National Health Insurance Plan for South Africa

Prepared by the Task Team on National Health Insurance on behalf of the Health and Education Sub-Committee

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Executive Summary

The South African health care system is characterized as fragmented due to the huge disparities in the funding and delivery of services. Consequently, access to health care is unequal with the majority of the population relying on a public health care system that has a disproportionately less amount of financial and human resources at its disposal. To address these imbalances in access and utilisation of health services as well as health outcomes amongst the different socio-economic groups, the health care system requires a fundamental transformation into an integrated health care system that guarantees the progressive realisation of the right to health care for all.

The introduction of a National Health Insurance System is founded on three key arguements: First, that it is a Constitutional right that the public has access to quality health services; second, that the empirical evidence suggests that the population is willing and able to contribute towards mandatory health insurance; third, that it makes economic sense to invest in human capital development, reorganise the funding model for public purposes and ensure cost containment by reducing administrative and transaction costs in the system, and most importantly achieve redistributive justice through the principle of universal coverage.

Structure of the NHI Authority

At the core of the proposed health sector reforms is the reconfiguration of institutions and organisations involved in the funding, purchasing and provision of health care services. A National Health Insurance Authority will be established within the confines of the appropriate laws whose major responsibility will be to receive funds from various sources, pool these resources and purchase services on behalf of the entire population. The Authority will be a public entity and structured as a single purchaser with sub-national offices at the provincial and district level. The Authority will be run by a CEO that directly reports to the Minister and is supported by an Executive Management and specific technical committees including the technical advisory committee, audit committee, pricing committee, remuneration committee, benefits advisory committee and others.

Revenue generation and pooling functions

The main sources of revenue for the National Health Insurance Fund will be **general tax** and **a progressive mandatory contribution**. Both employers and employees will contribute to the fund. Mechanisms will be gradually developed to get contributions from the self-employed. External funding for health will be included in the Fund. All this will result in the creation of a single risk pool that promotes cross-subsidisation between the rich and the poor, the healthy and the sick, and young and old.

Health Sector Budgeting Process and Funding Flows

Plans for infrastructure maintenance and expansion (capital costs), and service provision (recurrent costs) will be developed by the District Health Councils, Provincial Health Authorities, and the National Department of Health in consultation with the NHI Authority. The annual plans will be approved by the Minister. Funds will flow from the NHIA to the Provinces, District Health Councils and directly to providers based on agreed plans and using a combination of agreed payment mechanisms.

Provider payment mechanisms for service providers

The ultimate objective is to have the following provider payment arrangements for all accredited providers: risk-adjusted per capita payments for Primary Care Facilities (GP group practices, Community Health Centres, Clinics and others), case-based payment mechanisms for hospitals, salaried doctors and specialists. However, given current capacity constraints in the public sector and the need to reduce the disruption of services to the population during transition, budgets will continue to be used for both primary care and hospital level providers in the public sector until such time a facility is accredited. The budgets will nonetheless be calculated on the basis of a risk adjusted capitation formula. Only under exceptional circumstances will out of pockets payments be used.

Establishment of District Health Councils

Capacity to deliver quality primary health services under a National Health Insurance system is premised on a revitalised and adequately capacitated district health system. District Health Councils throughout the country will be strengthened by improving political governance, oversight and accountability structures. The focus will largely be on improving service integration, quality of services, efficiency, effectiveness, and community participation, developmental and multi-sectoral approaches. Significant improvements in managerial capacity will be key to achieving all this.

Registration of population per district/catchment area

To ensure that all eligible citizens and permanent residents have access to comprehensive NHI services, people will be registered for NHI and be assigned to specific health care facilities closest to them. The registration process with be on the basis of the ID with the hope that a National Health Insurance Card will be ultimately used when the NHI is operational in a specific district. It is important that people are registered by catchment area and facility in order to facilitate the principal payment mechanism—capitation. The registration process will be pilot tested before it is rolled out nationally using various approaches and existing platforms including work-places, the Department of Home Affairs (ID system), Department of Social Development (registration for grants), STATS SA, and Independent Electoral Commission (election registration processes), to name but a few.

Services to be provided within the district and outside of the district

All accredited National Health Insurance providers (both public and private) will provide a comprehensive package of services at all levels of the referral hierarchy, that is, primary care services, secondary services, tertiary services, and quaternary services. In addition, an exclusion list of services is defined to contain costs. This exclusion list will be reviewed at agreed times by the Services Advisory Committee.

Increase autonomy and efficiency of public health care providers, including hospitals

As part of strengthening the delivery and provision of public health services, the Plan proposes concrete mechanisms for increasing the autonomy and efficiency particularly of hospitals, and increasing efficiency of public health care providers by giving them more managerial decision making space.

The accreditation process of providers (public & private)

The credibility of the NHI will rest on visible improvements in the provision of quality services to all. All facilities, private and public, will be accredited for NHI using agreed national norms and standards. A National Office of Standards Compliance will be established according to the National Health Act of 2004 to ensure that all health care facilities are appropriately licensed and accredited. The aim is to accredit at least 25% of facilities annually until all facilities are included during a five year phased period. In addition, the accreditation process will be supported by quality improvement and quality assurance programmes to make sure that all facilities reach accreditation status.

Development of Human Resources Plan for Health

Changing the financial arrangements of the health sector without dealing with the Human Resources for Health challenges will not bring the desired results. The Plan proposes comprehensive strategies for increasing the supply, quality, distribution and retention of various categories of health workers in the country. Innovative proposals are planned for dealing with the human resources for health in the short term: for example reviving the Cuban doctors programme, allowing legal foreign nationals to practice, importing specific specialist skills and attracting back those South African health and managerial professionals working in other countries.

General Infrastructure Inventory and Development

Expansion and rehabilitation of health care infrastructure strengthening is critical to improving universal coverage and reducing inequalities of access. The Plan proposes that a detailed audit of both public and private facilities in the country be done in order to establish the stock and distribution of these facilities. The audit will serve a dual purpose: First, assessment of current capacity and where it is located, and second, identifying gaps for expansion and facilities that require refurbishments. A refurbishment and expansion plan will be developed, in line with the existing health care facilities revitalisation programme.

Costing of NHI

The Plan provides a number of costing scenarios for National Health Insurance to demonstrate how much it will cost to establish and run a NHI system in a sustainable way. This includes costing of the various components of the Plan including the comprehensive package of services

Transitional Arrangements

To avoid disruptions, and ensure smooth transition towards a National Health Insurance system, a well-planned and phased transitional strategy is described that systematically takes into account what needs to occur and when, and under whose responsibility.

Actions Required of the ANC

The African National Congress has commissioned an NHI Task Team to develop a National Health Insurance (NHI) plan for financing health care in South Africa.

The ANC Task Team undertook detailed technical work from (July 2008 to February 2009. The accepted NHI policy was used as the basis for developing the detailed implementation plan which will guide policy decision making and implementation. The outcome from the discussions is a vision of **national health insurance plan for all South Africans,** to be introduced in a phased manner in the next five years.

Financial projections are being developed for costing the National Health Insurance system. These give policy-makers an indication of the financial implications of a policy under consideration. They do not constitute a complete and detailed actuarial analysis, which needs to be completed after the plan has been accepted.

Based on the stakeholder consultations, the financial scenario whose results are included here is one of a national health insurance with the following key characteristics and assumptions:

- The key principle upon which NHI is based is that of universal coverage for all. The plan is to ensure that all South Africans are enrolled as beneficiaries of NHI in five years.
- The health budget from general tax revenue is increased in real terms and is supplemented by a mandatory NHI's payroll levy. The current tax-deductible for medical schemes contributions will also be removed to provide additional funds into the NHI system.
- Formal sector employees make mandatory monthly contributions at a percentage still to be determined, that are shared equally between employees and employers.
- The poor, low income workers, pensioners and the unemployed and those in the informal sector, are exempted from paying contributions.
- The out-of-pocket payments are removed or minimised for only the services covered by NHI.
- The benefit package comprises comprehensive outpatient and inpatient care at public and private health facilities, including group practices (comprising primary health care teams) and authorized referrals to secondary, tertiary and quandary levels of care
- Substantial quality improvement will be implemented with the help of NHI financing.

The projected revenue and expenditure of such an NHI with the above input variables and assumptions are being worked out. The result will be phased introduction that ensures that registration of the 25% of the population per annum is linked to targeted schedule for collection of funds from general tax revenue and mandatory contribution.

A combination of general tax revenue and progressive mandatory contributions as the main sources of revenue for the NHI will promote social solidarity through income and risk cross-subsidization which are an inherent characteristic of the national health insurance.

Under the NHI system, the contributions rates for formal sector workers, which could start with a nominal percentage in the initial years and increase to X% (shared between employer and employee) and real increase from general tax revenue at X%
of the GDP; may be sufficient to balance NHI revenues and expenditure. Furthermore, any shortfall may be financed from the removal of tax deductibles for medical schemes.

The ANC is advised to take key decisions in the following areas:

- The mechanisms for resource mobilisation, i.e. the decision to increase the health allocations in real terms via the general tax revenue, supplemental national health insurance payroll level and rerouting of public sector employees' contribution to medical schemes to the national health insurance fund. In addition there should be removal of tax deductibles to the medical schemes.

- The way health services are to be improved to better serve all our people

- The type of proposed governance and management structure of the NHI.

Once these key decisions are made the ANC will have to decide on critical key design issues and to negotiate with the respective stakeholders, foremost the contribution rates and provider payment rates – mainly labour, employers and health providers. Also, it will have to develop and agree upon an implementation schedule to establish step by step the NHI system scheme and the national health authority/agency with personnel. This could be realized in the form of an "Implementation Project", with financial support for investments in infrastructure, administration and training of staff in the various management and administration skills required for the NHI.

The proposed NHI design is able to offer better comprehensive services to all South Africans, by addressing inequity in access and inequity in financing. When successfully implemented, it will lead to better health for all South Africans.

The main recommendations on key issues for the NHI are summarized below. These are based on the ANC NHI Task Team views as well as the pre-liminary financial feasibility assessment.

Recommendations for establishing a "Phased NHI for all South Africans"

Resource collection:

- The health budget from general tax revenue is increased in real terms in the next five years).
- Resources mobilized through NHI payroll levy do not reduce but complement existing government funding.
- Public sector payment for public sector worker's private medical schemes would be rerouted towards NHI
- Tax deduction for medical schemes contributions is removed *(**Note**: National Treasury is making a different proposal which is as follows: Replacement of the medical scheme contribution deduction with a non-refundable tax credit which will be set at about 30 per cent of the prevailing deduction. In other words medical scheme contributions will cease to qualify as tax-free fringe benefits. All contributions paid by an employer will be regarded as taxable and the employee will be permitted to claim a tax deduction (or a credit) for contributions up to the cap. A consultation paper will be released during 2009. Implementation is proposed in two years' time so that SARS, employers and payroll providers will have sufficient time to make the necessary administrative adjustments – source 2009 National Budget Review (Tax proposals) pg.62, National Treasury)*

Contributors

- Formal sector contribution is extended rapidly at 25% of the targeted population per annum.
- Contribution is mandatory – with opt out

Contribution rates:

- The formal sector pays a progressive contribution based on their salary.
- The poor and unemployed are exempted from contributions and the state will provide a subsidy to cover for that.

Benefit package:

- The benefit package is comprehensive, with the current public health services as its benchmark, and covers in-patient and out-patient care at all levels, including primary health care.

Provider payment mechanism:

- The payment mechanism is an important factor that should be linked with quality

Improvements and cost containment. Providers can be remunerated on the basis of a combination of risk-adjusted capitation and global budgets. There may be an element of better payments for increased performance.

Accreditation and quality management

- An accreditation scheme would be developed for all health care providers – private and public - and will be executed by an independent accreditation body.

Governance and management of the NHI Authority:

- The NHI authority will be a public authority which is responsible and accountable to the Ministry of Health. It will be a publicly administered

public entity in the sense of the NHI Act and there will be no role for private intermediaries.

Legislation:

- It is recommended to develop a separated NHI Act.

Specific recommendations of the NHI TASK TEAM:

- Further progress of developing and implementing a better health financing system is currently in the hands of the NHI TASK TEAM working together with the Department of Health, National Treasury, SARS and Department of Social Development, member of the ANC and its allies as well as the health professionals operating in the public and private health sector. The work of the Task-Team needs to be extended further.
- The ANC-Task-Team will include a dedicated team of international experts and specialists in NHI and systems development to assist in the implementation process
- An awareness raising campaign needs to be developed, which is tailored to the specific information needs and group interests of the various stakeholders .

CHAPTER 1: OVERVIEW OF THE HEALTH CARE SYSTEM

1.1 Introduction

South Africa post-1994 inherited a highly inequitable health system from the Apartheid era. Although South Africa has relatively high levels of health care expenditure as a percentage of GDP relative to comparable other middle-income countries, Its health status indicators are much poorer, due in part to various social and economic determinants such as poverty and unemployment, unhealthy life styles such as smoking, alcohol abuse and risky sexual behaviours that fuel HIV/AIDS and other sexually transmitted diseases, and injury from interpersonal violence. Another critical factor contributing to poor health outcomes is differential access to quality health care resulting from the mal-distribution of human, financial and physical resources between the public and private sectors. The majority of financial and human resources for health care are located in the private health sector serving a minority (the 14% of the population who are medical scheme members). In contrast, the public health system struggles to meet the health care needs of the vast majority of the population with limited resources.

1.2 Successes of the post-apartheid government

Since 1994, the government has achieved significant progress in pursuit of an equitable and coherent health system, putting in place structural, policy and programme oriented innovations. Transformation began with the integration of the fourteen [14] departments of health of the apartheid era into a single health system consisting of a central ministry and nine [9] provincial departments of health. In "*The White Paper for the Transformation of the Health System in South Africa*" the government undertook to create a national health system based on the primary health care [PHC] approach predicated on a district health system; a unified national health system integrating the public and private sectors with the objective of reducing inequities and expanding access to essential health care. Many of the policies and strategies envisaged in the White Paper were incorporated in the National Health Act of 2005, which lays the framework for the elimination of fragmentation of services offered by provinces and municipalities. The Act assigns PHC as a provincial competency, and defines the District Health System (DHS) whereby the boundaries of the DHS correspond with those of the first tier of local government. It establishes the National Health Council, Provincial Health Councils and District Health Councils and mandates community participation in the governance of the health system at all levels.

