%
Scenario B: Payroll tax and surcharge on taxable income	2016/17 2019/20 2022/23 2025/26	0.5% 1.0% 1.5% 2.0%	0.5% 1.0% 1.5% 2.0%	
Scenario C: Surcharge on taxable income and VAT increase	2016/17 2018/19 2019/20 2020/21 2022/23 2024/25 2025/26		0.5% 0.5% 1.0% 1.0% 1.5% 1.5% 2.0%	 0.5% 0.5% 1.0% 1.0% 1.5% 1.5%
Scenario D: Payroll tax and VAT increase	201617 2017/18 2019/20 2022/23 2024/25 2025/26	0.5% 0.5% 1.0% 1.5% 1.5% 2.0%		 0.5% 0.5% 1.0% 1.5% 1.5%
Scenario E: Surcharge on taxable income	2016/17 2017/18 2019/20 2021/22 2022/23 2023/24 2024/25 2025/26		0.5% 1.0% 1.5% 2.0% 2.5% 3.0% 3.5% 4.0%	

Costs and benefits of implementing NHI: These have not been quantified by they will relate to the following areas:

Group	Implementation Costs Relate to human resource, equipment and infrastructure e.g. Health IT System	Costs of changing behaviour Relate to adaptation costs, change management, change of operating procedures, manual, training, reskilling, communication, awareness	Costs/Benefits from achieving desired outcome The ultimate benefit for costs incurred- e.g. if you invest in a Health IT infrastructure what will be the ultimate benefit for that- will the benefit outweigh the cost or the other way round?	Comments
INTERNAL STAKEHOLDERS				
) Provincial Treasuries	Nil	Costs will be related to seperating developing budgets that combine personal and non-personal health care to developing and monitoring non-personal and public health programme budgets	Reduction in fragmentation and a semi-fiscal federal arrangement will improve equity and efficiency in health resource utilisation	
) National Treasury	Nil	Nil	Improvement in equity considerations and resource allocation and utilisation	
) Provincial Departments of Health	– Health Infrastructure Coordination – Smaller provincial health departments requiring that staff at head-office is relocated to districts and sub-districts	Since provinces will no longer be passive purchasers but having a different role of providing non-personal services as well as policy, planning , coordination and monitoring,	– Reduction in staff over-head costs due to decentralisation – Reduction in fragmentation and fiscal-federal arrangements – Removal of passive purchasing arrangements	
) National Health Department	a) Moving central hospitals to national sphere b) Infrastructure development c) Health Human Resource Development d) Establishment of the following Committees: – National Teriary Health Services Committee – National Governing body on Health Profession training and development – HTA Advisory Committee	Training in Regulatory oversight especially over private sector providers in areas of HTA and Benefits design	More oversight and stewardship role over the entire health sector (public and private	
) District Health	– Establishment of Contracting Units for PHC at Subdistrict level	Training in Contract management and planning	Better coordination and understading of community priorities in a decentralised systems will result in a responsive health	

Group	Implementation Costs Relate to human resource, equipment and infrastructure e.g. Health IT System	Costs of changing behaviour Relate to adaptation costs, change management, change of operating procedures, manual, training, reskilling, communication, awareness	Costs/Benefits from achieving desired outcome The ultimate benefit for costs incurred- e.g. if you invest in a Health IT infrastructure what will be the ultimate benefit for that- will the benefit outweigh the cost or the other way round?	Comments
			system	
) NHI Fund	– Accreditation – NHI Information Systems and Risk Engine – NHI Management and Governance Structures – National Pricing Advisory Committee – Health Care Benefits Ministerial Advisory Committee	Skills required in planning, health financing, health economics, health policy management, contracting, prioritisation and general management	A single fund will improve the efficiency of a strategic purchaser thereby reducing fragmentation and costs	
EXTERNAL STAKEHOLDERS				
) Health care providers	Not available	Costs will relate to training on new forms of contracting and provider payments	Supply side cost containment measures will be achieved	
) Users of the health system	Not available	Costs will enatil public education on rights and responsibilities required to ensure that access and equity are improved whilst also ensuring sustainbility	Demand side cost-containment will be achieved	

NHI Implementation costs

The implementation costs were calculated using a number of crude estimates for infrastructure, accreditation of health care facilities for contracting and training of human resources to deliver NHI services.

