Regional Hospitals

93. The regional hospitals will offer a range of general specialist services. Hospitals at this level render services at a general specialist level, receive referrals from district hospitals and provide specialist services to a number of district hospitals (preferably six or less). The eight general specialist services that will be provided is general surgery, orthopaedics, general medicine, paediatrics, obstetrics & gynaecology, psychiatry, radiology and anaesthetics.

Tertiary Hospitals

94. Tertiary hospitals render super specialist and sub specialist care. They also serve as a main platform for training of health workers and research. Most care provided in these hospitals, requires the expertise of teams led by experienced specialists. This includes cardiology, cardiothoracic surgery, craniofacial surgery, diagnostic radiology, ear, nose and throat (ENT), endocrinology, geriatrics, haematology, human genetics, infectious diseases, general surgery, orthopaedics, general medicine, paediatrics, obstetrics & gynaecology, radiology and anaesthetics. These services may be included in more developed tertiary services Cardiothoracic Surgery, Renal Transplant, Neurosurgery, Oncology, Nuclear Medicine, and a range of Paediatric sub-specialties.

Central Hospitals

95. These are national referral hospitals that are attached to a medical school and provide a training platform for the training of health professionals and research. Central hospitals render very highly specialized tertiary and quaternary service on a national basis. It also functions as highly specialized referral units for the other hospitals. These hospitals employ high technology and highly trained staff.

Specialized hospitals

96. The specialized hospitals are usually one disciple focused and are extremely vertical in the range of services offered at the hospital. There are a wide range of possible specialties that could be focused in a hospital, the two most common being TB and

Psychiatry, but they may also include spinal injuries, maternity, heart, orthopaedics, urology and infectious diseases. These units may also provide either acute, sub acute or chronic care or all of four levels of care.

12. ACCREDITATION OF PROVIDERS OF HEALTH CARE SERVICES

12.1The Office of Health Standards Compliance

97. The Office of Health Standards Compliance (OHSC) will be established through an Act of Parliament. It will have three units, namely: inspection, norms and standards and the office of the ombudsperson. It will set norms and standards and undertake the inspection of all health facilities. This process will be undertaken in close collaboration with the implementation of quality improvement plans to ensure facilities are ready for accreditation and contracting with the National Health Insurance. Interim assessments, focusing on high-risk elements in public health facilities, will be conducted within regular intervals to ensure that set standards are maintained. Recommendations will be made on the introduction of continuous quality improvement in public healthcare facilities, with associated training.

98. The OHSC will facilitate the development of multidisciplinary organisational standards for healthcare facilities using evidence-based principles for standard development to evaluate compliance and to monitor progress. The certification process will enable management at all levels of the health system to use the information generated to make informed decisions about quality improvement.

99. All health establishments (public and private) that wish to be considered for rendering health services to the population will have to meet set standards of quality. There are six core standards that form part of a comprehensive quality package. These standards deal with key quality principles that will improve safety and facilitate access to healthcare services. These standards will form only one aspect of accreditation, other criteria for accreditation will include service elements, management systems, performance standards and coverage.

12.2 Accreditation Standards

100. The accreditation standards will specify the minimum range of services to be provided at different levels of care. Central to the accreditation is the provision of primary health care services that can demonstrate performance linked to health outcomes. This will entail involvement of competent health and medical staff with appropriate skills. In addition, providers at all levels of care must adhere to the referral procedures as defined by the National Health Insurance and the referral system will be clearly defined for services within and outside the health sub-district, district and province to assure continuity of care and effective cost containment.

13. PAYMENT OF PROVIDERS UNDER NATIONAL HEALTH INSURANCE

101. In order to ensure effective cost-containment and the future sustainability of the National Health Insurance, existing provider payment mechanisms and associated accountability processes will be changed.

102. At the primary care level, accredited providers will be reimbursed using a risk-adjusted capitation system linked to a performance-based mechanism. The annual capitation amount will be linked to the size of the registered population, epidemiological profile, target utilization and cost levels.

103. At the hospital level, accredited and contracted facilities will be reimbursed using global budgets in the initial phases of implementation with a gradual migration towards diagnosis related groups (DRGs) with a strong emphasis on performance management.

104. In preparation for contracting with private providers, mechanisms for achieving cost-efficiency will be investigated including international benchmarking from countries of similar economic development that have successfully implemented such processes.

105. Public emergency medical services will be reimbursed through the public hospital global budget initially and a case-based mechanism as the system matures. Contracted private emergency services will be reimbursed using a case-based approach.

106. The provider payment mechanisms must ensure incentives for the health workers and professionals in the public sector and it is also important to consider the implementation of performance-based payment mechanisms.

107. While capitation should be maintained as one of the basic forms of provider reimbursement, adjustment should be made in its application, with the following principles:

a) the capitation amount will be a uniform amount for the defined levels of providers;
b) the capitation amount should be linked to an appropriate index;
c) the public and private health providers contracted by the National Health Insurance, will be assisted in controlling the expenditure through recommended formula, and adherence to treatment protocols for all conditions covered under the defined package of care. This will be necessary to ensure the appropriate level of service provision and avoid under-servicing which is a common characteristic of many capitation-based systems; and
d) the budgets will be calculated on the basis of a risk-adjusted capitation formula taking into account key factors such as population size, age and gender and disease/epidemiological profile.