Much has been achieved beyond the setting up of structures and development of policies and strategies. The focus on PHC resulted in the reprioritisation of budgets and resources to bring about an equitable redistribution between PHC and sophisticated curative and tertiary care. An essential PHC package was formulated which sets norms for the provision of a comprehensive PHC. To increase access to these services, user fees for public PHC and all fees [including at hospitals] for pregnant women and children under the age of 6 years were removed. To support the expansion of these services , 1 800 clinics and community health centers were built since 1994. Today 95% of the population of South African can access health care within five kilometer radius of their homes.

Hospital infrastructure was also improved significantly beginning with the programme of revitalisation that focused on improvement of infrastructure, equipment, management and quality. To date, 27 hospitals have been accordingly refurbished, and 18 new hospitals have been built and another 190 facilities upgraded.

There was also a major effort to promote human dignity and human rights in health care delivery culminating in the proclamation of the Patients' Rights Charter in 1999, and to improve the quality of care through the establishment of provincial quality assurance units and quality assurance systems including mechanisms to receive and redress complaints at all health delivery sites. Health worker awards systems were instituted to promote a culture of excellence in health service delivery.

Another major area of improvement since 1994 is in the realm of human resources. Initiatives were introduced to change the gender, racial and professional profile of the health workforce to redress apartheid legacies and to ensure that the composition of the service provider workforce represents the national population profile. In order to remedy shortages in the number of health professionals in rural areas, the government recruited Cuban doctors in the immediate post 1994 period, introduced compulsory community service for recent graduates, introduced scarce skills and rural allowances for health professionals, and developed a strategy for retention of skilled workers - Occupation Specific Dispensation for Nurses (other occupational categories to follow). To further broaden the number and skills spectrum of health workers the government introduced Community Health Worker Programme throughout the country, developed a cadre of mid-level workers and established training schools for an increasingly diverse set of health professions e.g. Emergency Services.

To make medicines affordable, the state introduced a comprehensive national drug policy in 1996, one of the main pillars of which was the Essential Drug List for the public sector. It provided for much more rational drug prescribing and the introduction of generic prescribing throughout the health system. There is a need to review this policy to evaluate its impact and to improve areas where necessary.

The government introduced many health care programmes, some of which are summarised below:

1.2.1

Disease / target population	Interventions
Women	Free heath care services for pregnant women Choice on termination of pregnancy Confidential enquiry into maternal deaths Sexual assault services including post-exposure prophylaxis
Children	Free health care for children under 6 years Expanding immunisation programme and mass campaigns Integrated management of childhood diseases programme
HIV/AIDS	Public education campaign Strengthening of the South African National AIDS Council (SANAC) Condom distribution Voluntary counselling and testing Treatment and surveillance of sexually transmitted infections Community based care and support programmes Prevention of mother-to-child transmission of HIV Comprehensive HIV & AIDS Care Management and Treatment Programme

Disease / target population	Interventions
	Extensive ARV roll-out
Tuberculosis	Implementation of the WHO-advocated "DOTS" (directly observed therapy, short course) policy Improved national surveillance Integration of HIV and TB
Tobacco	Legislation / regulations to control tobacco product advertising, promotion and sponsorship Increasing the price of tobacco products
Malaria control	Regional co-operation as part of the Lubombo Spatial Development Initiative including Mozambique, Swaziland and South Africa involving household spraying, new artemisinin-based drug regimens and improved surveillance
Mental Health	Promulgation of the Mental Health Act - integration of mental health into PHC services Violence and suicide prevention programmes for schools including a suicide toll free line
Nutrition	Fortification of maize meal and wheat Promotion of exclusive breastfeeding Implementation of food-based dietary guidelines Implementation of integrated nutrition programmes (INP) Promotion of community-based growth monitoring Development of community gardens

Notwithstanding these achievements, many challenges continue to confront the South African health system today. Some of these are explored in more detail in the following sections.

1.3 Health outcomes challenges in South Africa

Unlike many other low- and middle-income countries which experience a double burden of disease, South Africa has a quadruple burden of disease associated with the epidemiological transition between diseases of poverty and lifestyle-related diseases. The country still bears a heavy burden of poverty-related illnesses such as infectious diseases, malnutrition and diarrhoea. In 2005 the incidence of diarrhoea was estimated to be 258 per 1,000 children under-five years of age (Sen, Östlin and George 2005). At the same time, South Africa displays a growing burden of non-communicable diseases, including strokes and ischaemic heart disease (see Table 1). This epidemiological transition became apparent in the 1980s. The 'third' burden relates to premature deaths due to violence and injuries. The 'fourth' burden has developed very rapidly into becoming by far the greatest burden, namely HIV/AIDS, which by the turn of the century accounted for nearly 40% of all years of life lost due to premature death.

Table 1.3: Ten leading causes of premature mortality (2000)

Cause of death	% of years of life lost
HIV/AIDS	39.0%
Homicide and violence	6.8%
Tuberculosis	4.7%
Diarrhoeal diseases	4.2%
Lower respiratory infection	3.9%
Road traffic	3.7%
Stroke	2.8%
Ischaemic heart disease	2.5%
Low birth weight	1.7%
Protein-energy malnutrition	1.5%

Bradshaw et al. (2006)

South Africa is far from achieving the health-related Millennium Development Goals 4, 5 and 6, which entail reducing child mortality, improving maternal health and combating HIV and AIDS, TB, malaria and other communicable diseases. Instead of rates falling, there is a reversal of gains and the country trends are moving in the opposite direction from what is desired. Infant mortality has increased from an average of 45.4 deaths per live births between 1993 and 1998 to 69 in 2005 (Bourne, et al., (in press; United Nations World Population Prospects, 2006). Maternal mortality is also increasing at unacceptable rates from 200 per 100 000 live births in 2000 to 400 per 100 000 by 2005 (UNICEF,undated).

The country ranks highest in the world in terms of the number of people living with HIV. Estimates suggest that 5.5 million people or 37% of all people living with HIV and/or AIDS in Sub-Saharan Africa are living in South Africa. There have been numerous challenges in implementing programmes to treat those living with AIDS in the country. These include delays in rollout of prevention of the mother to child transmission of HIV programme and universal roll-out of antiretroviral therapy (ARVs). Its delay to implement a known and feasible intervention to prevent HIV transmission from mother to child failed to avert new infections among 35 000 babies (Chigwedere, Seage, Gruskin, Lee & Essex, 2008). The government's delay in implementing an evidenced-based antiretroviral therapy programme, is reported by scientists to have caused the premature mortality of 330 000 people between 2000 and 2005 (Chigwedere, Seage, Gruskin, Lee & Essex, 2008). Failure to implement this intervention left the country with a large proportion of the population that is sick from HIV and AIDS-related illness, which further led to overcrowding of health facilities. With pressure from civil society and academics, the government is now implementing the largest ARV programme in the world, with more than 700,000 HIV positive persons expected to be receiving this treatment at the end of 2007/08 (Treasury, Intergovernmental Fiscal Review, 2007)

Another major communicable disease that is highly prevalent is tuberculosis (TB). South Africa has the 7th highest incidence of TB in the world (Department of Health strategy on TB, 2007). The number of people with tuberculosis in South Africa has increased from 109,000 in 1996 to 341,165 in 2006. The incidence has increased from 269 cases of TB per 100,000 population to 720 per 100,000 (cited in Department of Health, 2007). The high prevalence and incidence of tuberculosis is exacerbated by the emergence of multi-drug resistant TB (11,000 cases between January 2004 to April 2007) and the Extreme Drug Resistant (XDR) TB (over 800 diagnosed in 2006 and the first quarter of 2007). which is difficult to treat and has a very high case fatality

rate (Department of Health, 2007). Many of those who are infected with TB are also infected with HIV. This is clearly a major public health threat for the country, which the health care system has failed to contain. The epidemics of HIV and AIDS and TB are responsible for high levels of use of public sector clinics and hospital services and consume a large share of the budget.

1.4 Health system challenges in South Africa

This section will address challenges in the health sector, including inadequate funding, inequities in access to health care, lack of sustainable human resources to provide quality health care and inadequate access to medicines. The private health sector also poses challenges, particularly in terms of unsustainable increases in expenditure. Failure to integrate the public and private health sectors, despite the existence of clear policies, remains a challenge. Other challenges include low bed occupancy in the private sector, while there is overcrowding in the public sector. Common to both sectors are difficulties in adequately treating TB patients.

1.4.1 Challenges facing the public health sector

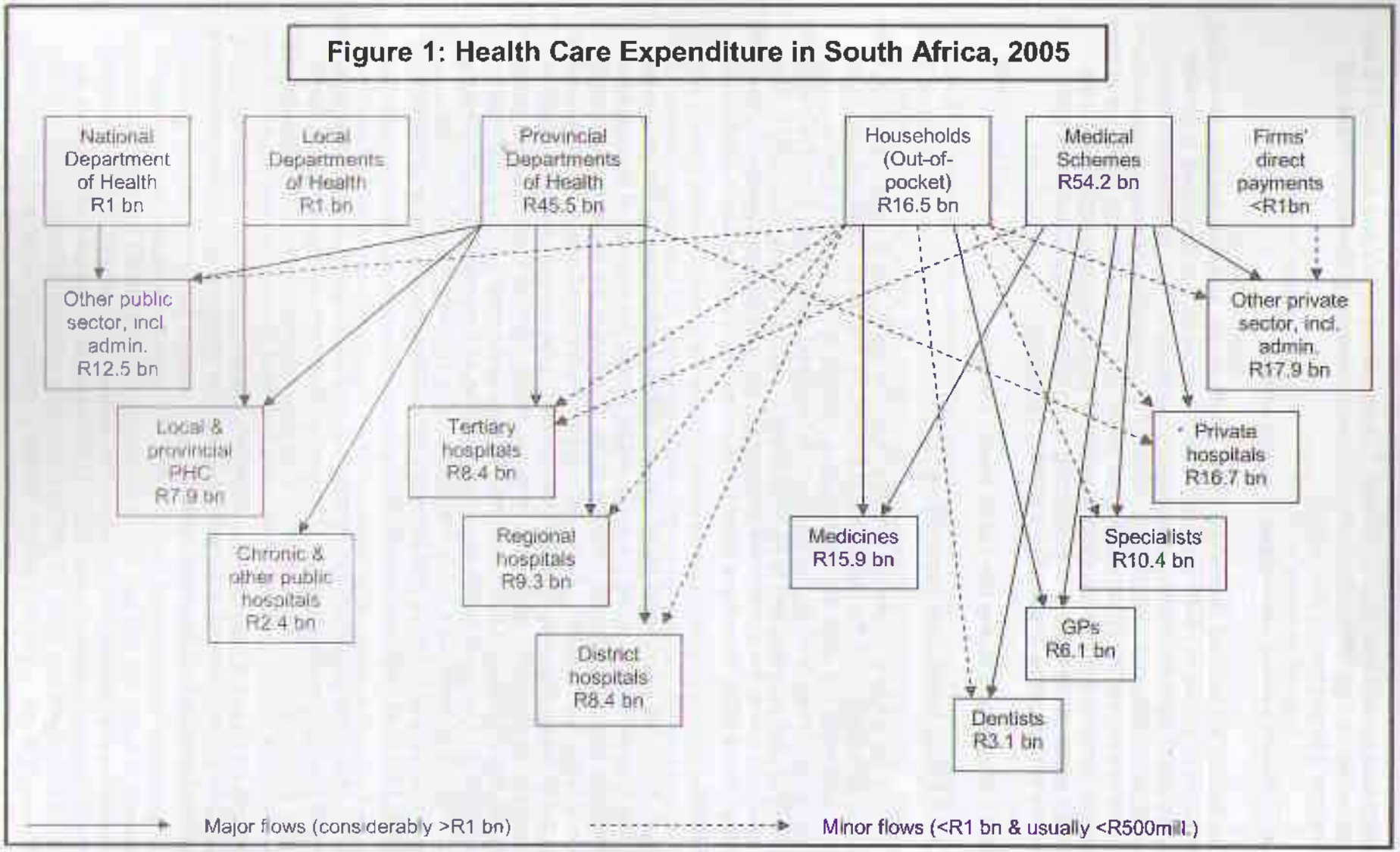
1.4.1.1 Public health care expenditure

Probably the greatest challenge that has faced the public health sector since the 1994 democratic elections is the stagnation in funding for the public health sector. In real per capita terms (i.e. after taking account of inflation and population growth), government expenditure on the health sector declined consistently from the mid 1990s until 2002, and only returned to its 1996 levels in 2005 (McIntyre et al. 2007). This was largely due to the constrained government expenditure associated with the GEAR policy. Since 2005, there have been some increases in real per capita public health budgets.

South Africa has a two-tiered health system, with a large private sector serving the higher income minority, while the public sector serves the majority of the population. The figure below provides an overview of the structure of the health system and the flow of funds in the system. About 40% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local Departments of Health), while 60% flows via private intermediaries. Medical schemes are the largest financing intermediaries, accounting for nearly 46% of health care expenditure. Provincial health departments follow as the next largest intermediary, with 38% of all health care funds flowing via them. Households' out-of-pocket payments directly to health care providers also account for a sizeable contribution, at nearly 14% of all health care expenditure.

About 14% of the population are members of medical schemes: this group largely uses private for-profit health services. The General Household Survey (Statistics South Africa 2004) suggests that a further 21% of the population uses some services in the private sector (mainly general practitioners and retail pharmacies) and pays for these services on an out-of-pocket basis. However, this group is heavily dependent on the public sector for specialist and inpatient care. The remaining 65% of the population is entirely dependent on the public sector.

Figure 1: Health Care Expenditure in South Africa, 2005



Source: McIntyre et al (2007)

1.4.1.2 Inequity in access to health care

The public health sector faces a range of challenges. A key challenge has been that of constraints in access to health services for people dependent on public sector services. In particular, many South Africans did not have good geographic access to care. Over the past 14 years, government has tried to address this problem through the Presidential Clinic Upgrading and Building Programme which prioritised underserved areas. By 2005, more than 1,300 clinics and health centres had been built with the aim of increasing access to health services for all, especially the poor, bringing the number of clinics in the public sector to more than 4 500. Despite these achievements; a number of challenges remain.