NHI implementation cost – breakdown of base scenario results							
Year	Infrastructure cost - PHC	Infrastructure cost - Hospitals	Infrastructure cost Repair/rehabilitation	Infrastructure cost – IT platform	Accreditation cost	Additional training	Total implementation cost
0					191,862,440		191,862,440
1	5,117,262,209	18,771,276,755	4,216,782,456	1,000,000,000	206,827,710	14,512,513,196	43,824,662,326
2	5,516,408,661	20,235,436,342	4,545,691,487	1,000,000,000	222,960,272	11,005,610,241	42,526,107,003
3	5,946,688,537	21,813,800,376	4,900,255,423	1,000,000,000	240,351,173	8,829,757,260	42,730,852,769
4	6,410,530,242	23,515,276,806	5,282,475,346	1,000,000,000	259,098,564	9,518,478,326	45,985,859,285
5	6,910,551,601	25,349,468,397	5,694,508,423	1,000,000,000	279,308,252	3,897,095,077	43,130,931,751
6						3,578,237,974	3,578,237,974

Initial Report on Modelling of NHI Costs prepared by Ministerial Advisory Committee on NHI and Price Waterhouse Coopers

2.2 Describe the changes required in budgets and staffing in government in order to implement the proposal. Identify where additional resources would be required for implementation. It is assumed that existing staff are fully employed and cannot simply absorb extra work without relinquishing other tasks.

The establishment of NHI will require that theNHIFund is structured as a Schedule 3b public entity that is created by law. The NHIF will not form part of the National or Provincial Department of Health. Thetotal budget for NHI is estimated as outline in the Table below. Administration costs are estimated at increasing gradually to 3% by 2025/2026.

NHI costing module – Base scenario results in real terms (R'm) - Green Paper								
Year	**Non-AIDS-related services**	**AIDS-related services**	**Additional services**	**Total Direct Healthcare costs**	**NHI Operational costs**	**Total costs in delivering services**	**NHI Implementation costs (Cost of improving quality of existing healthcare system)**	**Total costs modelled**
2011	0	0	0	*0*	0	0	103	103
2012	57,773	17,166	42,271	117,210	586	117,796	7,563	125,359
2013	63,019	19,716	43,467	126,201	873	127,075	7,688	134,763
2014	68,744	21,987	44,663	135,394	1,197	136,591	7,818	144,408
2015	74,548	26,245	45,874	146,667	1,578	148,245	7,951	156,196
2016	80,828	28,729	47,095	156,651	1,986	158,638	8,088	166,726
2017	87,641	31,031	48,326	166,998	2,438	169,436	8,229	177,666
2018	95,053	33,150	49,569	177,771	2,937	180,708	8,375	189,083
2019	103,127	35,111	50,825	189,063	3,486	192,549	8,417	200,966
2020	111,940	36,941	52,094	200,976	4,092	205,068	8,568	213,636
2021	121,577	38,660	53,377	213,614	4,759	218,374	8,723	227,097
2022	127,855	40,286	53,612	221,752	5,366	227,119	8,882	236,001
2023	134,560	41,834	53,831	230,225	6,013	236,239	9,045	245,284
2024	141,731	43,304	54,036	239,071	6,704	245,774	9,212	254,987
2025	149,407	44,716	54,226	248,348	7,450	255,799	16	255,815

For the NHI Fund to be established, a project team with support staff will be established as outlined in the table below:

Area of Expertise	Description of Function
1. Health Financing and Economics	a) Develop mechanisms for determining cost-effectiveness of interventions b) Costing of health service entitlements c) Reimbursement tools d) Budget impact assessment
2. Public Health	a) Health Service entitlements b) Accreditation systems c) Research, Monitoring and Evaluation progress towards UHC
3. Health Policy	a) Legislative Review and Development b) Institutional Arrangements
4. Contract Management	a) Development of national framework for provider contracting b) Performance Management Systems c) Monitoring and Evaluation
5. NHI Information System	a) Development of: i. NHI- ICT Architecture ii. NHI Risk Engine iii. Population Registration Strategies

Area of Expertise	Description of Function
6. Financial Management	a) Accounting b) Supply Chain Management c) Asset management
7. Legal Drafting	a) Legislative and Regulatory Review and Development
8. Administrative Support	a) Human Resource b) Legal c) Administration d) Stakeholder Management and Communication e) Provision of administrative, logistical and related support (including travel and accommodation)
9. Overall Project Management	a) General Stakeholder Management b) Project Management