13.1 HEALTHCARE CODING SYSTEMS AND REIMBURSEMENT

108. Coding systems are an important component of health informatics and reimbursement. National Health Insurance will adopt a coding system that allows providers to uniformly report on the services rendered or goods provided for the purpose of reimbursement. The coding system must allocate a code relating to a particular service so that the National Health Insurance would be able to reimburse for the service with a full understanding of the service delivered or goods supplied. It is also important that the

coding system provides the necessary health information on the burden of disease for the purposes of planning and decision making.

109. The reimbursement system for inpatient services will be according to disease related groups. A case mix or grouper system will be adapted for the South African environment drawing on good practices that are internationally accepted and have been successfully implemented in other jurisdictions.

13.2 UNIT OF CONTRACTING PROVIDERS OF HEALTH CARE SERVICES

110. It is envisaged that the District Health Authority, as part of the health service provision system, will be established and given the responsibility of contracting with the National Health Insurance in the purchasing decisions for health services. The District Health Authority as a contracting unit will be supported by the National Health Insurance Fund's sub-national offices to manage the various contracts with accredited providers.

111. A further role of the District Health Authority will be to ensure that services that are planned for are adequate and accessible for the population that is located within a defined health district. Initially all districts may not be able to participate in purchasing decisions due to capacity constraints. Nonetheless, over a period of time, District Management teams will be strengthened.

112. Accredited providers will be contracted and reimbursed on the basis of the payment levels determined by the National Health Insurance. Accreditation will also take into account the need for particular providers within a particular area, type of health services required as well as available resources within the district. The District Health Authority will monitor the performance of contracted providers within a district and performance will be linked to a reimbursement mechanism that is aimed at improving health outcomes in the district.

113. There will be a separation of the functions of purchasing and provision of services within the National Health Insurance. A clear delineation of the roles and functions of provincial and national spheres of government on the one hand and National Health

Insurance will be undertaken in order to ensure an effective purchaser – provider split. The purpose of this is to avoid the potential duplication of administrative processes so as to minimise administration costs.

14. PRINCIPAL FUNDING MECHANISMS FOR NATIONAL HEALTH INSURANCE

114. Universal coverage to affordable health care services is best achieved through a prepayment health financing mechanism. To achieve universal coverage, pooling of funds requires that payments for health care are made in advance of an illness, and these payments are pooled and used to fund health services for the population. The funds can be from a combination of sources (e.g. the fiscus, employers and individuals). The precise combination of these sources is the subject of continuing technical work and will be further clarified in the next 6 months in parallel to the public consultation.

115. An important consideration is that the revenue base should be as broad as possible in order to achieve the lowest contribution rates and still generate sufficient funds to supplement the general tax allocation to the National Health Insurance. As the National Health Insurance matures, consideration will be given to the alignment and consolidation of health benefits offered by other relevant statutory entities.

14.1 The Role of Co-Payments under National Health Insurance

116. Ordinarily universal coverage does not encourage co-payments. Even the WHO does not encourage co-payments, and National Health Insurance will not be an exception. However, there are instances under which National Health Insurance may be forced to impose co-payments, and these may include amongst others:

a) Services rendered not in accordance with the National Health Insurance treatment protocols and guidelines;
b) Health care benefits that are not covered under the National Health Insurance benefit package (e.g. originator drugs or expensive spectacle frames)
c) Non-adherence to the appropriately defined referral system

d) Services that are rendered by providers that are not accredited and contracted by National Health Insurance
e) Health services utilised by non-insured persons (such as tourists)

15. HOW MUCH WILL NATIONAL HEALTH INSURANCE COST

117. The costing estimates presented in this section focus on providing an indication of the estimated resource requirements for achieving universal coverage, based on cost effective delivery of health services.

118. It is not possible to model with 100% accuracy the precise resource requirements of the future National Health Insurance, but the figures presented provide a good indication of the likely magnitude of resource requirements and more importantly allow for the implications of key National Health Insurance design elements (e.g. of different benefit packages) to be assessed. The figures presented here are preliminary estimates of the resource requirements for the National Health Insurance. The costing of the National Health Insurance is an iterative process and further work will be undertaken to refine cost estimates to take account of detailed proposals being developed, particularly in relation to strategies for gate-keeping at primary care level and provider payment mechanisms to avoid over-utilisation and over-provision of services.

119. The costing model used in this preliminary costing adopts the approach recommended by the International Labour Office (ILO), which is:

Total expenditure = user population **X** service utilisation rates **X** unit costs

It takes account of the population size and how population will grow over time as well as the age and sex composition of the current and future population (as young children, the elderly and women of childbearing age have greater health service needs). It also takes into account how frequently different groups use different health services and how this may change over time, particularly when financial barriers to access are removed under the National Health Insurance. Finally, it considers how much it costs (now and in future)

to provide each type of health service drawing on the current costs of provision of public sector services and the need to dramatically improve resourcing of public sector health services.