In a population survey undertaken in 2005, the majority of respondents used public health services (hospitals=45.4% or clinics =25.2% total public sector =70.6%), with a total private sector 26.2%), and the remainder utilised mining hospitals or traditional healers (Shisana, et al 2007). When asked whether they had difficulty affording health care, including the cost of prescription medicines, 16.6% or 5.2 million responded in the affirmative.

More than half (51.9%) of South Africans using public hospitals and more than 54.9% using the private hospitals say the health system needs a lot of improvement; people wait too long before being served. Satisfaction levels: 16% in public hospitals and 13.3% in private hospitals. The same results were found in public clinics (42.9%) and private clinics or GPs (54.5%), suggesting large dissatisfaction (Shisana, et al, 2007).

The government also initiated a hospital rehabilitation programme with the aim of revitalising existing public hospitals or building of new ones. So far, more than 249 out of the more than 400 hospitals have undergone renovation and 18 new hospitals were built, of which 3 were major teaching hospitals (Department of Health, 2006/7). However, of the R2.1 billion allocated for hospital revitalisation in 07/08, R241 million was unspent, suggesting there is a need to increase capacity to implement this programme.

These infrastructure development programmes have been accompanied by a relative redistribution of financial resources between geographic areas. The gap in per capita public sector spending between the most well resourced and least resourced province has reduced from a five-fold difference in 1992/93 to a two-fold difference in 2005/06. If spending on central hospitals, which are intended to serve all South Africans even though located in only a few provinces, is excluded, the gap has reduced to a 1.8 times difference (McIntyre 2007).

Another access dimension that has posed problems for South Africans is that of affordability of health services. A key government strategy to address this problem was announced by the then President Mandela in 1994 as part of his 100 days in office plan. He announced that all pregnant women and children under six years of age would have free access to health care at all public sector facilities. This was followed in 2006 by the introduction of free care for all (except those covered by medical schemes) at all public sector primary health care facilities. These policies have been critical in improving financial access to health care for poor South Africans.

These policies have resulted in the number of clinic visits increasing tremendously from 67 million in 1998 to more than 98 million in 2004; with visits increasing from an average of 1.8 to 2.1 per person per year during this period.

1.4.1.3 Challenges in securing and sustaining human resources

There is a serious maldistribution of health workers in the country, with 60% of the nurses and 40% of the doctors serving 85% of the population using the public health sector. Most of the health workers work in urban areas while there is a serious shortage in the rural areas. The disproportionate distribution is also by province, with the Western Cape and Gauteng having high numbers of doctor-to-population ratios when compared with the rest of the provinces.

Nurses form the backbone of the health care system, and yet they are in short supply. This is largely due to a number of factors including cuts in the provincial budgets and the closure of nursing colleges, which has resulted in fewer nurses being trained. But even those who were trained do not all go on to practice in this country. For example, it is estimated that about 67% of nurses who trained in the period 1997 to 2005 do not appear on the South African Nursing council register (Breier, et al, 2008). Some leave the country to seek greener pastures in countries that pay them higher salaries such as Saudi Arabia, Oman, UK, US, Canada and Australia.

Another indicator of the shortage is the vacancy rate. PERSAL data suggest that the vacancy rate was between 31.5% in 2006 to 36 % in 2007 (HST, 2007), which translates to 25 701 nurses that would be needed for different positions (Breier et al., 2008). However the authors also quickly remind us that vacancies cannot necessarily be equated with demand, because they may reflect frozen posts due to lack of funding. A good measure of shortage is failure to fill vacant posts following advertisements. Researchers at the HSRC found that the vacancy fill rate for registered nurses and midwives was 56%, suggesting that there is a shortage of nurses in general. Some of the reasons given by employers for failure to fill the vacant posts were that nursing is not a well-paying job, that it has low recognition, low promotion potential and long unsociable hours of work, that nurses run the risk of contracting HIV and that many migrate to other countries (cited in Breier et al., 2008). A major concern is that 16% of health workers are living with HIV (Shisana, at al, 2004) and 18.9% are classified as eligible for ARV therapy (Connelly, et al., 2007).

Linked to the issue of nurses is the shortage of medical practitioners. Access to quality health care for the majority of the population of South Africans using the public health sector is seriously hampered by inadequate supply of medical practitioners. Many migrate to the north in Europe, the Americas (north), Australia and New Zealand. In 2001, the OECD estimated that 8,921 doctors were in these regions. Some of the reasons advanced for migration of these doctors included crime, deteriorating public education, better pay abroad, deteriorating conditions in the public sector and foreign recruitment. These are challenges that the state will need to address if South Africa is to retain the doctors that it trains at heavy cost of R780 000 per doctor (figure cited Breier and Wildschut, 2006).

The shortage of doctors and nurses has happened at a time when the size of the population dependent on public sector services has been increasing, and the burden of ill-health among the population, primarily due to the HIV/AIDS and associated TB epidemics has also increased. As indicated above, utilisation of public sector services has also increased considerably during this period. This has placed incredible strain on public sector health services, and on the staff who work in public sector facilities.

Professional assistants or mid-level workers are a relatively new cadre of semi-skilled health care workers in the health sector in South Africa. This cadre of workers improves access to health care to all sectors of the population based on the Primary Health Care Approach, irrespective of geographical location, by making up for the scarcity or absence of professionals such as doctors, dentists, pharmacists, physiotherapists or nurses, etc. Professional assistants work in a team-based setting under the supervision of a qualified

professional. Depending on the field they are functioning in, they have been given many different titles, e.g. physician assistant, clinical associate, medical assistant, health assistant, health officer, nurse practitioner, nursing assistant, dental auxiliary, physiotherapy assistant, dental technician, speech therapy and audiology assistant and pharmacy assistant.

Professional assistants play a particularly important role in staffing rural health centres, primary health facilities and district hospitals, to bridge the gap between the urban and rural divide, and well resourced and under-serviced areas. Medical, pharmacist and nursing assistants also play a role in larger hospitals where they assist health professionals in their tasks. The midlevel workers have to address the challenges presented by the big shortages of medical, nursing, pharmacist and dental professionals available for the great demand for health workers in the population.

In South Africa, the development of this cadre of health worker has been informed by the Department of Health Strategy document on Health Human Resources (The Pick Report) and subsequently the 2006 DoH National Human Resources for Health Plan, to address shortages of various health professional groups, to facilitate the implementation of the primary health care (PHC) package within the country. Professional assistants (PA) have to receive training that will provide them with a higher skill level than basic assistants. The program for training is meant to ensure that skills acquired are appropriate to the level of work they are to execute and complements the functions performed by other team members.

A challenge with professional assistance is that whilst it provides 'relief' to shortages of health professionals, it may reduce the perception of the urgency with which the whole health system needs to be restructured. Failure to deal with the 'push' factors in rural and the public sector may result in professional assistants being the backbone of the human resource component in the public health system and providing care without the supervision of professionally qualified staff.

Another challenge pertains to role clarification, scope of practice overlap and formalisation of roles in relation to the professions that are supervisory to the PA or who are supervised by the PA. This will ensure that potential conflict of interests and confusion around roles and responsibilities is avoided. This challenge has manifested as attrition of professional assistants to the private sector such as is the case with pharmacy assistants or career diversion to the supervisory profession as a career-pathing solution as has been the case with dental assistants who have gone on to study for dentistry.

1.4.1.4 Access to medicines

Another challenge facing the public health sector is the shortage of drugs at health facilities especially AIDS drugs. Recently there were reports in the media about shortages of antiretroviral drugs experienced in the Free State and also in the country. To avert this crisis, the budget for Pharmaceutical Services in the Provinces must be ring fenced and be under the direct supervision of the Head of Pharmaceutical Services. This will greatly facilitate timeous payment of manufacturers who have supplied the products. This will then not disturb the manufacturing, delivery, payment cycle. Secondly, usage data on pharmaceuticals at the Province should be accurately captured and analysed so that correct estimates of quantities required can be put together. These estimates are very crucial during the award of tender, so that the manufacturers can appropriately plan their manufacturing and delivery logistics. Careful consideration should be given to the ability of manufacturers who win the tenders , to manufacture and supply. At times this capacity does not exist and leads to unavailability of medicines and shortages of quantities to be supplied. The intelligence on this crucial issue has to be consolidated with the State Tender Board that evaluates submissions and awards tenders. There is also a need to implement the

Polokwane resolution to establish a state company to produce drugs as a means of reducing the cost of medicines.

1.4.2 Challenges facing the private health sector

1.4.2.1 Private health care expenditure

In contrast to the public sector, expenditure in the private sector has continued to increase, at rates far exceeding the inflation rate, on an annual basis since the 1980s. Membership of medical schemes has become increasingly unaffordable for South Africans; as expenditure increases, so do the contribution rates or premiums that are charged by medical schemes. In the late 1980s and early 1990s, contribution rates were increasing at between 25% to 30% per year in real terms (McIntyre et al., 1995). The rate of annual contribution increases has reduced dramatically in recent years, but the average annual real increase in contributions of 7% between 2000 and 2005 is still of concern. Although medical scheme membership increased from about 6.5 million in the early 1990s to 6.9 million by 1997, the absolute total number of beneficiaries decreased in some years thereafter and had only reached 6.9 million again by 2005. Medical scheme membership has declined considerably as a percentage of the population, from 17% of the population being members of medical schemes in 1992 (McIntyre et al. 1995) to less than 15% in 2005 (Council for Medical Schemes 2006).

The main cost drivers of medical schemes expenditure have been private hospitals, specialists and medicines, medical administration and brokers. While in the 1980s and first part of the 1990s, expenditure on medicines was increasing more rapidly than other categories of medical schemes expenditure, expenditure on private hospitals has seen the most rapid increases in the latter part of the 1990s and the 2000s (McIntyre and Doherty 2004). Real per beneficiary expenditure on specialists increased by 53% between 1997 and 2005, while that on hospitals increased by 74% over this period. Very little of the hospitals expenditure was directed to public sector hospitals; spending on private hospitals accounted for 98.5% of all medical scheme expenditure on hospitals in 2005 (Council for Medical schemes 2006). Medical scheme expenditure on hospitals per beneficiary increased three times more rapidly than inflation between 1997 and 2005 (McIntyre et al. 2007).

There are a range of reasons for the large increases in medical scheme expenditure, including the fee-for-service reimbursement mechanism which encourages providers to supply more services than may be strictly necessary from a clinical perspective. There has also been a growing imbalance in the relationship between purchasers (medical schemes) and providers. This is particularly the case with private hospitals, where three large hospital groups own about 84% of all private hospitals (van den Heever 2007).

1.4.2.2 Low bed occupancy rates

South Africa had 684 hospitals in 1990, and Baragwanath Hospital had nearly 3,000 beds. In 1989, South Africa had 143,519 hospital beds at a ratio of 4.8 per 1,000 people in the population. In 2005 South Africa had 28 beds per 10 000 population in both the public and private sectors. The public sector had 63 regional and 14 tertiary hospitals with some 100 000 in these regional and tertiary institutions serving 80% of the population. The current public hospitals occupancy rate is above 80%.

Ten years ago there were 161 private hospitals, with 142 of these in urban areas. In 2006 the private sector increased its for-profit hospital numbers by more than 34% from about 161 hospitals in 1998, to 216 hospitals in 2006. Whilst hospital beds in the public sector are reducing, the number of private hospitals and clinics continue to grow. The private sector has added almost 7 000 beds between 1998 and 2006. The 2007-2008 Council for Medical

Schemes (CMS) Annual Report indicates that there are presently 28,000 private beds in South Africa, with an additional 4,000 added between 2004 and 2008.The bed occupancy rate in the private sector is currently at 65%. and the bed over-supply is roughly 10,000. The bed occupancy increased slightly from 62,09% to 64.52% between 2006 and 2007. The mining industry also provides its own hospitals, and has 60 hospitals and clinics around the country in which surplus capacity resides,.

The admission rates to private hospitals increased to 180.6 per 1 000 beneficiaries from 171 per 1 000 beneficiaries in 2006, and this translates to the number of admissions increasing by 7.3%. However, the number of medical aid.beneficiaries admitted to public hospitals decreased slightly to 8.0 per 1 000 beneficiaries in 2008 from 8.2 per 1 000 beneficiaries in 2006. The 2007-2008 CMS Annual Report, also indicates that the utilisation of private hospitals (including day clinics) per 1 000 beneficiaries reflects a downward trend in the number of beneficiaries admitted.

The 2007-2008 CMS Annual Report reflects increases on the total amount spent on healthcare in the private sector by schemes. Schemes paid R20.2 billion (36.0% as % of total spent) to hospitals. This increase translates to a 12.5% unadjusted increase or a 5.3% real increase in expenditure on private hospitals when adjusted for inflation. Existing members of schemes pay indirectly for the full cost of all unoccupied beds (the surplus 10,000 beds) through iincreases in utilization and hospital stays. This is confirmed by the results of a study conducted in 2008 by Deloitte & Touché on private hospitals on behalf of the Hospital Association of South Africa. The results confirm that to address the inefficiencies, more patients occupy hospital beds on week days than over week-ends. This variation in bed occupancy is predominantly as a result of increased utilisation (1.91%) and to a lesser extent (0.52%) as a result of increased length of stay in the hospital driven largely by an increase in chronically ill patients.

The CMS Annual Report also indicates that specialists, are the key drivers of increased hospital utilisation and costs, as they are the professionals who predominantly admit patients in private hospitals. Specialists generate around 70% to 80% of hospital costs incurred, aside from their own professional fees and costs. Private hospital cost increases are also as a result of the excessive issuing of licensing for acute beds and expensive technology by provincial health administrations.