The following are budget items based on indicative proposals and NDoHprojected NHI Allocations for 2017/18 to 2019/20 financial years:

Focus Area	Indicative Budget (2017/18 - 2019/20)
1. Health Information Systems and ICT Architecture for NHI Fund including Population Registration	R967 840 000.00
2. Health Professions Contracting	R1 009 987 000.00
3. Reimbursement Strategies -development of DRG and Capitation	R36 166 000.00
4. NHI Risk Engine	R31 600 000.00
5. Accreditation of Providers	R 100 000 000.00
6. Development of Monitoring and Evaluation for UHC	R20 000 000.00
TOTAL	**R2 133 903 000.00**

2.3 Describe how the proposal minimises implementation and compliance costs.

Government will implement various measures to effectively control costs and to ensure that NHI remains sustainable and affordable. The cost containment measures implemented will 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 as outlined in the Table below:

Summary of supply side and demand side cost containment measures

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

Reforms that support cost containment at the service planning, delivery and provision level.Strategic purchasing will ensure that the health system operates efficiently, and does not experience uncontrolled expenditure increases and maintains quality in health services on an ongoing basis.

a) Strategic purchasing will ensure affordability and sustainability through ensuring that:
   i. There is a strong emphasis on disease prevention and health promotion and not only on curative services through a re-engineered PHC platform.

ii. With the exception of medical emergencies, health services must be accessed at the primary health care level, with referral to specialist services when needed.
iii. The most cost-effective, evidence-based interventions will 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.
iv. Centralised procurement of pharmaceutical products, medical and surgical consumables and medical equipment;
v. Efficient use of laboratory services, and blood and blood products;
vi. 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

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 from whom services will be purchased will 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) 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.

There are other strategic purchasing actions that will be implemented to further strengthen cost containment interventions as phased implementation progresses. The NHI Fund will

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 will 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.

3 Managing Risk

3.1 Describe the main risks to the achievement of the desired ends of the policy/bill/regulations/other and/ or to the national priorities (aims) that could arise from adoption of the proposal. Also describe the measures taken to manage the identified risks. Add more rows if necessary.

There may be some key issues that might hinder or enhance implementing the NHI policy namely:

i. **Continuous stakeholder engagement (general public and healthcare providers)**to the principle of universal health coverage and the mechanisms that government plans to utilise to achieve this (which is NHI within the South African context). Evidence shows that the lack of coordination and collaboration among key stakeholders has created difficulties for the further development and implementation of universal health care in different contexts. Government must also implement a proactive communication strategy for the communication of key information/messages to stakeholders and the management of public expectations as the public may expect immediate improvements and results;

ii. **The need for sustained political commitment** – a collective political will from local to national government is critical for the sustainability and the effectiveness of the system as it draws resistance from other sectors;

iii. **Robust and reliable information systems**. This will require a comprehensive review of the current information systems deployed in government and the private sector and to develop technology that will allow for the integration of these systems. Duplication of information systems leads to unreliable information systems and inefficient and fragmented planning systems. The health sector will require integrated information systems under NHI to ensure effective and efficient planning and service delivery as well as streamlined provider reimbursement and quality monitoring and evaluation;

iv. **Intersectoral collaboration**– NHI will not yield the desired health and economic benefits unless appropriate investments are made in the sectors that have a defining impact on health outcomes. This is particularly the case for addressing the social determinants of health, which include employment and income, water, sanitation, nutrition, primary schooling and road infrastructure;

v. **Service provider collusion (corporate and health professionals)** - the big health industry players have a tendency to collude and mobilise resources and use this as a bargaining tool to entrench their positions or, in some cases, to create resistance when

they realise that it threatens their profit margins and existence. Therefore, the State must be wary of this and supporting bodies such as competition authorities must be readily drawn upon where necessary to address emerging risks in this area;

vi. **Fiscal space** – sustainable financing is of paramount importance particularly in the initial stages and it will be indicative of the commitment to the NHI;

vii. **Office of Health Standards Compliance** – Government must ensure that this Office has adequate resources and regulatory power to undertake inspection of all health facilities, public and private, with regards to compliance with the National Core Standards. Inadequate oversight and supervision, information disparity, lack of enforcement of existing laws and poor ethics regulating healthcare provision and other policy failures might weaken the phased implementation process by adversely influencing the general public with regards to the poor quality of care for services offered under NHI;