120. The model presents the estimated resource requirements using a 'public sector framework'. This implies that a defined comprehensive package of services is provided for all South Africans, but this package is not specified as in current medical schemes in terms of specific services that will be covered (e.g. whether or not chronic medicines for depression are covered). Instead, the comprehensive package is defined in terms of individuals having access to primary care facilities and to specialist and hospital care on referral. For each of these broad categories of services, there are 'norms' in relation to the type of staff that should be employed, equipment that should be available and the range of services that should be provided. In addition, it is based on public sector unit costs, but at substantially improved resourcing levels than at present.

121. The improvement in resourcing is phased in over the initial 7 year period (i.e. it is regarded as an urgent intervention). The model makes allowance for large increases in utilisation when financial barriers to service use are removed under the National Health Insurance (of over 70% in outpatient care and about 80% in inpatient care for those who are currently 'uninsured' relative to their current utilisation levels). These projected increases in utilisation are comparable to the extent of utilisation increases experienced in Thailand when a universal health coverage system was introduced. It will take considerable time for the supply capacity (facilities and health professionals) to grow to accommodate such utilisation increases. For this reason, these increases are phased in over a 14 year period.

122. This model indicates that resource requirements under this model increases from R125 billion in 2012 to R214 billion in 2020 and R255 billion in 2025 if implemented gradually over a 14-year period. These figures are expressed in real terms (i.e. these are the values in real 2010 financial terms).

123. These figures should be placed within the context of current spending levels. The 2010/11 health MTEF budget is R101 billion and increases to R110 billion in 2012/13 (2010 prices). This does not include spending by other departments (such as health spending by Defence and Correctional Services). In addition, a similar amount is being

spent on medical scheme contributions (totalling R90 billion (2010 prices)) in 2009 – the most recent year for which audited figures are available[i] – and estimated to total about R92 billion in 2010 based on the rate of increase between 2006 and 2008). This represents a total of over R227 billion being spent on health services in South Africa in 2010, which is equivalent to almost 8.5% of GDP.

124. **Table 1** below shows preliminary cost estimates of the health care package, implementation as well as administration costs. Further costing will be undertaken by the National Treasury and the Department of Health to further refine the model and to look at long term fiscal implications and effects of the National Health Insurance contribution on households.

Table 1: Healthcare delivery and National Health Insurance implementation Preliminary Cost estimates 2011 – 2025

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	Total costs modelled
2011	0	0	0	0	0	0	103,315,363	103,315,363
2012	57,773,124,913	17,166,207,505	42,270,916,229	117,210,248,647	586,051,243	117,796,299,890	7,562,523,092	125,358,822,983
2013	63,018,663,899	19,715,909,555	43,466,836,571	126,201,410,025	873,313,757	127,074,723,782	7,688,065,131	134,762,788,914
2014	68,743,700,878	21,986,952,564	44,663,128,851	135,393,782,293	1,196,881,035	136,590,663,329	7,817,527,358	144,408,190,686
2015	74,548,475,525	26,244,506,794	45,874,322,881	146,667,305,200	1,578,140,204	148,245,445,404	7,950,910,914	156,196,356,317
2016	80,827,911,456	28,728,750,718	47,094,626,628	156,651,288,802	1,986,338,342	158,637,627,144	8,088,221,201	166,725,848,345
2017	87,641,230,832	31,030,939,052	48,325,812,591	166,997,982,475	2,438,170,544	169,436,153,019	8,229,467,732	177,665,620,751
2018	95,052,680,344	33,149,581,757	49,568,979,121	177,771,241,221	2,936,780,905	180,708,022,126	8,374,663,993	189,082,686,119
2019	103,126,628,663	35,111,160,178	50,824,874,097	189,062,662,938	3,486,315,505	192,548,978,442	8,417,349,306	200,966,327,749
2020	111,940,398,283	36,941,489,310	52,094,075,790	200,975,963,382	4,091,870,614	205,067,833,997	8,568,371,192	213,636,205,189
2021	121,576,843,333	38,660,495,022	53,376,896,309	213,614,234,664	4,759,325,148	218,373,559,813	8,723,363,285	227,096,923,097
2022	127,854,878,098	40,285,667,400	53,611,943,556	221,752,489,054	5,366,410,235	227,118,899,289	8,882,352,922	236,001,252,211
2023	134,559,644,807	41,834,116,750	53,831,486,738	230,225,248,294	6,013,483,485	236,238,731,780	9,045,370,841	245,284,102,621
2024	141,730,835,738	43,303,832,918	54,036,013,619	239,070,682,276	6,703,541,931	245,774,224,207	9,212,451,095	254,986,675,302
2025	149,406,746,586	44,715,842,637	54,225,907,657	248,348,496,879	7,450,454,906	255,798,951,786	16,410,894	255,815,362,679