1.4.2.3 Inability to adequately treat people with TB

According to the Department of Health and the WHO, South Africa is one of the 22 High Burden Countries that contribute approximately 80% of the total global burden of all TB cases. It has the seventh highest TB incidence in the world as a result of the double burden of disease as a result of co-infection with HIV, South Africa has seen a rise in the incidence of tuberculosis in the adult population with a threefold increase in the numbers of people with TB from 109,000 in 1996 to 341,165 in 2006 or 269 cases of TB cases per 100,000 population to 720 per 100,000 population. This has resulted in increased morbidity, mortality and poor performance on our Millennium Development Goals 2015 target.

Drug resistant TB arises as a result of failures of the health system to adequately deal with patients who have TB. According to the Drug Resistant Surveillance, MRC (2001-2002), the proportion of people with extra-pulmonary TB trebled to around 15% and the proportion of people who were co-infected with HIV in 2002 was around 55%. TB patients who are HIV positive need to commence ARV's early. In addition, 900 cases of Extensive Drug Resistant TB were reported between 2004 and 2007. Although the cure rates and treatment success have gradually increased from over the last five years with 66% in 2000 to 70% in 2004, the defaulter rates remain high. This has created hurdles in achieving the targets for treatment success and cure and has increased the probability for drug resistance.

The most critical component in the management and eradication of TB pertains to addressing the social determinants of TB. These include poverty eradication, nutrition, housing and improvement of living and working conditions. However, effective public health, as well as clinical interventions, is also critical in ensuring adequate and effective management and eradication of TB and its complications. To this effect, the Department of Health developed the Draft Tuberculosis Strategic Plan for South Africa 2007-2011.

The Plan has identified systemic challenges in the management of TB and reflects that "major deficiencies" that have impacted very negatively on South Africa's ability to eradicate, contain, manage and prevent TB and its complications. These relate to provision and allocation of resources including skewed provincial allocations, quantity and quality of human resources, TB-HIV collaboration, access to diagnostic services and the proper use of the reporting and recording system. On access to diagnostic services, the Plan indicates that the smear conversion rates for the year 2006 show that one in three patients (28%) do not have sputum results available to confirm the diagnosis TB and /or its complications including extra-pulmonary TB or the MDR and XDR.The challenge of quantity and quality of human resources requires a rigorous effort to strengthen the programme through training and supervision.

1.4.3 Challenges in terms of the public/private health sector mix

A significant challenge facing the South African health system is to address the inefficient and inequitable distribution of resources between the public and private health care sectors relative to the population served by each. Table 2 summarises the disparities that exist between these two sectors in relation to hospital beds and human resources. There is more than twice as many hospital beds per beneficiary of private sector hospital services as there are for those dependent on the public sector. The disparities are even greater in relation to health professionals; each pharmacist in the public sector serves 12 to 30 times, and each generalist doctor in the public sector serves 7 to 17 times, more people than those in the private sector (depending on whether one focuses only on the medical scheme population or assumes that up to 36% of the population use private pharmacists and private general practitioners). There is a six-fold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor, working in the public and private sectors in South Africa.

Table 2: Distribution of health care resources between public and private sectors (2005)

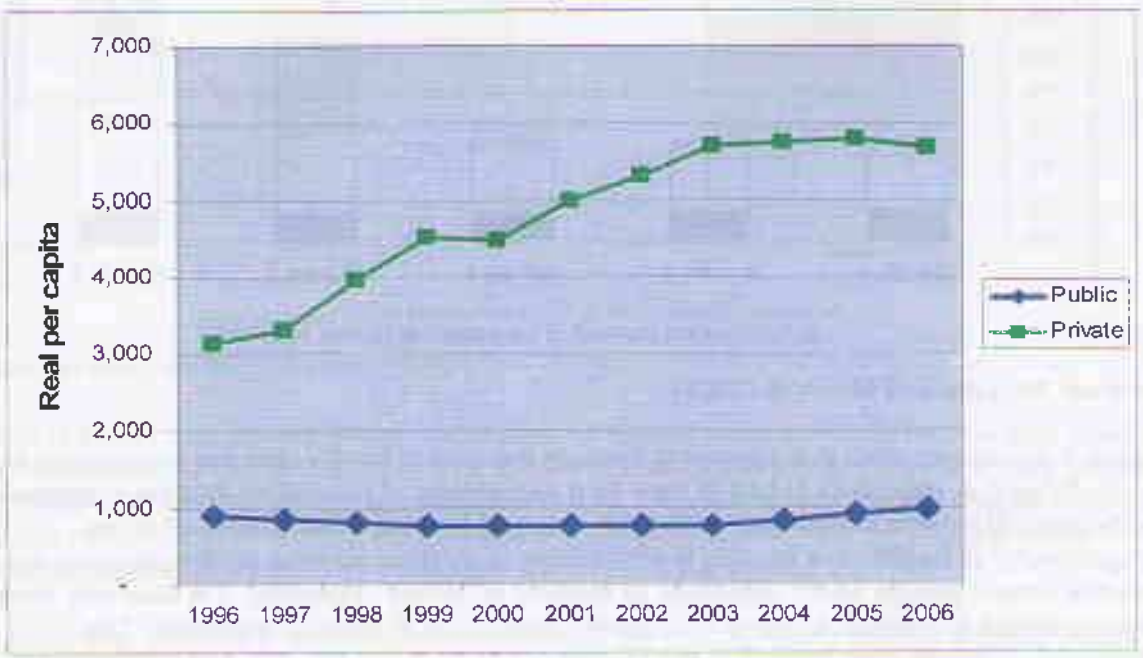
	Private sector	Public sector
Population per general doctor	(243) 588*	4,193
Population per specialist	470	10,811
Population per nurse	102	616
Population per pharmacist	(765) 1,852*	22,879
Population per hospital bed	194	399

* Data in brackets represents only medical scheme members (14.8% of the population), main estimate assumes that private GPs and pharmacists may be used by up to 35.8% of South Africans.
Source: Data on personnel and bed numbers from Health Systems Trust's South African Health Review, 2005/06.

What is of considerable concern is that public-private mix disparities have deteriorated remarkably over the past decade (see Figure 2). While real expenditure per medical scheme member (health care benefits and administration and other management costs) were about three times greater than government health care expenditure per person who is

not a medical scheme beneficiary in 1996, the difference in expenditure was about six times greater on medical scheme beneficiaries by 2006. This is due to the fact that real per capita expenditure in the public sector was relatively stagnant over this period, while medical scheme contributions and expenditure have been growing at rates far exceeding overall inflation throughout the period. This pattern of diverging public and private sector expenditure patterns was seen throughout the 1990s as well.

Figure 2: Trends in real per capita health care expenditure in public sector and medical schemes (2000 base year); 1996-2006



Source: McIntyre et al. (2007)

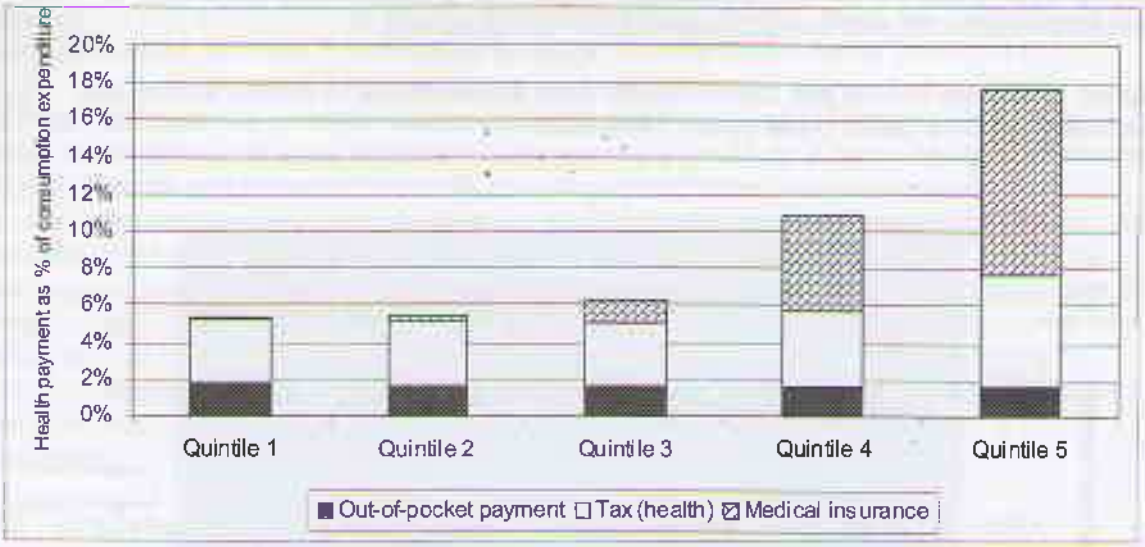
The incidence of health care financing and service benefits in South Africa

The disparities in health care financing and service benefits alluded to above can best be illustrated through comprehensive financing incidence and benefit incidence analyses. A financing incidence analysis determines which socio-economic groups bear what burden of funding health services. A benefit incidence analysis determines what benefit (expressed in monetary terms) different socio-economic groups derive from utilising health services. These analyses enable one to assess how equitable a health system is; financing is regarded as equitable if contributions to funding health care are according to ability to pay, and health service use is regarded as equitable if benefits are distributed according to need for health care

Figure 3 shows the distribution of the burden of health care financing across socio-economic groups. It shows that the poorest 20% of the population (quintile 1) contribute almost 6% of their household income towards funding health care. This is mainly through making out-of-pocket payments (e.g. fees at public hospitals or payments to a private GP or pharmacy) and through tax contributions (in the lowest income households, this mainly takes the form of indirect taxes such as VAT, excise duties, fuel levies etc.). This is similar for the next two quintiles. The richest 20% of the population contribute about 18% of their household income towards health care, with most of this in the form of contributions to medical schemes; their contributions to health care funding in the form of out-of-pocket payments and general tax payments is less than 8% of their income. The second richest 20% of the population

contributes just over 10% of their average household income to health care payments, with nearly 6% being in the form of out-of-pocket payments and general tax payments.

Figure 3: Incidence of health care financing in South Africa, 2006

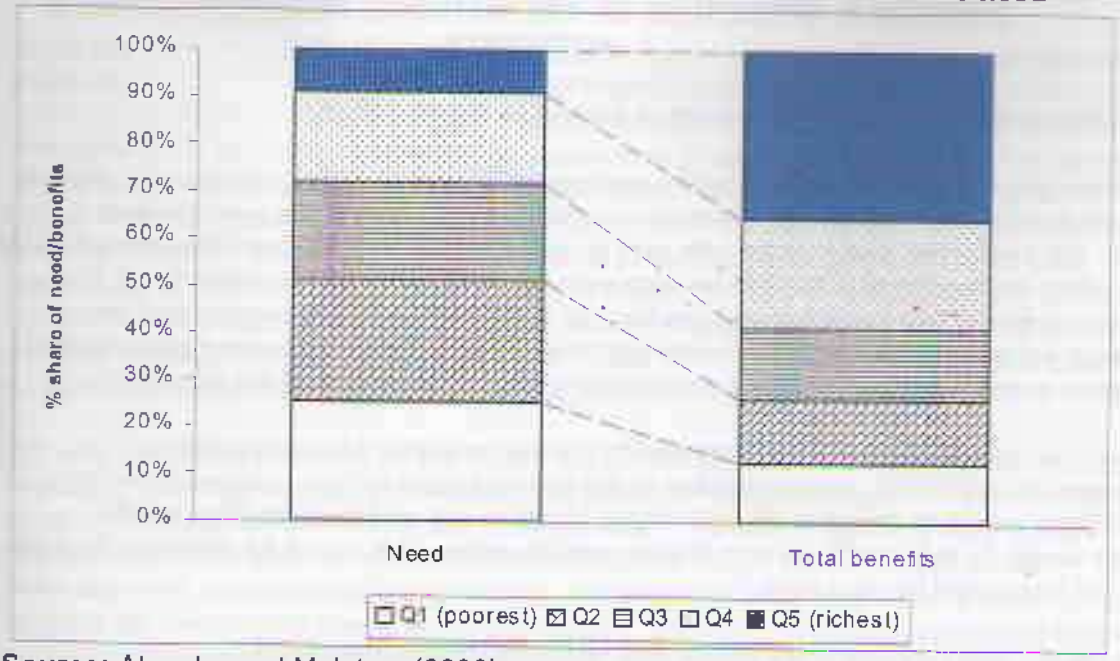


Source: Ataguba and McIntyre (2009)

Figure 3 clearly indicates that payments towards the cost of health care are progressive in South Africa (i.e. payments to health care as a percentage of household income increases as the level of income increases). However, it should be noted that almost all of the 'progressivity' of health care funding is attributable to medical scheme contributions as it is only the richest groups which contribute to medical schemes. However, it is also only those who contribute to medical scheme who benefit from funds in medical schemes. The distribution of health care funding in the form of out-of-pocket payments and general tax payments is relatively evenly distributed across socio-economic groups – although general tax payments are progressive, they are only slightly so, with the poorest 80% of the population (quintiles 1 to 4) bearing a very similar burden of funding these payments.

The fact that a large share of health care funding is attributable to medical schemes contributions and that only a small share (14%) of the South African population benefit from the services funded by these schemes heavily influences the distribution of benefits from health care utilisation across socio-economic groups. Figure 4 shows that benefits are heavily concentrated on the richest 40% of the population, who receive about 60% of the health care benefits. This is particularly due to the use of private providers by this group, but also due to this group deriving the greatest share of benefits from the most highly specialised public hospitals.

Figure 4: Comparing total benefit incidence with levels of health care need



Source: Ataguba and McIntyre (2009)

What is even more striking is that health care benefits are not distributed in line with need[1] for health care services. 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%).

In summary: "there is a lack of cross-subsidies in the overall health system in South Africa. Although health care financing is 'progressive', this is largely due to the richest groups bearing the burden of medical scheme funding; however, the richest groups are the exclusive beneficiaries of these funds. It is indisputable that benefit incidence in South Africa is inequitable; benefits from health care are not distributed according to the need for health care" (Ataguba and McIntyre 2009).