viii. **Human resources for health constraints** –the quality and the safety of patients can be compromised if there is a shortage of human resources for health capacity; Government must work closely with training institutions to ensure adequate intake and throughput for key health professional categories in the medium to long term, taking into account changing population demographics and epidemiology;

ix. **Immigration law** – the current immigration law militates against easy access to foreign skilled workers, in its current form the system is inflexible and rigid, the application process is cumbersome and the system is insensitive to the economic needs of South Africa. On the other side of the coin is the relatively high numbers of undocumented immigrants that are currently in the country and thus can utilise social services, including health services under some circumstances e.g. emergencies. These matters need to be adequately addressed by government, including consideration for the creation of a contingency fund to meet the health needs of undocumented migrants, refugees and asylum seekers. This must be done through working in close partnership with regional bodies such as the SADC and the African Union;

x. **Traditional health practitioners sector** –there will be a need to work with and incorporate the informal medical sector (including traditional healers and alternative medicine practitioners) in the planning and roll out of the NHI. These service providers are utilised by a sizeable proportion of the population and hence would have to progressively form part of the health service entitlements covered by the NHI Fund;

The table below provides a summary of key risks (using the four dimensions of funding, pooling, purchasing and provision) that may arise as a result of the phased implementation of NHI and the risk mitigation interventions

		Risk Level (Scenario)		Mitigation Strategies	
Risk Area	**Identified risks**	**Low**	**High**	**Low**	**High**
FUNDING	Underfunding of NHI by a hostile government: a government that favours privatisation might take measures to undermine a strong public health system and NHI.	**X**		In South Africa, this is unlikely given the increased attention to accelerating service delivery including health and as the NDP Vision 2030 clearly envisions NHI. It is generally acknowledged that funding for health care has to increase significantly as part of revitalising that sector	
	Recession and economic downturn: the funding of NHI and a transformed health system will rely on the ability to raise taxes, which may be constrained during recessions and periods of economic downturn.		**X**		i. South Africa currently spends 8.9% of GDP on health most of which disproportionately benefits the wealthy and employed. ii. The current economic downturn will affect the tax revenues collected and constrain the fiscal space. However, innovative budgeting as it relates to how the current allocations are restructured through the reforms to the IGFR Framework for health will go a long way in improving equity and efficiency in the health sector. iii. The budgets allocated for national priority sectors such as Health, will be ring-fenced through the NHI Fund and will have immediate and long-term benefits on productivity and quality of life of our people
	Constitutional challenges to NHI (Legal challenges)		**X**		Promulgate an NHI act that incorporates all current legislation in compliance with the Constitution. This provides the legal framework to operate with the constitution.
	Provision of duplicative cover by medical schemes		**X**		Single NHI fund with no opting-out and provision of complementary cover by schemes. This will be provided for by appropriate legislation
	Political resistance by vested interests (incl. media) within society	**X**			i.Conduct massive campaigns on NHI benefits ii.Engage stakeholders at all stages of implementation of NHI
POOLING	Governance of the Fund: a) Board		**X**	Although the choice of board members is meant to be independent, experience has shown otherwise Establish an Independent board with robust and accountable nomination processes and procedures to minimise the possibility of it being vulnerable to capture and vested interests	

		Risk Level (Scenario)		Mitigation Strategies	
Risk Area	**Identified risks**	**Low**	**High**	**Low**	**High**
				The criteria in selection of a board members must be stringent	
	Governance of the Fund: a) Board	**X**		The composition of the NHI Board 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 NHI Board will also include civil society representatives. No one with a conflict of interest in the functions of the NHI Fund may be appointed to the Commission.	
PURCHASING	Poor participation and/or reluctance from private providers such as doctors and private hospitals to participate in NHI (including GP contracting)	**X**		Creation of an incentives regime that promotes the participation of service providers within the NHI environment. This will include offering providers volume contracts and performance based contracts. Changes to the contracting plans (contracting in or out) and reimbursement strategies as well as a review of the policy of Remunerated Work Outside of Public Service (RWOPS) has to be undertaken. There is currently excess capacity in the private sector as it is conceivable that these providers in order to optimise the available capacity will want to participate.	
	Fraud and Abuse/Corruption/ Cronyism		**X**	Government will ensure that it puts into place systems and procedures that support transparent appointment of appropriately qualified personnel to staff the NHI Fund. The NHI Fund operations will be supported by a robust risk identification and management engine that is based on an electronic platform. This will assist with ensuring that all fraudulent	The NHI Commission with appropriate governance structures/accountability. The NHI Fund structure with the following units: i. Contracting unit ii. Provider payment unit iii. Provider performance unit iv. Performance monitoring unit
	Mismanagement/mal-administration: the risk of inept or corrupt management could misallocate funds in a single payer system, taking away money from vital services and decreasing quality.	**X**			