Year	Non-AIDS-related services	AIDS-related services	Additional services	Total Direct Healthcare costs	NHI Operational costs	NHI Implementation costs
% of total in 2012	46.10%	13.70%	33.70%	93.50%	0.50%	6.00%
% of total in 2025	58.40%	17.50%	21.20%	97.10%	2.90%	0.00%

125. It should be noted that increased spending on the National Health Insurance will be partially offset by the likely decline in spending on medical schemes (as all South Africans will be entitled to benefit from National Health Insurance services). In addition, National Treasury is projecting real GDP growth of 3.1% in 2010/11, 3.6% in 2011/12 and 4.2% in 2012/13. National Health Insurance will require an increase in spending on health care from public resources (general tax revenue and a mandatory National Health Insurance contribution) that is faster than projected GDP increases. However, the ultimate level of spending on a universal health system relative to GDP (of 6.2%) is less than current spending by government and via medical schemes (of 8.5%).

126. This National Health Insurance contribution should be compared to the current level of medical scheme contributions. Based on data from the 2005/06 Income and Expenditure Survey, the overall average level of contributions for all medical scheme members is over 9% of income. The lowest income medical scheme members currently contribute over 14% of their income to medical schemes (for the lowest 40% of scheme members), the middle 20% of scheme members spend nearly 12% of income on medical scheme contributions, the second wealthiest 20% of medical scheme members devote over 9% of their income to contributions while the richest 20% of scheme members devote about 5.5% of their income to medical scheme contributions. The intention is that the National Health Insurance benefits, to which all South Africans will be entitled, will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply draw on their National Health Insurance entitlements.

127. The preliminary costing estimates provided above indicate that the National Health Insurance is affordable for South Africa. However, the present system of fragmentation, associated with the high cost, curative and hospi-centric approach and excessive and unjustifiable charges, especially within the private health sector is unsustainable. No amount of funding will be sufficient to ensure the sustainability of National Health Insurance unless the systemic challenges within the health system are also addressed.

128. The challenges of sustainable financing do not apply only to South Africa but have also been experienced in other countries that follow the route that is currently dominant in the South African private health sector. An example of this problem has been experienced in the United States of America (USA) where the concentrated private hospital and

specialists' market power coupled with a fee-for-service reimbursement system that promotes over-servicing of patients has resulted in a high cost, curative care.

129. The high cost, curative and hospi-centric system cannot be sustainable not only for the implementation of National Health Insurance but also for any form of healthcare financing mechanism including the present medical schemes environment. In order to effectively implement such a large health systems reform programme, strengthening of the public health system and transformation of the health services delivery platform is critical for the success of National Health Insurance.

15.1 Funding Flows

130. All revenue collection would be undertaken by the South African Revenue Services (SARS), including the mandatory contribution. All funding for personal health care services will flow through the National Health Insurance Fund. Treasury will allocate general tax revenue for personal healthcare services and the payroll-linked mandatory contribution to National Health Insurance in consultation with the Minister of Health and the National Health Insurance.

16. THE ESTABLISHMENT OF THE NATIONAL HEALTH INSURANCE FUND

131. In order to implement an effective National Health Insurance, there will be a reconfiguration of the institutions and organisations involved in the funding, pooling, purchasing and provision of health care services in the South African health system.

132. The National Health Insurance Fund will be established as a government-owned entity that is publicly administered. It will be a single payer entity with sub-national offices to manage nationally negotiated contracts with all appropriately accredited and contracted healthcare providers. The covered services will be defined as a comprehensive package of services that includes personal care, health prevention and promotion services. The main responsibility of the National Health Insurance Fund will be to pool funds and use these funds to purchase health services on behalf of the entire population from contracted public and private health care providers. Nonetheless, a multi-payer system in a National Health

Insurance will also be explored as an alternative to the preferred single-funder, single-purchaser publicly administered Fund.

133. The National Health Insurance Fund will be an autonomous public entity reporting to the Minister of Health and Parliament. It will be governed by the relevant statutes. The Fund will be established through the passing of enabling legislation and supporting regulations. The Minister of Health will have oversight of the National Health Insurance Fund.

134. The Department of Health will continue to play its overall stewardship role of the health system, such as development of overall health policy, planning to meet changes in the country's health care needs as determined by changes in population demography, epidemiological profile, health technology and any other relevant developments. The Department of Health will also remain a major provider of services through its national, provincial and district level structures and facilities. Furthermore, the Department of Health will continue to provide non-personal services including overall responsibility for infrastructure development and direction of health worker training and planning. The responsibility of coordinating the development of overall health plans including personal services will be retained within the Department of Health. The National Health Insurance Fund will purchase personal services in accordance with the approved plans by the National and Provincial Departments of Health.

135. At the national level, the National Health Insurance Fund will be managed by a Chief Executive Officer (CEO) who will report directly to the Minister of Health. The CEO will be supported by a competent Executive Management Team and specific technical committees including the technical advisory committee, audit committee, pricing committee, remuneration committee, benefits advisory committee and others.