1.4.4 Purpose of this Plan

The aim of this plan is to translate the National health insurance policy into a plan. This plan does three things:

a layout what the challenges of the health system are
b outlines plans to respond to the challenges, which will require an annual operational plan
c provides costing estimates of the National Health Insurance
d provides details of the key elements that must be con In the transitional arrangements of working towards a national health insurance system for South Africa

[1] In order to measure the distribution of need across socio-economic groups, household survey data must be used. In this case, self-assessed health status is used as the measure of need. This is the most widely used household survey based indicator of need for health care used in international studies.

CHAPTER 2: STRUCTURE OF THE NATIONAL HEALTH INSURANCE AUTHORITY

2.1. Rationale for the establishment of an NHI in South Africa

The status quo in the South African health system in Chapter 1, cannot remain. On the one hand, the public health sector has been systematically under-resourced over the past decade; this sector has had to cope with very limited financial, human and other resources at a time when the burden of ill health was increasing dramatically. On the other hand, the amount of financial and human resources located in the private health sector has been increasing equally dramatically for several decades, despite the fact that medical schemes have been unable to extend insurance coverage to a greater section of the population.

The rationale for introducing a National Health Insurance is that it would provide a mechanism for improving cross-subsidies in the *overall* health system, whereby funding contributions would be linked to an individual's ability-to-pay and benefits from health services would be in line with an individual's need for care. This would be achieved through having an integrated funding pool.

2.1.1. Public and Political Support for the National Health Insurance

There is public and political support for the establishment of the national health insurance as a means to increase access to good quality health care for all. The Human Sciences Research Council conducted a national household survey of the South African population in 2005 and included questions on the desirability of the national health insurance. Interesting results were found. When asked "Which of the following is more important: Providing health care coverage for all South Africans even it is means raising taxes or holding down taxes even if it means some South Africans do not have health care coverage?" a surprisingly large percentage indicated that it is more important to provide health care coverage for all (54.7%), while a small percentage (21.2%) said it is better to hold down taxes.

Participants were asked "Which would you prefer: The current medical aid system or a universal national health insurance programme?" and a surprising 46.5% of all South Africans indicated that they would prefer a universal national health insurance over the current medical scheme, and a small proportion preferring the existing medical schemes (26.9%), and 26.6% not expressing an opinion (Shisana, et al., 2006).

A more recent national household survey, conducted in 2008, shows that there is even greater support for NHI amongst the general public than previously recorded. There is a good understanding of the need for pre-payment to ensure financial protection from the costs of health care with 76% of all respondents agreeing with the statement: "I would agree to pay a small amount each month so that if I get sick, health care will be free, even if I am not sick now". More than two-thirds of respondents (67%) agreed with the statement: "I would join a publicly supported health insurance scheme if my monthly contribution was less than for current medical aid schemes". Importantly, an even greater number of medical scheme members (71%) agreed with this statement, strongly suggesting that there is widespread dissatisfaction with the high costs of medical scheme membership. Another important finding of this survey is that despite reported widespread concern about the quality of care in public sector facilities, 73% of South Africans agreed with the statement: "I would join a publicly supported health insurance scheme if I could use public health services for free" (McIntyre et al 2008).

2.1.2. Economic reasons for introducing the National Health Insurance

There are a number of sound economic reasons for pursuing a national health insurance in South Africa. In particular, public funding of health services is in effect an investment; as noted by the World Health Organisation's Commission on Macroeconomics and Health: "Investments in health are **essential for economic growth** and should be a key component of national development strategies. ... The links between ill health and poverty are now well known. Poor and malnourished people are more likely to become sick and are at higher risk of dying from their illness than are better off and healthier individuals. Ill health also contributes to poverty. People who become ill are more likely to fall into poverty and to remain there than are healthier individuals because debilitating illness prevents adults from **earning a living**. Illness also keeps children away from school, decreasing their chances of a **productive adulthood**" (World Health Organisation 2005; our emphasis).

Not only will public spending on the health sector contribute to economic growth through improving the health status, and hence productivity, of the population, but also through employment creation for health care professionals. The health sector is very human resource intensive and it is well documented that the South African health system, particularly the public sector, is significantly understaffed relative to what is required to address the health care needs of the population. The NHI, through its integrated funding pool and cost-containment benefits (see later), will provide the financial resources to fill currently vacant posts within the public health sector and open new posts. In addition, additional employment opportunities will be created for trainers of health professionals in tertiary education institutions (including nursing colleges), given the urgent need to increase health professional training outputs.

Another key macroeconomic benefit that the NHI will provide is cost-containment within the health sector. At present, the health sector accounts for a sizeable share of the economy (at around 8% of GDP). As indicated in Figure 1.2, the medical schemes sector is the component that is experiencing increases in expenditure that far exceed inflation, despite serving a small share of the population and the population share not increasing. The most important factor contributing to these expenditure increases are increased fee levels charged by health care providers, rather than increased health service outputs. This is in large part due to a mismatch in the balance of power between a large number of fragmented purchasers (medical schemes) and concentration among health care providers. The system of a single NHI purchaser has been shown internationally to contribute greatly to cost containment in the health sector.

There are two major benefits from such cost-containment. Firstly, the health sector will be a more efficient (in the sense of increasing service outputs with available financial resources) contributor to the South African economy. Secondly, there are frequently concerns about the potential macroeconomic impact of an NHI in terms of increasing the cost of labour (given that employers will pay part of the NHI contribution). As will be demonstrated in the chapter on NHI costing, the NHI contribution will not impose a greater burden on employers than the current medical scheme contributions. More importantly, the inbuilt cost-containment mechanisms within the NHI will ensure that employers are not faced with annual contribution increases at far above the inflation rate as currently occurs with medical scheme contributions.

While there are other economic benefits of the proposed NHI, the abovementioned examples illustrate the economic implications. Further information on the macroeconomic impact of the NHI are presented in the chapter on the financial resource requirements for the NHI.

2.1.3 Constitutional rationale for introducing the National Health Insurance

At present funding for health services in South Africa is fragmented on a number of different legislative and policy planes which leads to inefficient utilization of resources, wasteful duplication of health cover and unnecessary overlapping of functions between various agencies. People continue to fall 'between the cracks' in the system with the result that their constitutional rights to human dignity, bodily and psychological integrity and access to health services are being compromised. It is necessary to create a single focus for the funding of health care services that respects the rights of the wealthy, the poverty- stricken and all those in between alike.

The constitutional mandate of government to ensure the progressive realization of the right of access to health services requires the most efficient and effective utilization of resources in order to ensure such access for South Africans and permanent residents. There are urgent health care needs, for example those of the elderly, the indigent and very young that are not being adequately met due in part to the continued fragmentation of the current system combined with historical inequities within that system.

The status quo in the South African health system, as outlined above, cannot be perpetuated. On the one hand, the public health sector has been systematically under-resourced over the past decade; this sector has had to cope with very limited financial, human and other resources at a time when the burden of ill health was increasing dramatically. On the other hand, the amount of financial and human resources located in the private health sector has been increasing equally dramatically for several decades, despite the fact that medical schemes have been unable to extend insurance coverage to a greater section of the population.

The rationale for introducing a NHI is that it would provide a mechanism for improving cross-subsidies in the *overall* health system, whereby funding contributions would be linked to an individual's ability-to-pay. Benefits would be in line with an individual's need for care and not on the person's ability to pay. Health services would be accessible to all on an equitable basis, on the principle of non-discrimination.

In view of the challenges facing the public health system and the inequities in the national health system due to the prevailing two-tiered system (described in Chapter 1), the introduction of a National Health Insurance system aims at strengthening the under-performing public sector and pooling resources in both sectors in order to progressively realise the right of all to access quality health care services. The introduction of a National Health Insurance system will go a long way towards establishing a health care system in compliance with our constitutional rights.

2.1.3.1 The right to health as a human right

The South African constitution is a transformative one, that seeks to transform economic and social conditions inherited from apartheid to a more equitable one- where human dignity, equality and advancement of human rights and freedoms, non-racialism and non sexism form the founding values of the constitution. It is also, one of the few constitutions in the world that includes socio-economic rights in the Bill of Rights. These include the right to access health care services as well as the underlying determinants of health such as the right to clean drinking water, the right to adequate housing, the right to clean and a safe environment, the right to sufficient food & nutrition and social security. For a person to enjoy good health it is therefore essential that the underlying determinants of health are also enjoyed. In other words these rights are indivisible and interdependent and governments are obliged to take steps to ensure that everyone has access to quality health care.

2.1.3.2 What is the right to health?

It is a right to the enjoyment of a variety of facilities and conditions that are necessary for good health. These can be divided into two basic components: those related to *health care* and those related to *general living conditions affecting health*, such as safe water, food, sanitation and shelter. More specifically, the right to health can be understood as a right to an effective and integrated health system, encompassing health care and other determinants of health.

Several clauses enshrined in the constitution are related to the right to health. The principal clause guaranteeing universal access is:

- S 27 (1) that states "Everyone has the right *to have access*
  a) to health care services, including reproductive health care..."
  (b) sufficient food and water
  (c) social security & social assistance
- S 27 (2) The state must take reasonable legislative measures within its available resources, to achieve the progressive realization of each of these rights
- Access right to health care services and not the highest attainable physical and mental health
- S 27 (3) No one may be denied emergency medical treatment
- S 35(2)(e) provides for "adequate medical treatment" for detainees and prisoners at the State's expense
- S 24 " every one has a right to an environment that is not harmful to their health or well-being.

Other rights, such as the right to life, the right to safety and security of person, the right to bodily and psychological integrity are also relevant to the right to health.

The constitution also provides for equity and non-discrimination in section 9 of the constitution and this clause is fundamental to equal access for all South Africans to access health care on the basis of non-discrimination.

2.1.3.3 The States Obligations

- **S 7 (2)** – The state must respect, protect, promote and fulfil the right in the Bill of Rights

Section 27 (1) has an internal limitation clause:

- **S 27(2)** – state must take reasonable measures within its available resources to achieve progressive realization of the right

2.1.4 International Obligations with respect to the right to health

According to the UN Committee on Economic, Social and Cultural Rights (CESCR) the state is obliged to put into place national plan and legislation on how achieve targets over specified time periods in order to provide quality health care for all. According to the Limburg Principles, states must take immediate steps to provide minimum core entitlements and has move expeditiously toward the progressive realization of the right. This means that states have to report to the UN Committee on Economic, Social and Cultural Rights on what measures they have taken to realize the right to health. States cannot abrogate their responsibilities by invoking the lack of available resources clause but have to show that available resources have been efficiently utilized.

The state is obliged to

- provide equitable distribution of health facilities, goods and services

- Adopt & implement a nation public health strategy and plan of action based on epidemiological evidence
- Devise and review strategy
- Address health concerns of whole population
- Give particular attention to vulnerable groups
- Prevent, treat & control epidemic & endemic diseases

South Africa also has international and regional obligations due to the fact that is either signatory or ratified several human rights instruments that contain the right to health. Amongst these are the Universal Declaration of Human Rights, the International Covenant of Economic, Social and Cultural Rights, The African Charter of Human and People's Rights, the Covenant of the Rights of the Child, The Covenant for the Elimination of all Forms of Discrimination Against Women, The SADC Declaration against AIDS amongst others.

The state is therefore obliged to provide a national health service that provides quality care and is accessible to everyone without any form of discrimination.

2.1.4.1 What is the meaning and content of the right to health?

➢ **Minimum Core Entitlements**
In General Comment No.3 the CESCR enjoins States parties to ensure the satisfaction of minimum essential levels of all the rights enunciated in the ICESCR.[1] Failure to do constitutes a violation of the right. In CESCR´s view, this core includes at least (amongst others)

- to provide essential primary health care
- to ensure equitable distribution of health facilities, goods and services;
- to provide of essential drugs as defined by WHO's Programme on Essential Drugs;
- to adopt and implement a national public health strategy and plan of action on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised and periodically reviewed.

The Committee also confirms that obligations of comparable priority include taking measures to prevent, treat and control epidemic and endemic diseases.

➢ **The Normative Content of the Right to Health is based on four principles:**
(General Comment No. 14 of CESCR)

- Availability
- Accessibility
- Acceptability
- Quality

1. *Availabilty:* Must be a functioning public health system & health care facilities. Goods, services & programmes must be available in *sufficient quantity for all.* They will include the underlying determinants of health, such as safe and potable drinking water and sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by WHO's Action Programme on Essential Drugs.

2. Accessibility has four overlapping dimensions:

- *Non-discrimination*- Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized ..., in law and in fact, without discrimination on any of the prohibited grounds-sex, race, age, disability

- *Physical accessibility*- Health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups.[1] – rural populations, poor, indigenous peoples, older persons. Accessibility further includes adequate access to buildings for persons with disabilities

- *Economic accessibility (affordability)* - Health facilities, goods and services must be affordable for all. Payment for health care services must be based on the principle of equity. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

- *Information accessibility*- includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

3. *Acceptability*- All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

4. *Quality*: Health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

The National Health Insurance System should be planned and implemented using a human rights approach as outlined above. All levels of health care workers must be trained to respect a human rights approach to providing services and to respect the rights of patients.

2.2. Structure Of The National Health Insurance Authority

2.2.1 The National Health Insurance Authority (NHIA) must seek to give effect to the aim of pooling the public and private sector contributions in a single universal health system. Such a system must aim to:

2.2.2 Ensure equity in the raising and allocation of financial health resources

2.2.3 Promote the optimal mobilisation of financial resources through combining both earmarked and general taxes

2.2.4 Ensure that a consistent link is realised between what the country can offer and what it can afford

2.2.5 This document sets out to provide a conceptual framework for a National Health Insurance Authority. It must be borne in mind that the conceptualisation is constrained by the absence of an overall agreed upon institutional framework for social security and of healthcare in South Africa.