		Risk Level (Scenario)		Mitigation Strategies	
Risk Area	**Identified risks**	**Low**	**High**	**Low**	**High**
				activities (on the part of providers and users) are immediately identified and addressed.	v. Risk and prevention unit Each of these units will have systems and processes, policies and regulations for preventing fraud and abuse.
	Under-servicing by service providers	**X**		Service contracts will detail performance levels, and these will be monitored regularly. Strong monitoring and evaluation programmes will be put into place to monitor provider behaviour, particularly to ensure that quality services are rendered to all patients and that there is adequate compliance to treatment guidelines and clinical protocols. Introduction of robust provider reimbursement mechanisms to ensure appropriate risks are shared between the NHI Fund and providers. This will include risk-adjusted capitation for PHC services and global budgets (and Diagnosis Related Groups) for the hospital level.	
	Escalating health care costs		**X**	The NHI Fund will have to use strong/robust 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).	Introduction of a National Health Tariffs Commission to take responsibility for the determination, negotiating and setting of health services tariffs for all services offered in the health system. This will be the case for all providers who are accredited and contracted by the NHI Fund. - Annual review of prices based on available and approved NHIF budgets - Central procurement of goods and health products - Monitoring of claims and utilisation through expenditure and utilisation reviews - Conducting random audits and inspections of contracted providers - Amend NHLS Act and introduce fairer and more transparent laboratory prices
	Increase in the burden of diseases			Establishment of the National Health	

		Risk Level (Scenario)		Mitigation Strategies	
Risk Area	**Identified risks**	**Low**	**High**	**Low**	**High**
	especially NCDs and aging	**X**		Commission which will be specifically responsible for health promotion, education and prevention across the country to complement the NHI Fund's service entitlements. Strengthening of and continued roll-out of the re-engineered Primary Health Care approach to put more emphasis on health promotion, community outreach and prevention programmes. Strengthening of regulatory and policy interventions against specific products e.g. Anti-Tobacco and Anti-Alcohol policies. Consideration for the creation of a contingency fund to carve out revenue streams to ensure that it considers changing aging profile of the population and adequately funds long age care needs.	
	Demand for new technology	**X**		Introduction of an essential medicines and equipment list as part of the broader interventions to ensure adequate treatment guidelines and clinical protocols. NHI will be supported by a Benefits Advisory Committee that will annually review the service benefits to be covered. The work of the Benefits Advisory Committee will be supported by the Health Technology Assessment and economic evaluation platform to support the functions. This will ensure that any demands for new technology inclusion into the package will be based on the principles of efficacy, cost-effectiveness and evidence-based interventions. The inclusion of any new technologies and interventions will also take into account the resource envelope available to	

		Risk Level (Scenario)		Mitigation Strategies	
Risk Area	**Identified risks**	**Low**	**High**	**Low**	**High**
				the NHI Fund and the need to address priority programmes.	
PROVISION	Guaranteeing a comprehensive Health Entitlements	**X**		Introduction of an essential medicines and equipment list as part of the broader interventions to ensure adequate treatment guidelines and clinical protocols. NHI will be supported by a Benefits Advisory Committee that will annually review the service benefits to be covered. The work of the NHI Benefits Advisory Committee will be supported by the Health Technology Assessment and economic evaluation platform to support the functions.	
Population Coverage	Migration from neighbouring countries into South Africa by undocumented migrants and economic refugees to derive NHI Benefits	**X**		The registration process for NHI will be based on the Department of Home Affairs population register. The registration system that is deployed for NHI will be developed and deployed in collaboration with other government departments such as the Department of Science and Technology (including CSIR). Government through liaison with regional bodies such as the African Union and SADC will consider the creation of a contingency fund to meet the health needs of migrants. This process will be phased in as the NHI Fund matures and implementation lessons expand.	The issue of refugees and asylum seekers as well as undocumented migrants will be addressed through the provisions of international conventions as well as domestic laws as pertains to the Immigration Act under the auspices of the Department of Home Affairs.
Service Coverage	Improved quality of care in the health system	**X**		The establishment of the Office of health Standards Compliance (OHSC) provides the institutional mechanisms for improving quality in the short/medium/long term to building people's confidence in the system. This is supported by the phased implementation of the National Core Standards. All health service facilities, public and private, will be required to same	