136. The National Health Insurance Fund will be advised by a technical advisory committee made up of experts in health care financing, health economics, medical and nursing services, pharmaceutical services, public health planning, research, monitoring and evaluation, public health law, labour, administration of public insurance schemes, actuarial sciences, information technology and communication. At a sub-national level, the National Health Insurance Fund will establish sub-national structures that will be responsible for

managing the nationally negotiated contracts with the District Health Authorities that are located within particular health districts.

17. THE ROLE OF MEDICAL SCHEMES

137. Membership to the National Health Insurance will be mandatory for all South Africans. Nevertheless, it will be up to the general public to continue with voluntary private medical scheme membership if they choose to. Accordingly, medical schemes will continue to exist alongside National Health Insurance. However, there will be no tax subsidies for those who choose to continue with medical scheme cover.

138. The exact form of services that medical schemes will offer may evolve to include top-up insurance. However, no South African and legal permanent resident can opt out of contributing to National Health Insurance even if they retain their medical scheme membership.

139. There is existing expertise residing in the health sector in the area of administration and management of insurance funds. Where necessary and relevant, this expertise may be drawn upon within the single payer publicly administered National Health Insurance, to ensure that adequate in-house capacity is developed.

18. REGISTRATION OF THE POPULATION

140. The National Health Insurance Fund will only deal with registered citizens as provided by the Department of Home Affairs. Only those registered will have access to the defined comprehensive package of services. Accredited and contracted health providers will provide services to the registered population.

141. A National Health Insurance card will be issued for the registered population and it will allow for ease of access to patient information and for the portability of health services. The National Health Insurance card will be the same for the entire population, regardless of their contributory or other status, in order to avoid the stigma that may be associated with subsidised households and individuals.

19. INFORMATION SYSTEMS FOR NATIONAL HEALTH INSURANCE

142. The National Health Insurance will contribute to an integrated and enhanced National Health Information System. National Health Insurance information system will contribute towards the determination of the population's health needs and outcomes. The information system will also be essential for portability of services for the population. The National Health Insurance information system will be based on an electronic platform, with linkages between the National Health Insurance membership data base (with updated contribution status) and accredited and contracted health care providers. The information system will need to be adequately budgeted for in the initial stage to help ensure effective implementation. Developmental work will be conducted on a National Health Insurance patient card and supporting information platform.

20. MIGRATION FROM THE CURRENT HEALTH SYSTEM INTO THE NATIONAL HEALTH INSURANCE ENVIRONMENT

143. The transitional process from the current to the proposed National Health Insurance environment within the South African health system will require a well-articulated implementation plan. The implementation of National Health Insurance will be done in a phased and systematic manner at both the national and sub-national levels. The migration period will occur in three phases over the fourteen years of implementation.

144. The initial phases of implementation will include the real-life demonstration of the key administrative and technical aspects of National Health Insurance so as to ensure the smooth roll-out of the systems as it matures and new information becomes available. A number of interrelated elements must be carefully addressed to ensure an effective transition process. These elements include:

145. Development of a strategy that allows for the strengthening of district health structures to support service delivery within the National Health Insurance. This will entail accelerating the re-engineering of the Primary Health Care Approach through the incremental

establishment of Municipal Ward-based family health teams, District-based specialist teams and the roll-out of the school-based health programmes. The strengthening of the District Health Management teams will be accelerated to improve the capacity to contract with the National Health Insurance Fund by the District Health Authority;

146. Development and implementation of a comprehensive plan for quality improvement, assurance and compliance for all providers supported by the Office of Health Standards Compliance. The Office of Health Standards Compliance will inspect, licence and certify all health care facilities. The National Health Insurance Fund will contract with accredited health care providers based on prescribed criteria and standards;

147. Determination of a transition and long term plan for addressing the current Human Resources (HR) shortages in the health system. This will include increasing capacity of nursing colleges and health science faculties to produce more health professionals. Furthermore, mobilisation of additional financial and HR resources will be undertaken to support enhanced health systems delivery within the National Health Insurance;

148. Conducting real-life demonstrations and pilots in prioritized health districts on the management capacity, appropriateness of the service package, and ability of the accredited and contracted providers to deliver on the defined comprehensive package of health services to be provided at the appropriate level of care. The prioritized districts will be selected based on demographic, socio-economic and epidemiological profiles as well as management functionality at the selected health districts;

149. The assessment of existing health infrastructure (including facilities, technology and management capacity) in the country and a plan to improve its capacity and effectiveness to support health services delivery and provision within the National Health Insurance;

150. Implementation of hospitals management reforms that include governance reforms, improvements in financial management, decentralization of authority associated with hospital management autonomy and accountability;

151. Development of a plan that informs the processes around implementing innovative purchasing and procurement processes to allow the National Health Insurance to yield the best economies of scale;

152. Development of an integrated plan to support processes around population registration. This plan must be informed by building on existing capacities in the country and through involving various stakeholders. The plan will also include conducting research on the type of National Health Insurance Card that will be used to allow the ensured population to be identified, access the defined comprehensive cover and benefit from the portability of health care benefits;