2.2.6 In the pursuit of a National Health Insurance Authority, the following guiding principles must be adopted.

a) *Allocation of National Resources for Health* - The NHIA shall advocate for the importance for government to give appropriate priority to health as a strategy for bringing about improved human and faster economic development.

b) *Universality* - The NHIA shall provide all South Africans and permanent residents with the mechanism to gain access to health care services. The National Health Insurance Authority shall give the highest priority to achieving coverage of the entire population with a comprehensive health care package;

c) *Equity* - The NHIA shall provide for uniform health care benefits for all, funded from contributions structured according to a person's ability to pay, and for access to care as a function of a person's health needs.

d) *Responsiveness* - The NHIA shall adequately meet the needs for essential health services at all stages of a person's life;

e) *Social Solidarity* - The NHIA shall be guided by the spirit of community and social solidarity. It must enhance risk-sharing among diverse income groups, age groups, and persons of differing health status, and people residing in different geographic areas;

f) *Effectiveness* - The NHIA shall seek to balance the economic use of resources against desired outcomes;

g) *Fiduciary Responsibility* - The NHIA shall exercise effective and responsible stewardship in the management of funds and maintenance of reserves.

h) *Informed Choice* - The NHIA shall enable members to choose from among accredited health care providers both public and private. The NHIA shall provide its members with objective information on the full range of providers involved in the program and of the services and privileges to which they are entitled as members. This information, which the member may use as a guide in selecting the appropriate and most suitable provider, shall be given in clear and simple terms in the official languages that are prevalent in the district;

i) *Compulsory Coverage* - All South African citizens and permanent residents shall be required to enrol in the National Health Insurance system in order to obviate adverse selection and social inequity

j) *Free Services: services shall be free at point of use;*

k) *Professional Responsibility of Health Care Providers* - The NHIA shall ensure that all participating health care providers are responsible and accountable in all their dealings with the Authority and with the people served;

l) *Quality of Services* - The NHIA shall promote quality of health services through the institutionalization of quality assurance programmes at all levels of the health service delivery system. The satisfaction of beneficiaries shall be a determinant of the quality of service delivery;

m) *Cost Containment* - The NHIA shall incorporate measures and controls in its design and operations to ensure cost containment.

2.3. GOVERNANCE OF THE NATIONAL HEALTH INSURANCE FUND

2.3.1 Principles of governance arrangements

2.3.1.1 The NHIA will adhere to corporate governance principles and pillars, enshrined in the King I and II Reports,

2.3.1.2 The NHIA will be a public entity accountable to the Minister of Health (the Minister).

2.3.1.3 The Minister will be ultimately accountable to Parliament for the performance of the NHIA.

2.3.1.4 The Governance framework will include the Minister, Parliament and the Executive Team assisted by members of Advisory Committees of Stakeholders and Experts, Governance Committee, Audit Committee, Remuneration Committee and Grievance and Appeal Review Committee.

2.3.1.5 The role of each party must be clearly defined and understood by all parties.

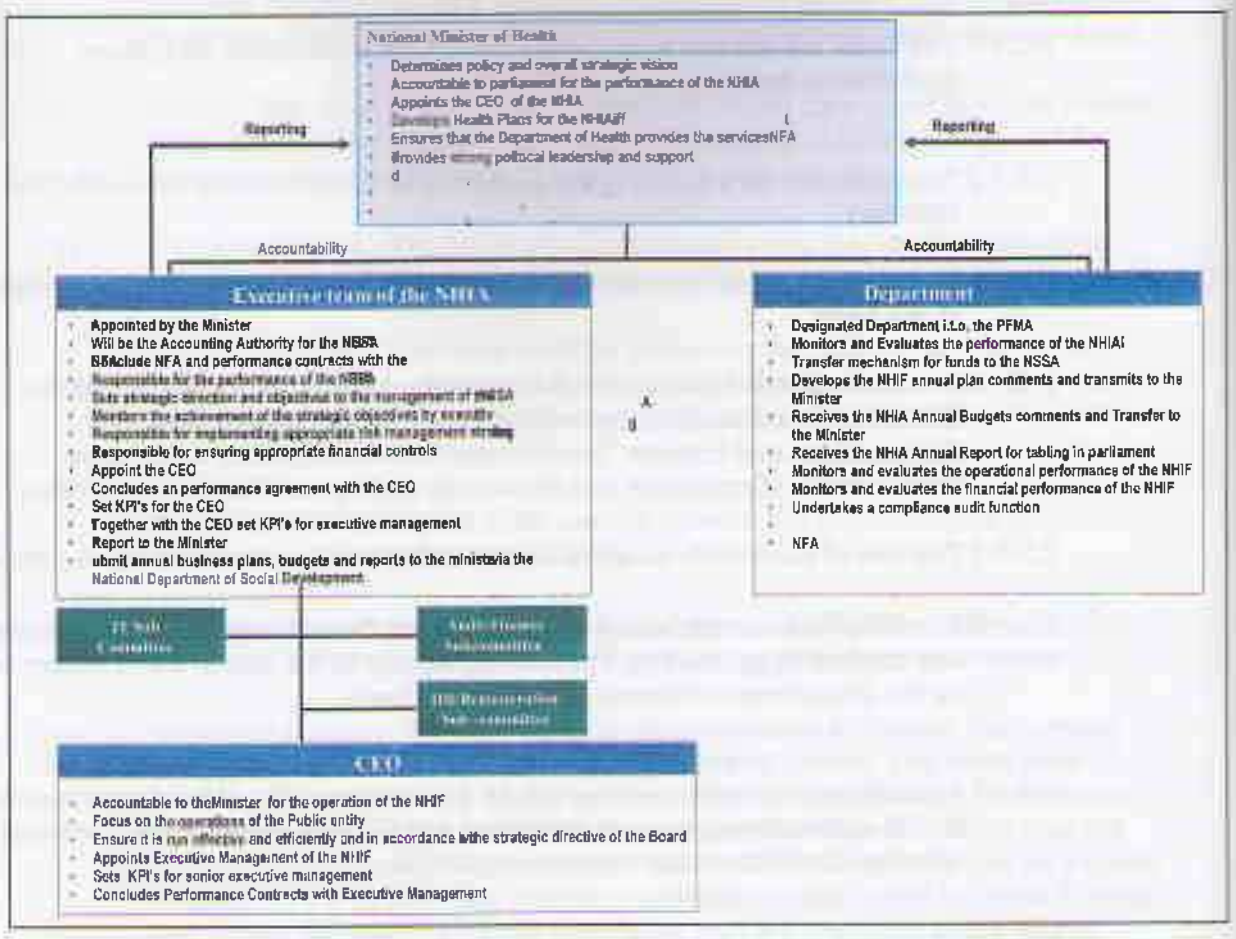
2.3.1.6 The NHIA will operate within the ambit of the Department of Health policies and confine its purchasing and funding activity to the health plans determined by the Department of Health on an annual basis.

2.3.1.7 The delivery of health services will be the responsibility of the Department of Health administered through Provincial and District services in accordance with the Constitution and relevant legislation.

2.3.1.8 The NHIA will pool the funding, interrogate the health plans, purchase and fund the relevant health services which will be delivered by public and private facilities at primary, secondary, tertiary and quaternary supervised by the National, Provincial and District Health.

2.3.8.9 The NHIA shall have an autonomous administration and management, with separate accounts, under the Ministry of Health. This model is in line with those of many developing countries.

The recommended governance structure is set out in the diagram below



2.3.2 Reporting and Accountability Framework

2.3.2.1 The Minister of Health must appoint a Chief Executive Officer (CEO) that will report and account to him or her directly. The CEO will be the Accounting Officer in line with the provisions of the Public Finance Management Act, 2000 (PFMA) This appointment will be provided for in the NHIA Act and other related legislation.

2.3.2.2 The CEO will be responsible for the overall management of the NHIA and the conduct of its operations, and for such other related duties as may be assigned to him/her by the Minister.

2.3.2.3 The CEO must have a comprehensive understanding of healthcare operations, financing and service provision. He or she must possess, demonstrated managerial and leadership skills backed by appropriate training and qualifications. He/she must have a record of achievement in the healthcare sector and an in-depth understanding of the healthcare industry. He /she must demonstrate commitment to the ideal and principles of the NHI as a healthcare financing mechanism in the context of the National Health System (NHS) in South Africa.

2.3.2.4 The CEO shall receive market-related remuneration approved by the Minister of Health in consultation with the Minister of Finance and Public Service Administration.

2.3.2.5 The CEO may not be involved in any activity or business that may constitute a conflict of interest, such as ownership or membership of the TAC of an entity connected to health delivery, provision of medical supplies or pharmaceuticals.

2.3.2.6 An Executive Team (ET) will be appointed consisting of full-time employees of the NHIA with the appropriate qualifications and skills mix to properly carry out the activities of the NHIA. The ET reports directly to the CEO

2.3.2.7 The management structure supporting the CEO will include the following skills units, *inter alia*, each headed by an appropriately qualified ET member: health finance, health economics, actuarial sciences, human resources management and development, operations and logistics, health services management, and communications and public affairs.

2.3.2.8 The heads of the NHIA services at the Provinces must be members of the ET.

2.3.2.9 This ET must regularly interact with the Advisory Committee of Experts and the Advisory Committee of Stakeholders for advice and feedback on the strategic direction of the NHIA, and on the latest technical developments relevant to the NHIA operations.

2.3.2.10 The Advisory Committees will be non-executive.

2.3.2.11 The CEO will appoint the members of the Advisory Committees.

2.3.2.12 The Advisory Committee of Stakeholders must be composed of the following stakeholders:

One representative each from the Health Professions' Council of South Africa, South African Pharmacy Council, South African Nursing Council, Allied Health Professions' Council and the Traditional Healers Council

One representative from the Labour organisations and Trade Unions; one representative from the SA Chambers of Commerce

Two representatives from Tertiary Institutions, which train Health Professionals.

Two Community representatives from each Province

2.3.2.13 The functions of the Advisory Committee of Stakeholders will include:

- Advise on the functioning of NHIA in a way that will enhance its performance.
- Facilitate community participation in the planning, provision and evaluation of the health services.

- Provide a conduit for interaction between the community and the NHIA on the performance of health services relative to the Patient Rights Charter and Batho Pele principles.

- Provide inputs with respect to the NHIA health plans, policies, basket of services, alignment of resources with health policy priorities and the annual reports of the NHIA.

2.3.2.14 The Minister may terminate the appointment of any member of the Advisory Committees for reasonable cause such as misconduct, physical or mental incapacity.

2.3.2.15 The Advisory Committees shall hold regular meetings at least once a month. Special meetings may be convened at the call of the Chief Executive Officer.

2.3.2.16 The members of the Advisory Committees shall receive a *per diem* for every meeting actually attended subject to the rules and regulations on compensation and allowances fixed by the provisions of the Public Finace Management Act 2000.

2.3.2.17 The Advisory Committee of Experts must be made up of people with specific skills and expertise that will provide the necessary direction and guidance to the Executive team of the NHIA. These skills should include:

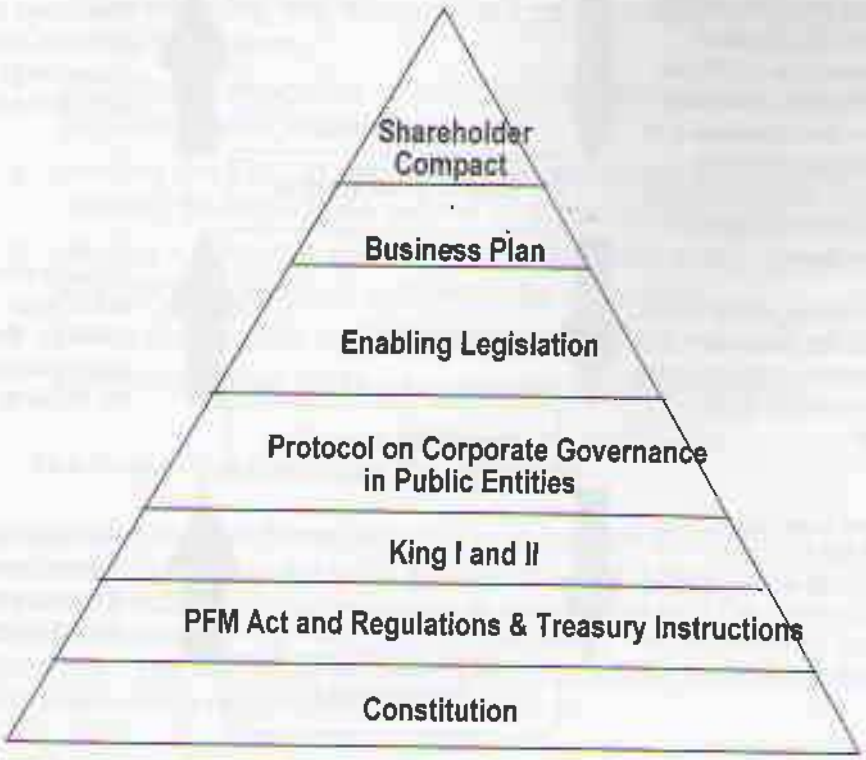
- Health Financing and Economics
- Health Insurance
- Actuarial Sciences
- Public Health and Epidemiology
- Human Resources management and development
- Health care provider needs and conduct
- Patient needs and conduct
- Health Technology Assessment
- Pharmaco-economics
- Medical specialities
- Pharmaceutical, nursing, laboratory, physiotherapy, speech therapy, and radiology expertise.
- Logistics and operations, information technology
- Medical devices and equipment

2.3.3 Governance Arrangements

Governance as a concept should not be seen in a vacuum. There is a significant body of legislation, regulation and protocols pertaining to the governance of juristic entities, both public and private. The objective should not be to recreate what already exists, but rather to utilise and base decisions on existing knowledge and provisions.

The diagram below depicts the hierarchy of governance instruments which the NHIA can usefully employ in its governance processes. This includes the recognised and standard governance directives such as the PFMA, Guidelines on Corporate Governance in the Public Sector, the King Reports, IFRS as well as other instruments of governance which the NHIA can utilise in respect of the strategic and business plans, and the National Framework Agreement (NFA)

The objective should be to rely as much as possible on established practice, and to rely on its founding and enabling statutes to regulate specific medium to long term issues.