		Risk Level (Scenario)		Mitigation Strategies	
Risk Area	**Identified risks**	**Low**	**High**	**Low**	**High**
				standards and norms as pertains to the rendering of quality health services. 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. It is expected that all facilities must be fully compliant with the Core Standards at all times The OHSC ombudsman will ensure objective assessments of complaints. The 7 quality 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 Department of Health is implementing quality improvement interventions across the country, with a specific focus on the pilot districts, through *Operation Phakisa Ideal Clinics Realisation* project.	
	Shortages of human Resources—healthcare workers	**X**			The Department of Health has already published the Human Resources for Health strategy which outlines government's programme of action to increase the intake and throughput at training institutions with regards to the health sciences and health professionals. Infrastructure improvement programmes are also being implemented across the country. Emphasis is directed at refurbishing training institutions such as nursing colleges. At the end of 2014/15, there were a total of 1761 infrastructure projects at 888 facilities, majority of which are located in the pilot districts. Working closely with the Development Bank of South Africa and the CSIR, the

Risk Area	Identified risks	Risk Level (Scenario)		Mitigation Strategies	
		Low	High	Low	High
					Department developed and published The Health Infrastructure Norms and Standards Guidelines in Government Gazette No. 37790 R512, 30 June 2014. These norms and standards are directed at ensuring that there is a minimum set of requirements that are met for infrastructure building and maintenance across all provinces. The intention is improve quality of health infrastructure in South Africa by ensuring all new health facilities are compliant with health facility norms and standards as per the gazetted guidelines.
	Strengthened district health system	**X**		Improving access to PHC Services and referral system to higher levels of care through PHC re-engineering and building community systems	District Health Management Offices (DHMOs) will need to be adequately capacitated in key areas of programmatic planning, contracting of service providers, procurement and supply chain management, data collection and monitoring and evaluation. All these aspects will help to strengthen service delivery capacity at the district level, which is a key pillar of the institutional and organisational reforms required to support the phased roll-out of NHI.
	Medico-legal issues	**X**		Providers accredited and contracted by the NHI Fund must have medico-legal insurance cover	The establishment of the Office of health Standards Compliance (OHSC) provides the institutional mechanisms for improving quality in the short/medium/long term to building people's confidence in the system. This is supported by the phased implementation of the National Core Standards. All health service facilities, public and private, will be required to same standards and norms as pertains to the rendering of quality health services. These interventions will also be supported by an Ombud function.
	Unnecessary use (Moral Hazard) – Users may visit providers unnecessarily or providers may over service patients unnecessarily		**X**		The NHI Fund will have to use strong/robust 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. Introduce media campaigns e.g. NHI TV channel to

		Risk Level (Scenario)		Mitigation Strategies	
Risk Area	**Identified risks**	**Low**	**High**	**Low**	**High**
					educate people on appropriate use of NHI benefits
Cost coverage	Affordability of NHI	**X**			Access to and utilisation of health service entitlements will be through appropriately defined treatment protocols and clinical guidelines. All services included in the service entitlements will be assessed by the NHI Benefits Advisory Committee will determine and regularly review the service entitlements to be covered by the NHI Fund. Additionally, these entitlements will be determined with reference to health technology assessments based on principles of affordability, cost-effectiveness and efficacy.

3.2 Describe the mechanisms included in your proposal for monitoring implementation, evaluating the outcomes, and modifying the implementation process if required. Estimate the minimum amount of time it would take from the start of the implementation process to identify a major problem and remedy it.

The implementation of NHI consists of expanding the three dimensions of universal health coverage namely: health services, finance, and population coverage.The dimensions of coverage are influenced by changes to the demographic, epidemiological and technological trends.Monitoring will be an ongoing process that takes into account intermediate and long-term final objectives of NHI.