153. Further refinement of the financial resource envelope that will be required to adequately fund the National Health Insurance and service delivery platforms at the primary secondary, tertiary and quaternary levels, including the concurrent health systems strengthening activities that are informed by the Department of Health's Ten Point Plan;

154. Refinement of the revenue mobilisation strategy and pooling systems that will be implemented to ensure National Health Insurance provides the appropriate financial risk protection for the entire population and yields the full economies of scale from the publicly administered monopsony structure to support the single-purchaser National Health Insurance. This will also include alignment of health benefits and tariff system under the Road Accident Fund, Compensation for Occupational Diseases and Injuries, Compensation Commission for Occupational Diseases and the Occupational Diseases in Mines and Works Act.

155. Refinement of the provider payment mechanisms strategies and implementation of interim mechanisms to move from the current reimbursement system to the proposed performance-based payment system under the National Health Insurance;

156. Development of a detailed transition process from the current fragmented health information system to an integrated health information system that supports efficiency, effectiveness, information portability, confidentiality and enhanced proactive decision making and system planning.

157. Review of existing legislative and regulatory laws to inform the preparation of the Bill/Act that will create an enabling environment for the implementation of the National Health Insurance in South Africa. Furthermore, passing of an enabling legislation to establish the National Health Insurance Fund will be undertaken. The fund will be established initially as a national office and later to sub-national offices at provinces.

158. A National Health Insurance Conditional Grant will be allocated to the National Department of Health as part of the resource allocation processes intended to support activities directed at piloting key aspect of the National Health Insurance. These resources will be used to fund the shadow processes for implementing and rolling out of the key service delivery, administrative and technical functions required by the National Health Insurance in the initial years.

159. A summary of some of the key elements that will be addressed through the phased implementation are shown in following tables:

Table 1: Phasing-In of National Health Insurance – The First 5 years

Key features	Time-frames
1. NHI White Paper and Legislative Process • Release of White Paper for Public Consultation • Launch of Final NHI Policy Document • Commencement of NHI Legislative process	10 August 2011 December 2011 January 2012
2. Management reforms and Designation of Hospitals • Publication of Regulations on Designation of Hospitals • Policy on the management of hospitals • Advertisement and appointment of health facility managers	August 2011 August 2011 October 2011
3. Hospital Reimbursement reform • Regulations published for comment on Hospital Revenue Retention • Development of a Coding Scheme	April 2011 January 2012
4. Establishment Office of Health Standards Compliance (OHSC) • Parliamentary process on the OHSC Bill • Appointment of staff (10 inspectors appointed)	August 2011 January 2012

5. Public Health Facility Audit, Quality Improvement and Certification
• Audit of all public health facilities
  • 21 % already audited (876 facilities)
  • 64% completed (2927 facilities)
  • 94% completed (3962 facilities)
• Selection of teams to support the development and support of quality improvement plans and health systems performance
• Initiate inspections by OHSC in audited and improved facilities
• Initiation of certification of public health facilities
	End July 2011
	by end of December 2011
	by end March 2012
	
	October 2011
	February 2012
	March 2012

6. Appointment of District Clinical Specialists* Support • Identification of posts and adverts • Appointment of specialists • Contract with academic institutions on a rotational scheme	August 2011 December 2011 February 2012
7. Municipal Ward-based Primary Health Care (PHC) Agents • Training of first 5000 PHC Agents • Appointment of first 5000 PHC Agents • Appointment of PHC teams	December 2011 March 2012 April 2012
8. School - based PHC services • Establish data base of school health nurses including retired nurses • Identification of the first Quintile 1 and or Quintile 2 schools • Appointment of school-based teams led by a nurse	August 2011 October 2011 November 2011
9. Public Hospital Infrastructure and Equipment • **Refurbishment and equipping of 122 nursing colleges** First 72 nursing colleges by end of financial year 2011-2012	March 2012

• **Building of 6 Flagship hospitals and medical faculties through PPP's** • King Edward VIII Academic (KZN) • Dr George Mukhari Academic (Gauteng) • Nelson Mandela Academic (E. Cape) • Chris Hani Baragwanath Academic (Gauteng) • Polokwane Academic (Limpopo) • Nelspruit Tertiary (Mpumalanga) • Refurbishment of public sector facilities	**Commence 2012** Ongoing
10.Human Resources for Health (HR) • Launch of HR Strategy • Short to medium term increase in supply of medical doctors and specialist • Increase in production of nurses • Increase in production of pharmacists • Increase in production of allied health professionals	 September 2011 2012 – 2014 2012 – 2014 2012 – 2014 2012 – 2014
11.Information Management and Systems Support • Establishment of a **National Health Information Repository and Data Warehousing** (NHIRD) • Provincial and District roll-out of the NHIRD • Appointment of Information Officers and Data Capturers	 July 2011 November 2011 November 2011
12.Build capacity to manage NHI through the strengthening of District Health Authority • Creation of NHI district management and governance structures • Selection of Pilot Sites (First 10 districts) • Development and test the service package to be offered under NHI in pilot sites • Extension of Pilots from 10 districts to 20 districts	**April 2012** June 2013
13.NHI Conditional Grant to support piloting of initial work in 10 districts • Piloting of the service package in selected health districts • Piloting fund administration	**April 2012**
14.Costing model • Refinement of the costing model • Revised estimates	 2012 2013
15.Population registration • Partnership between Departments of Science and Technology, Health and Home Affairs on: ▪ Population identification ▪ Population registration mechanisms	**Commences April 2012**
16. ICT • Scoping exercise with Department of Science and Technology and CSIR ▪ Design of ICT architectural requirements for NHI	**April 2012**
17.Establishment of NHI Fund • Appointment of CEO and Staff • Establishment of governance structures • Establishment of administrative systems	**2014**
18.Accreditation and contracting of private providers by NHI Fund • Establishment of criteria for accreditation • Accreditation of first group of private providers	 2013 2014