The governance framework for the majority of Public Entities consists of four key parties:

- Parliament
- The Executive Authority
- The Governing Body, most often a Technical Advisory Committee
- The Executive Management of the entity.
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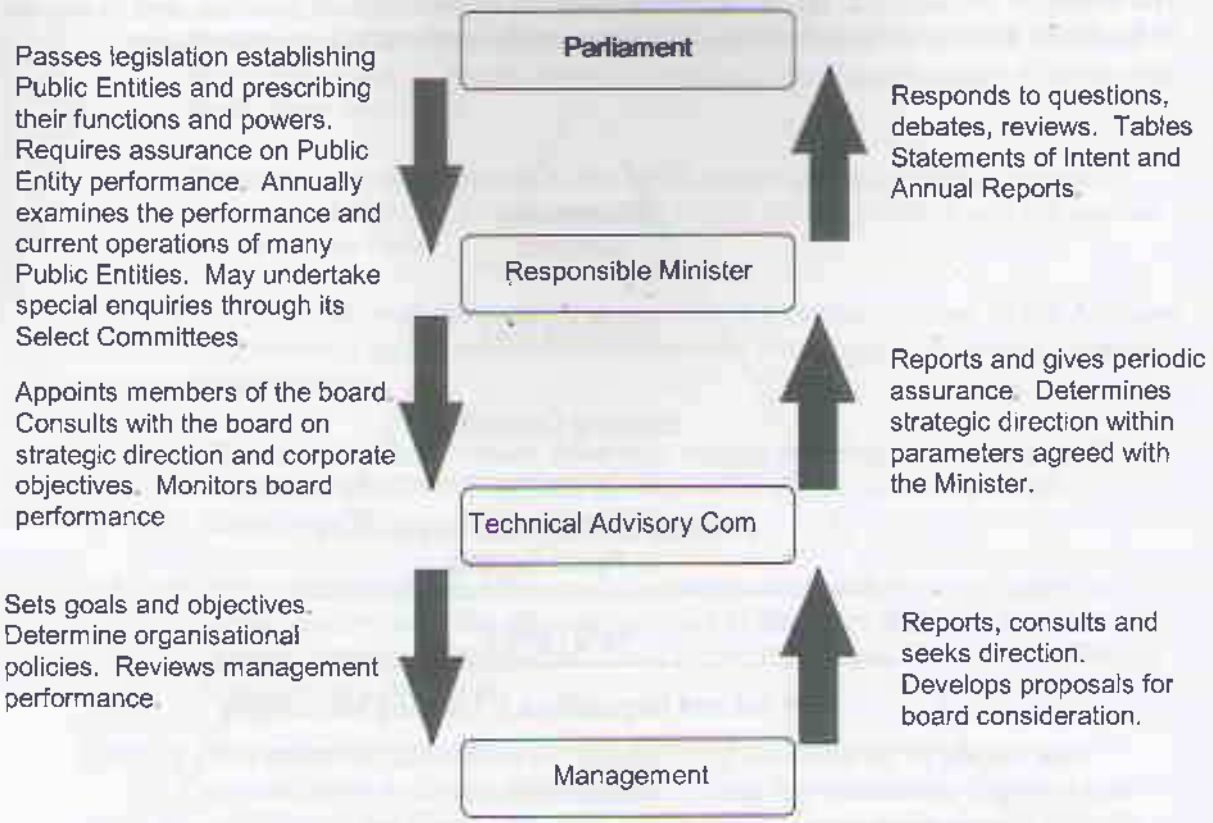


The pre-requisites for effective governance of a Public Entity include:

- The role of each of the parties is clearly defined and understood by all parties.
- Constructive relationships based on those roles.
- An effective governing body.
- A regime for monitoring entity performance that reflects a balance between the interests of Parliament, Government oversight, and the autonomy of the governing body.

2.3.4 Roles and Responsibilities within the Governance Framework

- **The Role of Parliament**

Parliament is the ultimate owner of the Public Entity, and through enacting legislation, establishes the Public Entity, prescribes their functions and powers and their statutory mandates. Parliament annually examines the performance of the Public Entity and calls the relevant Minister to account. Parliament entrusts the executive responsibility for these Entities to the Executive. The Executive Minister is accountable to Parliament, and Parliament is accountable to the electorate.

- **The Role of the Minister**

The executive authority for a public entity can be constituted as the Minister directly, or the relevant government Department. In either event, the responsible Minister is the person ultimately accountable to Parliament for the Public Entity. The executive authority can oversee the management of the Public Entity either directly, or as in most instances, establish a TAC of Directors to undertake this function.

The Minister will be responsible for:

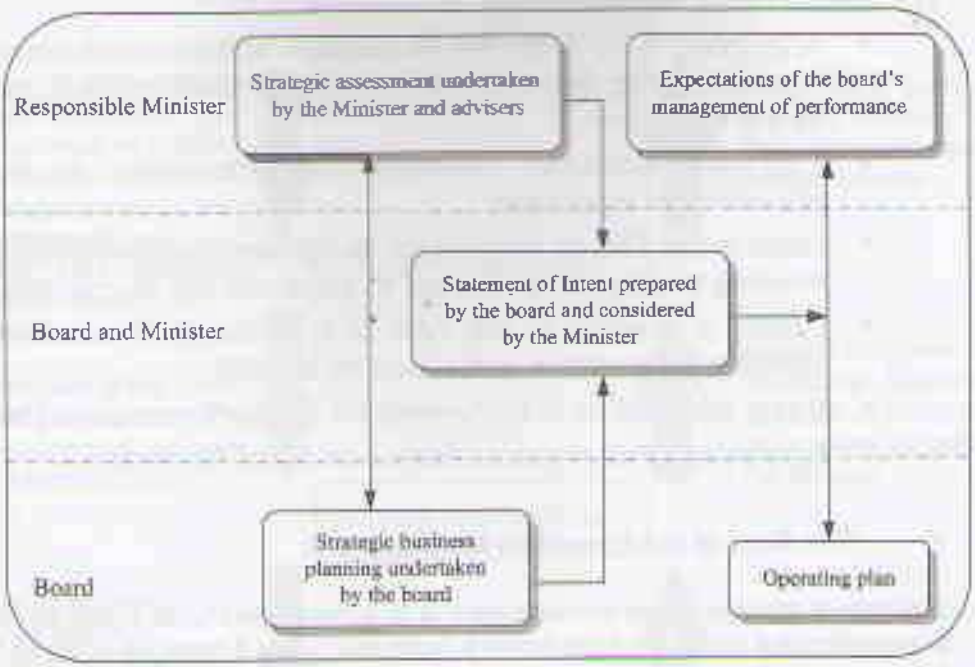
- Appointing TAC from the population served, or in some instances recommending the appointment or dismissal of TAC, as prescribed by the legislation.
- Exercising executive oversight over the entity, in line with the provisions of legislation.
- Holding the TAC to account for its stewardship responsibilities and for meeting the objectives set out in accountability documents.
- Issuing a directive to the TAC or to make other executive decisions affecting the Entity, if authorised by legislation.
- Being answerable to Parliament for the performance of the Entity.
- Exercising other rights as contained in the legislation.

➢ **The Role of the Executive Management:**

The role of the Executive Management is to govern the Public Entity by directing and supervising the conduct of the entity's business. This it must be achieved by setting the strategic direction of the organisation in accordance with the strategic vision and priorities as provided by the TAC, and for overseeing management of the resources entrusted to it. The TAC must account to the responsible Minister for the discharge of these stewardship responsibilities.

The TAC's purpose is not to manage day-to-day operations, which is clearly the function of senior management, but it is responsible for overseeing the management of operations and for monitoring results to ensure that plans are being carried out successfully.

Once plans are put in motion, the TAC needs to ensure that it has reliable means to assess the organisation's ongoing performance, while monitoring external conditions that could enhance or jeopardise success. If objectives are not being met, it is the TAC's responsibility, through management, to initiate and oversee implementation of corrective action. The Directors act as professional trustees independent of entity management, but they need to establish a dynamic and challenging relationship with the Chief Executive Officer to promote effective operations



The minimum requirements regarding the substance of the National Framework Agreement are specified in the PFMA regulations. The NFA represents a public expression of the TAC's commitment to a set of operating parameters for the forthcoming three years. In addition to the NFA, the enabling legislation may require the Entity to prepare another accountability document; namely a "Performance Agreement". Unlike the NFA, which must be made public, the performance agreement need not be a public document.

- **Composition of the Advisory Committee (TAC):**

The TAC must comprise the appropriate range of skills and expertise needed to provide and develop the strategic input and direction required by the Public Entity. The population servedhip of the TAC should comprise a majority of non-executive Directors in order to enable it to fulfil its role of providing independent direction to, and oversight of, the executive management of the public entity.

Public servants sitting on the TACs of Public Entities can provide useful advice on public policy issues, contribute personal knowledge and experience, and build networks within the sector. This arrangement can, therefore, make a positive contribution to the quality of TAC discussions and decision-making. On the other hand, the presence of officials may inhibit the free operation of the TAC and undermine formal lines of communication between the TAC and the Minister. Officials sitting on TACs may also face conflicting interests where they are called on to advice the Minister on TAC performance. The role of these officials needs to be clearly understood by the individuals, the TACs, and the Minister.

- **Appointment of TAC's of Directors**

To discharge its role and functions competently, a Public Entity needs to have the right mix of skills and experience. In some instances, the nature of the business may demand technical skills and specific expertise. As far as possible, the appointment process should provide assurance that TAC members have been chosen from the available candidates best able to meet the requirements of the position.

Responsible Ministers appoint Public Entity TACs. In carrying out this task, Ministers must comply with the provisions of the enabling legislation, and with the administrative procedures. The legislation should provide for an appointment process that, as a minimum, includes the following steps:

- Identify the skills, experience and other attributes required for the position.
- Identify candidates (by seeking nominations or other expressions of interest and provide the opportunity for all suitable candidates to make their availability known).
- Evaluate the candidates against objective criteria.
- Select from the short list of candidates the person most likely to fulfil the requirements of the position.
-

➢ **Establishment of the Benefits Advisory Committee**

The Benefits Advisory Committee ("Committee") will be established as part of the National Health Insurance Authority (NHIA). The BAC will be an independent statutory body established under the National Health Act 2004 to make recommendations and give advice to the Minister of Health about which medical interventions, drugs and medicinal preparations should be made available as part of the comprehensive package of benefits to be covered by the NHIA .

No new medical intervention, drug and/or medicinal preparation may be made available as a healthcare benefit unless the Committee has so recommended.

The Committee will be required by law to consider the effectiveness and cost of a proposed medical intervention, medical technology, drug and/or medicinal preparation benefit compared to alternatives available locally and internationally. In making its recommendations the Committee, on the basis of the population's epidemiological profiles and usage, will recommend maximum quantities and repeats of the intervention, drug and/or medicinal preparation and may also recommend restrictions as to the indications where this is deemed ethically acceptable. When recommending listings, the Committee provides advice to the NHIA regarding comparison with existing alternatives or their cost effectiveness.

The Committee will be staffed by persons who when severally considered, have qualifications or experience in appropriately identified clinical disciplines (i.e. general medicine, surgery, dentistry, pharmacology, cardiology, pediatrics, urology, trauma), health economics; law; pharmacoeconomics; and health administration.

➢ **The key functions of the Committee will include**

1. To make recommendations and give advice to the Minister of Health and the NHIA about which medical interventions, medical technology, drugs and medicinal preparations should be made available to the population as part of the comprehensive package of benefits to be covered by the NHIA.

2. To advise the Minister of Health and the NHIA on evidence relating to the safety, effectiveness and cost-effectiveness of new medical intervention, medical technology, drug and/or medicinal preparation.

3. To recommend new and existing medical interventions, medical technologies, drugs and/or medicinal preparations that will improve health outcomes for patients by ensuring that they are supported by evidence of their safety, clinical effectiveness and cost-effectiveness.

4. To systematically collate and review available evidence on existing and new medical intervention, medical technology, drug and/or medicinal preparation.

5. (In clearly indicated circumstances) to recommend interim funding to enable data collection, within an agreed research framework, in order to establish the evidence base and effectiveness of any medical intervention, medical technology, drug and/or medicinal preparation.

6. To regularly publish information, in collaboration with the NHIA, on all evaluations of evidence associated with any medical intervention, medical technology, drug and/or medicinal preparation.

- **The Terms of reference for the Committee are**

1. Advise the Minister of Health and the NHIA on the strength of evidence pertaining to any new and emerging medical intervention, medical technology, drug and/or medicinal preparation in relation to their safety, effectiveness and cost-effectiveness and under what circumstances public funding should be supported.

2. Advise the Minister of Health and the NHIA on which new and emerging medical intervention, medical technology, drug and/or medicinal preparation should be funded on an interim basis to allow data to be assembled to determine their safety, effectiveness and cost-effectiveness.

3. Advise the Minister of Health and the NHIA on references related either to new and emerging medical intervention, medical technology, drug and/or medicinal preparation.

4. Undertake comprehensive assessment of any medical intervention, medical technology, drug and/or medicinal preparation and report its findings to the Minister of Health and the NHIA.

Establishment of an Audit Committee

The CEO shall establish an Audit Committee within the NHIA to carry out the auditing functions. The members of the Committee must be financially literate

- The Committee must conduct an internal, external and performance audit.

- Perform other oversight functions as requested by the Minister of Health after consultation with the CEO. Ensure that the CEO and the Minister of Health is aware of the matters which may significantly impact the financial condition or affairs of the NHIA.

- The Committee will review the annual financial statements and determine whether they are complete and consistent with the information known to committee members; assess whether the financial statements reflect appropriate accounting principles.

- The Audit Committee, under direction of the Chairperson, as authorised has the power to conduct interviews with Advisory Committee members, the Executive team, executive officers, advisers or staff members of the NHIA.

- The Committee can also liaise directly with the external and/or internal auditors, investigate matters that it considers necessary and to obtain advice from external experts and co-opt suitable persons to serve on the Audit Committee where specific expertise is required; and to seek any information from external parties.

- The Audit Committee may lay claim to the required resources that it may find necessary to perform its duties properly and that are reasonably affordable; and have access to records and information of the NHIA

- The Committee can make recommendations to the CEO on the appointment and/or re-appointment of the external auditors and consideration of the budgeted audit fees and remuneration paid to the external auditors.

- The CEO, reserves the right to remove any members from the Committee and to fill any vacancies created by such removal.

- Meetings of the Audit Committee may, as arranged by the Chairperson, be attended by representatives of the external auditors, the Executive team and its officers and the Internal Auditor.