The intermediate objectives of implementing NHI are to:

a) Achieve equity in resource distribution
b) Efficiency
c) Transparency and accountability

Measuring and monitoring the equity dimension will entail understanding health needs, availability of services, accessibility, utilisation patterns and whether coverage is effective or not. Monitoring equitable access to health care will require focusing on two key components of UHC: coverage of the population with quality, essential health services and coverage of the population with financial protection

Efficiency will be monitored by measuring the following indicators based on resource utilisation:

a) Technical efficiency
b) Allocative efficiency
c) Productive efficiency

Transparency and accountability is part of governance of the health system and will be measured through rules-based indicators and outcome-based indicators. The rules based indicators that will be measured will include:

a) Availability of policies in health establishments
b) Existence and use of protocols and guidelines
c) Ownership arrangements
d) Decentralisation of management function
e) Stakeholder participation

Monitoring implementation of NHI will also require monitoring of outcome-based indicators such as:

a) Availability of medicines
b) Absenteeism of health workers

The final objective for implementing NHI are:

a) Utilisation of healthcare services based on need
b) Improving quality of health care
c) Universal financial protection.

To monitor health service coverage based on need the following indicators will be measured:

a) services for health promotion, illness prevention, and tracer indicators such as for antenatal care, immunisation, family planning, availability of ARV and effective TB Treatment, NCDs including mental health, substance abuse and addictions to tobacco;
b) treatment including rehabilitation and palliative care services and
c) social determinants of health and measuring these through defined economic and social indicators such as for water and sanitation.

To monitor quality, the following areas will have indicators developed:

a) Leadership
b) Information
c) Patient and population engagement
d) Regulation and standards
e) Organisational capacity
f) Models of care

To monitor universal financial risk protection the following two indicators will be measured:

a) Government expenditure on health;
b) Out-of-pocket (OOP) expenditure in the broader funding context;
c) the incidence of impoverishment resulting from Out-of-pocket (OOP) health payments;
d) the incidence of financial catastrophe from the same causeandthe severity of financial catastrophe (can be calculated from household expenditure surveys);
e) the extent to which people are pushed further into poverty.

There is a perception that implementation of UHC-oriented reforms istoo diffuse a concept, and that the progress is unquantifiable. There are three main challenges that have been identified in the implementation of NHI:

a) Sourcing reliable data on a broad set of health service coverage and financial protection indicators;
b) Disaggregating data to expose coverage inequities;
c) Measuring effective coverage, which not only includes whether people receive the services they need but also takes into account the quality of services provided and the ultimate impact on health

Monitoring the implementation of NHI will combine the experiences of users of health services across socioeconomic groups, especially the socially disadvantaged taking into account social determinants of health such as vulnerability, livelihoods, empowerment health seeking and navigation skills; whilst also monitoring the characteristic of the health system in terms of resources, the organisation, service outreach, participation and permeability.

Any proposed changes on Intergovernmental Relations and Fiscal Arrangements (IGFR) will only be made after consultation with the Health MINMEC / the National Health Council (NHC), Budget Council and Presidential Coordination Committee (PCC). The Financial and Fiscal Commission will be consulted once the PCC on IGFR have been consulted on the revised role of Provinces to accommodate a more unified and distributive approach to health care in the national interest

NHI Information systems will enable ongoing monitoring of progress made in following areas:

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 those entitled to NHI services and how this information must be used to support planning and decision making around contracting, purchasing and communication strategies;
e) Quality assurance programmes for 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.

Annual evaluation will undertaken to monitor progress towards universal health coverage namely: population, service and cost coverage (financial protection) by measuring equity, efficiency and tranparency and accounatiblity dimensions.