Table 3: Phasing-In of National Health Insurance – Second Phase (2016-2020)

Phase	2016 – 2020
Key features	Further real-life demonstration and further contracting independent providers
1. NHI Act	
2. Build capacity to manage NHI	√
3. NHI Conditional Grant (to support creation of Fund and piloting of initial work)	
4. Establishment of NHI Fund	Provincial branches of Fund
5. Alignment of Funds: NHI, RAF + COID + ODIMWA + CCOD	NHI progressively takes over admin for Health functions
6. Family Health Teams	7 000
7. Accreditation and contracting of General Practitioners and networks	3 000
8. Public Hospitals QI and accreditation	**QI and Accreditation**
9. Public hospital Infrastructure	√
10. Private Hospitals accreditation	Contracting model Pilot selected Priority areas
11. Management reforms	√
12. Health Workforce	Increase production
13. Office for Standards Compliance	**Certification and licensing**
14. Hospital Reimbursement reform	Implementation of Coding Schema and DRGs
15. Population registration	Population registration
16. NHI Card	Simple
17. Population-based capitation payments	Capitation to all PHC providers

Table 3: Phasing-In of National Health Insurance – Third Phase (2021-2025)

Phase	2021 - 2025
Key features	Maturing
1. NHI Act	
2. Build capacity to manage NHI	√
3. NHI Conditional Grant (to support creation of Fund and piloting of initial work)	
4. Establishment of NHI Fund	
5. Alignment of Funds: NHI, RAF + COID + ODIMWA + CCOD	
6. Family Health Teams	10 000
7. Accreditation and contracting of General Practitioners and networks	6 000
8. Public Hospitals QI and accreditation	**QI and Accreditation**
9. Public hospital infrastructure	√
10. Private Hospitals accreditation	Selected accreditation and contracting
11. Management reforms	√
12. Health Workforce	Increase production
13. Office for Standards Compliance	**Certification and licensing**
14. Hospital Reimbursement reform	
15. Population registration	Population registration
16. NHI Card	Further improvements
17. Population-based capitation payments	Capitation to all PHC providers

21. PILOTING OF NATIONAL HEALTH INSURANCE

160. The first steps towards implementation of National Health Insurance in 2012 will be through piloting. 10 districts will be selected for piloting. The NDOH is conducting audits of all healthcare facilities and criteria of choosing these 10 districts will be based on the results of the audits as well as the demographic profiles and key health indicators. In the selection of the 10 districts consideration will be given to a combination of factors such as health profiles, demographics, health delivery performance, management of health institutions, income levels and social determinants of health and compliance with quality standards.

161. After the initial 10 districts, additional districts will be determined on an annual basis for inclusion in the roll out. There are certain conditions that should be complied with for a district to be included as part of the pilots such as the re-engineered PHC streams, basic infrastructure, compliance with standards, appropriate management levels.

162. The first 5 years of National Health Insurance will include piloting and strengthening the health system in the following areas:

- Management of health facilities and health districts
- Quality improvement
- Infrastructure development
- Medical devices including equipment
- Human Resources planning, development and management
- Information management and systems support
- Establishment of the National Health Insurance Fund

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GLOSSARY OF KEY TERMS

Accreditation of Health Services Providers – The process through which an entity undertakes to certify healthcare and health services providers according to appropriate and specific criteria in order for them to be contracted and reimbursed for rendering services to a defined population.

Case Mix Reimbursement – This is a provider payment mechanism that uses case-based payment systems such as diagnostic-related groups (DRGs).The approach used is to bundle different pathologies or interventions into homogenous cost groups that are then ascribed an average treatment cost. It is commonly applied in the reimbursement of hospitals as an intervention to control costs and encourage efficiency in many countries, not just high-income settings.

Contracting of Health Services Providers – The process through which an entity enters into formal and legally binding arrangements with appropriately licensed and accredited healthcare and health services providers for rendering services to a defined population. The contractual arrangements may stipulate the rates for reimbursement of providers, the penalties and sanctions that may be imposed if specific provisions of the contract/s are violated.