4 Summary

4.1 Summarise the impact of the proposal on the main national priorities

National Priority	Impact
1. Social cohesion	– NHI will move towards the attainment of UHC through the creation of mechanisms for a common financial and risk pool that ensures that values such as equity and solidarity become a reality. – The effects of decreased health inequalities and improved health outcomes will have positive impact on other social sectors by contributing to the creation of a healthier population, improvement in education outcomes of learners, improved skills level of the labour force, a healthier labour force and happier homes thus driving a reduction in poverty and crime. – 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 run. This translates to increased happiness of the population for whom improved quality of life as increased longevity is within their grasp
2. **Security (Safety, Financial, Food, Energy and etc.)**	– Implementation of NHI will improve the capacity of the State to progressively delivery good quality and effective health services, giving all South Africans the best chance of enjoying a long and healthy life, and thereby decreasing the risk of service delivery protest and strengthening national security. – Households will enjoy financial risk as they benefit health care that is free at the point of care; from increased disposable income because of a significantly lower mandatory prepayment level; and from savings that will be made due to economies of scale, efficiency gains because of reductions in non-health care costs, and affordability of health care as a result of active and strategic, monopsony purchasing arrangements. – The State will benefit from a macro-level perspective on the introduction of NHI by slowing the growth in health care costs to create stability in the rate of escalation of NHI-related taxes and the escalating public health budget by improving the inefficiencies in the system througha) Price controls to regulate health care inputs using reference prices for pharmaceutical products and price setting for health servicesi; b) health care financing reforms that eliminate out-of-pocket spending and prohibiting low-quality benefits and benefit options that limit coverage and predisposing to catastrophic health expenditure; c) Delinking health insurance as an employment benefit, where people rely on their employers for insurance especially in situations of members having pre-existing medical conditions that confine them to a particular job, and instead making financial protection and access to quality care a universal entitlement.Thus, NHI will provide certainty to the tax-payers and employers. NHI taxes will be much lower than current medical scheme contributions, and can promote employment by reducing the cost of employment.
3. Economic growth	– Good health has been shown to be an essential value of the social and economic life of humans but also an indispensable prerequisite for poverty reduction, sustained economic growth and socio-economic development. Not only does the provision of

National Priority	Impact
	quality health care through NHI reduce poverty but it contributes to economic growth through increased productivity and higher household income. - The nexus between health-poverty-income suggests that per capita income and health status are strongly associated. A poorly performing health system affects the economy through the labour market through multiple channels. The economy of any country is constrained by the number of economic active years of the labour force. - Decreased life expectancy narrows the knowledge base in the economy as the gains to education decrease as life expectancy decreases. - A decreased "work-life" translates to decreased life earnings and thereby savings to support workers during retirement. These effects are further perpetuated as they become intergenerational.
4. **Economic Inclusion (Job Creation and Equality**)	Children who cannot access health care are less likely to exhibit strong cognitive skills and become healthy adults within the workforce. Those that have to support aging parents with insufficient savings are also less likely to add to the knowledge economy. - Where the existing work force is without access to health services, they are less productive and generate lower level of output due to decreased efficiency, effectiveness, and devoting less time to productive activities (i.e. more days off work, a shorter work life span). - - A weak health system that cannot attract or retain health professionals, nor distribute them according to need, further undermines efforts towards job creation and equitable access to health care services.
5. Environmental sustainability	The introduction of NHI as a path towards universal health coverage will create strong resilient health systems that can be used to respond to public health emergencies that result from outbreaks of disease that consequent to environmental degradation.

4.2 Identify the social and economic groups that would **benefitmost**and that would **bear the most cost**. Add more rows if required.

Main Beneficiaries	Main Cost bearers
a) Vulnerable populations b) Poor and unemployed c) Current members of medical schemes d) Employer groups	a) Tax payers b) Employees c) Employers

4.3 In conclusion, summarise what should be done to reduce the costs, maximise the benefits, and mitigate the risks associated with the policy/bill/regulations/other. Note supplementary measures (such as educational campaigns or provision of financing) as well as amendments to the draft itself, if appropriate. Add more lines if required.

South Africa aims to make significant strides in moving towards UHC through the implementation of NHI based on the principle of the Constitutional right of citizens to have access to quality health care services that are delivered equitably, affordably, efficiently, effectively and appropriately based on social solidarity and health as a public good and a social investment. NHI recognises that good health is an essential value of the social and economic life of humans and is an indispensable prerequisite for poverty reduction, sustained economic growth and socio-economic development. NHI will extend population coverage, improve the quality and quantity of services that the covered population will be entitled to, as well as provide financial risk protection to individuals and households whilst reducing the direct costs that the population will be exposed to when accessing 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. In order to adequately identify and manage risks for NHI, it is necessary to develop 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

4.4 Please identify areas where additional research would improve understanding of the costs, benefits and/ or risks of the policy/~~bill/regulations/other~~

N/A at the moment

For the purpose of building SEIAS body of knowledge please contact the following:

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Unit	**Director-Genral: Health**
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