Co-payments – These are user charges or fees levied for consultations with health professionals, medical or investigative procedures, medicines and other supplies, and for laboratory tests. They include charges levied by private health insurance companies to insured persons which must be paid directly through out-of-pocket payments to providers at the time they use health services because these costs are not covered by their specific benefit option.

Fee-for-Service Reimbursement – Fee-for-Service reimbursement is an approach to the payment of healthcare and health services providers based on the number of interventions conducted and/or the number of treatment episodes between a patient and a provider. This type of reimbursement mechanism has been shown to be responsible for cost escalation and patient over-servicing in many contexts.

Financial Risk Protection – The provision of adequate financial protection to all households from catastrophic health-related expenditures. This will ensure that they do not suffer financial

hardship and/or are not deterred from using needed health services. This involves minimising or eliminating the barriers that households face when accessing health services, such as the requirement to pay for needed care on the spot.

Health Benefits – This refers to the scope of health entitlements that are offered as part of the package of health services that everyone in a particular population is entitled to. In universal coverage health systems, these usually involve a mix of health promotion, prevention, curative and rehabilitation care. In some instances, this is referred to as the package/s of care.

Health Quality Assurance – This refers to mechanisms that are put in place by a relevant institution or a combination of institutions to monitor and evaluate the compliance of healthcare and health services providers to stipulated quality norms and standards. Within the South African health system this will be done by the proposed Office of Health Standards Compliance.

Health Quality Improvement – This refers to systems, processes and interventions that are implemented across all levels of the health system to progressively and sustainably enhance the quality of healthcare services that are rendered to the national population.

Health System – The combination of organisations, institutions and individuals that are directly and indirectly involved in the provision and delivery of health services to the national population. This includes public, private (for-profit, not-for-profit) as well as non-government organisations.

Mandatory Contribution – This is a compulsory amount of money that an individual or household is expected to make towards the financing of the health system. The mandatory contribution amount is usually expressed as a proportion of a household's or individual's income or earnings and is collected by a defined government agency as dedicated revenue allocated into the pooled pot of funds.

National Health Insurance – An approach to health system financing that is structured to ensure universal access to a defined, comprehensive package of health services for all citizens, irrespective of their social, economic and/or any other consideration that affects their status.

Pooling of Funds – A process of collecting and combining mobilised financial resources so as to spread the health-related financial risks across a wider pool. It involves the accumulation and

management of financial resources to ensure that the financial risk of having to pay for health care is shared by all members of the pool. In universal health systems, risk-pooling or pooling of funds is occurs where payments for healthcare are made in advance of an illness, these payments are pooled in some way and used to fund health services for everyone who is covered – treatment and rehabilitation for the sick and disabled, and prevention and promotion for everyone. The pooled funds can be either from direct tax revenues or a combination of some sort i.e. direct tax allocations supplemented by mandatory, payroll-related contributions.

Population Coverage – This refers to the proportion of the national population that has access to effective universal coverage and financial risk protection. The higher this proportion is, the better the level of financial risk protection and access to needed health services a given population or sub-population group has.

Primary Health Care – The provision of health promotion, preventive, curative and rehabilitative care as close to the household and community as is possible. This approach to health services provision and delivery is based on the recognition that the promotion and protection of health is essential to human welfare and sustained economic and social development. Therefore, health care and health services are rendered in a manner that integrally takes into account the circumstances in which people live, work and interact.

Purchasing – This refers to the systems and processes that government puts into place to create mechanisms for paying for health services that are delivered to the population. Purchasing includes appropriate institutions and organisations making decisions about what services should be provided to a given population and how these services should be funded.

Revenue Collection – This refers to the manner in which financial resources are mobilised or raised to pay for health system costs. Financial resources can be collected through general or specific taxation; compulsory or voluntary health insurance contributions; co-payments such as user fees; and donations from bilateral and multilateral institutions.

Risk-adjusted Capitation – This is a provider payment mechanism whereby healthcare providers are paid a predetermined fee to cover all the health needs of each person registered with them. The fee paid is usually adjusted to take into account of the patient profiles of each provider. The common adjusters include patient gender, age and epidemiological profile. This mechanism is commonly used to pay primary care providers or facilities for their services.

Social Solidarity – refers to building financial risk protection for the whole population through equitable and sustained health financing mechanisms that ensure sufficient cross-subsidisation between the rich and the poor, and the healthy and sick. It is linked to the concept of social justice which puts a limit to how much inequality is acceptable. Such a system allows for the spreading of health costs over a person's lifecycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life.

Universal Coverage – The progressive development of the health system, including its financing mechanisms, into one that ensures that everyone has access to quality, needed health services and where everyone is accorded protection from financial hardships linked to accessing these health services. This does not imply that the State must provide everything and anything to the population. Instead, it implies that everyone must be given an equitable and timely opportunity to access needed health services, which must include an appropriate mix of promotion, prevention, curative and rehabilitation care. The World Health Organisation defines a universal health system as one that provides *all* citizens with *adequate* health care at an *affordable* cost.

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