- If the Chairperson of the Audit Committee is absent from a meeting, the members present will appoint a Chairperson from among themselves.

- The Audit Committee must meet on a regular basis with a minimum of two meetings a year. The Committee determines the dates of meetings taking into consideration the dates on which interim and final reports of the external auditors become available.

- Members present at a meeting form a quorum with a minimum of three members of the Committee, provided that the majority of the members present must be persons who do not occupy an executive position at the NHIA.

- Matters are decided by a majority of votes and, should a tie of votes occur, the Chairperson does not have a casting vote.

- If a vacancy occurs on the Audit Committee, the Chairperson of the Audit Committee must inform the CEO without delay. The Minister of Health, after consultation with the CEO, must fill the vacancy on receipt of such notification or within a reasonable period of time thereafter.

- **Establishment of Governance Committee**

- The CEO will appoint a Governance Committee. This Committee shall at least once annually consider the extent to which the general corporate governance mechanisms of the NHIA are appropriate and effective in view of developments within the NHIA, its business environment, new corporate governance requirements and benchmarks. It shall then make recommendations to the CEO in this respect.

- The Committee will also be responsible for: (i) monitoring the ethical conduct of the NHIA, its executives and senior officials in terms of the provisions of the NHIA Code of Ethics (ii) reviewing any statements on ethical standards or requirements; (iii) monitoring compliance with the requirements of the Government policies (iv) monitoring compliance with legal requirements; (v) review of declarations of interests of the members of the various committees.

- The Committee will also consider and make recommendations on any existing or potential conflict of interest or questionable situations of a material nature.

- The Committee will report to the Audit Committee on legal and regulatory matters which may have an impact on financial statements.

➢ **Establishment of a Grievance Appeal Review Committee**

- The CEO, shall create a Grievance Appeal Review Committee, composed of three (3) to five (5) members, which shall receive and recommend appropriate action on complaints from members and health care providers, any violation of the rights of the patients.

- A grievance will include wilful neglect of duties of NHIA that results in the loss or non-enjoyment of benefits of members or their dependents, unjustifiable delay in actions on claims, delay in processing of claims that extends beyond the period agreed upon, and any other act or neglect that tends to undermine or defeat the purposes of the NHIA.

- The Grievance Appeal Committee must establish appropriate procedures that they will follow in line with all the legal provisions of South Africa.

- The NHIA shall establish a Provincial NHIA office in every Province or wherever it is deemed practicable, to bring its services closer to members of the NHIA.

➢ **Establishment of a Remuneration Committee**

- The CEO shall establish a Remuneration Committee for all the staff members at the NHIA, except the CEO.

- The Remuneration Committee for the CEO will be established and chaired by the Minister of Health. Both Committees will perform duties that determine remuneration related issues for the NHIA staff in accordance with their conditions of employment and other relevant policies and legislation.

2.4 FUNCTIONS OF THE NATIONAL HEALTH INSURANCE AUTHORITY

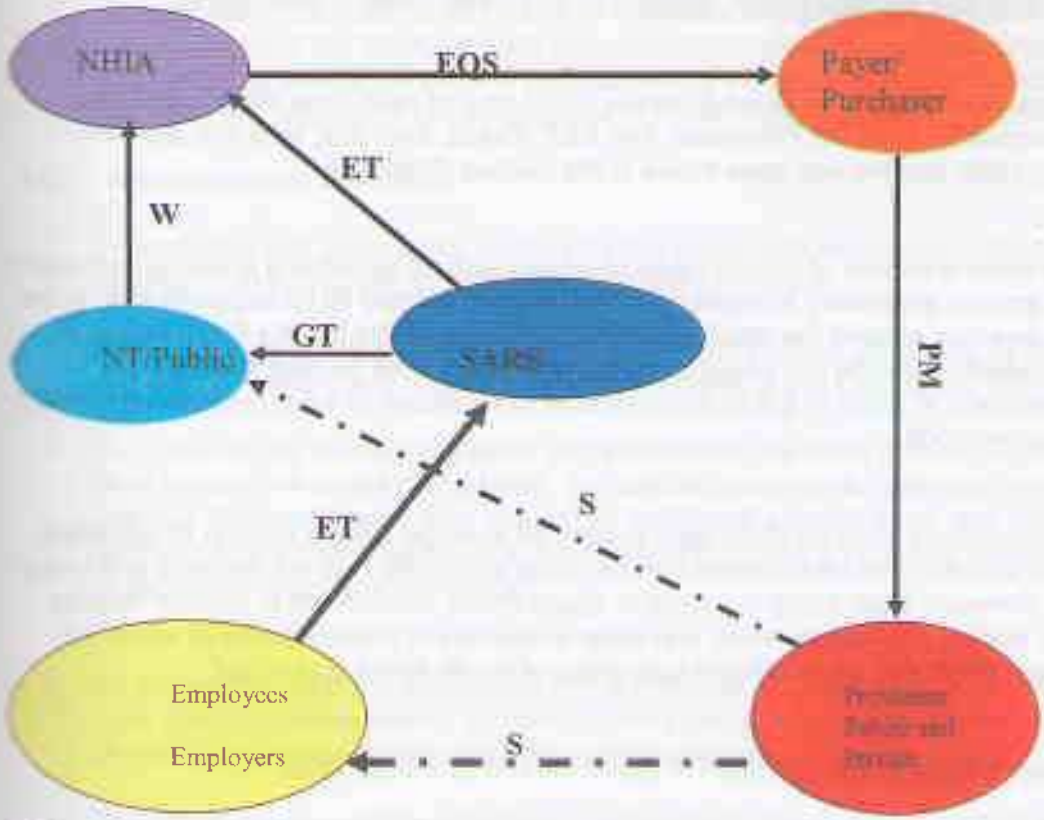
The functions of the NHIA are limited to:

- Obtaining the funding for health care services from the mandatory contribution and general tax revenue and other sources.
- Utilise the funds appropriately, as prescribed, to purchase the health services as outlined in the annual health plans that have been compiled by relevant providers and as approved district, provincial and national authorities.
- Make funds available to the Provinces and Districts that oversee rendering of the health services.

- Liaise with the National, Provincial and District Health government Departments when the annual NFA is developed, funded and implemented.
- Work with the Office of Standards Compliance (OSC) that is established in terms of Section 78 of the National Health Act 61 of 2003, in the process of accreditation and setting of quality standard

2.4.1 Financial Activities

The following diagram attempts to illustrate the financial and service flows in the planned NHI



KEY
ET: Earmarked Health Tax
GT: General Tax
W: Contribution subsidy for the indigent
S: Services
PM: Payment Mechanisms

To implement these financial and service flows the following financial activities will occur:

- To determine the overall budget for health care in the country. This must include the setting of the level of the mandatory contributions or levy in line with accepted tax and national health policies.

- In consultation with the Department of Health determine a reasonable, equitable and progressive contribution schedule for everyone who must contribute to the NHIA. This must be based on applicable actuarial studies and the prevailing income tax threshold (e g R54,200 in 2009/10).

- To discuss the budget proposal and business plan of the NHIA and passing it on to the Minister of Health for approval along with comments and recommendations.

- To keep records of the operation of the NHIA and its investments.

- To receive general tax funding from the National Treasury. The earmarked taxes will be collected via the South African Revenue Services (SARS) and then transferred to the NHIA after reconciliation.

- To receive and manage grants, donations, and other forms of assistance.

- To develop an Equitable Share Formula (ESF) so that resources are allocated by NHIA equitably to all the Provinces. The ESF should, *inter alia*, take into account demographic profiles and case mixes in the various Provinces.

- To set aside a portion of accumulated revenues without exceeding a ceiling equivalent to the amount actuarially estimated for two years' projected NHIA expenditures. In the event reserves exceed the required ceiling at the end of the NHIA's fiscal year, the NHIA benefits shall be increased or earmarked taxes shall be decreased prospectively, in order to adjust expenditures or revenues to meet the required ceiling for reserve funds.

- The investments must be short-term to earn an average annual income at prevailing rates of interest. The investments can be made in interest bearing deposits and loans in any domestic bank doing business in South Africa. Investment in interest bearing bonds, bonds, promissory notes and other evidences of indebtedness to which full faith and credit and unconditional guarantee of South Africa is pledged.

- To keep records of the operation of the NHIA and its investments.

2.4.2 Contract Management

- To perform the Strategic Purchasing function of health services directly from the providers. This must be done in a way that fully utilises the benefits of a Single Purchaser. Contractual arrangements on purchasing will be according to the National Framework Agreement (NFA)

- The NHIA Provincial offices will also purchase certain health services from providers in accordance with NHIA guidelines. In purchasing health services it must be ensured that the priorities of the Province are met, the services are responsive to the needs of individuals and communities and supports the integration of services and facilities in the district and Province.

- To negotiate and enter into contracts with health care institutions, professionals, and other persons, juristic or natural, regarding pricing, payment mechanisms, design and implementation of administrative and operating systems and procedures, financing, and delivery of health services.

- To formulate a NFA that will serve as a guide for contractual and service level agreements. The NFA will be contract or agreement between NHIA, government and providers of health care and health products. This contract will be limited to purchasing and payment of services rendered under the supervision of the Department of Health. No contract may be concluded on less favorable terms than the terms adopted by the NFA. Any contract shall be executed in writing for the term of validity of the NFA, and shall endure until conclusion of a new NFA or modification of the effective NFA. The Provincial NHIA offices may not refuse to conclude a contract with any provider satisfying the requirements of the law and of the NFA, including the private health providers.

- To authorize Provincial NHIA offices to negotiate and enter into contracts in the name and on behalf of the NHIA with any accredited government or private sector, for the purchasing of benefit package of national health services. This must be done in a way that does not jeopardize the advantages of NHIA being a Single Purchaser.

2.4.3 Administrative Functions

- To formulate and promulgate policies for the sound administration of the NHIA. These policies must be aligned to those of the Ministry of Health.

- To organize its office, fix the compensation of and appoint personnel as may be deemed necessary and upon the recommendation of the CEO of the NHIA;

- To submit to the Minister of Health and Parliament the NHIA Annual Report which shall contain the status of the NHIA, its total disbursements, reserves, average castings' to beneficiaries, any request for additional appropriation, and other data pertinent to the implementation of the NHIA and publish a synopsis of such report in newspapers of general circulation;

- To ensure the optimum functioning of the Actuarial Sciences unit in the NHIA. This unit must conduct the necessary actuarial studies and present recommendations on contributions,, investments and other related matters.

- To ensure the appropriate functioning of the Health Finance and Economics unit in developing a broad conceptual framework for the implementation of the NHIA through a health finance master plan to ensure sustained investments in health care, providing guidance for additional appropriations from the National Government, conduct research and studies toward the development of policies necessary to ensure the viability, adequacy and responsiveness of the NHIA.

- The Health Finance and Economics unit must also review, evaluate and assess the NHIA impact on access, cost of healthcare in the country. There must be a periodic review of fees charged, compensation rates, capitation rates, medical standards, health outcomes and satisfaction of members. The delivery, quality, use and cost of health care services of the different Provinces must be compared. Recommendations on policy and other operational issues must be made to the NHIA so that its objectives can be met.

- To establish various payment mechanisms to providers of healthcare services and products. Each Provincial NHIA office shall recommend the appropriate payment mechanism within its jurisdiction for approval by the NHIA in accordance with the NFA. Special consideration should be given to payment for services rendered by public and private health care providers serving remote or medically underserved areas. There

must also be acceptance, after negotiations. by providers of payment mechanisms, referral protocols, information system requirements, regular transfer of information and sharing arrangements set by the NHIA.

- To set up monitoring systems and mechanisms that safeguard against over-utilisation of services, unnecessary diagnostic and therapeutic interventions, under-utilisation of services, irrational medication and prescription, and inappropriate referral practices.

- To supervise the provision of health benefits with the aim of limiting and preventing fraud.

- To formulate guidelines on how certain funds paid to public facilities may be retained and utilised.

- To formulate and implement guidelines on contributions and benefits; portability of benefits, cost containment and health care provider arrangements, payment methods, and referral systems

2.4.4 Quasi-Judicial Powers

- To conduct investigations for the determination of a question, controversy, complaint, or unresolved grievance brought to its attention, and render decisions, orders, or resolutions thereon.

- To proceed to hear and determine the case even in the absence of any party who has been properly served with notice to appear.

- To conduct its proceedings or any part thereof in public or in executive session; adjourn its hearings to any time and place; refer technical matters or accounts to an expert and accept the reports as evidence; direct parties to be joined in or excluded from the proceedings; and give all such directions as it may deem necessary or expedient in the determination of the dispute before it;

- To summon the parties to a controversy, issue subpoenas requiring the attendance and testimony of witnesses or the production of documents and other materials necessary to a just determination of the case under investigation;

- To abide with the decision of the Office of Standards Compliance to suspend temporarily, revoke permanently, or restore the accreditation of a health care provider or the right to benefits of a member.

- To sue and be sued in court.

2.5 PROVINCIAL HEALTH INSURANCE AUTHORITY FUNCTIONS

Each Provincial NHIA office shall have the following powers and functions:

- to consult and coordinate, as needed, with the local government units within its jurisdiction in the implementation of the NHIA;

- to ensure the registration of members of the NHIA from all the areas within its jurisdiction;
- to ensure that there is updating of the membership list at community levels;
- to ensure that NHI ID cards are issued to all eligible persons.
- to process, review and pay the claims of providers, within a period not exceeding sixty (60) days, whenever applicable in accordance with the rules and guidelines of the NHIA;
- to pay fees, as necessary, for claims review and processing when such are conducted by the central office of the NHIA or by any of its contractors.
- to support the management information system requirements of the NHIA
- to establish referral systems and network arrangements with other Offices, as may be necessary, and following the guidelines set by the NHIA
- to establish mechanisms by which private and public sector health facilities and human resources may be shared in the interest of optimizing the use of health resources;
- to serve as the first level for appeals and grievance cases;
- to participate in information and education activities that are consistent with the government's priority programs on disease prevention and health promotion; and
- to prepare an annual report according to the guidelines set by the NHIA and to submit the same to the central office of the NHIA

2.6 DISTRICT HEALTH INSURANCE AUTHORITY FUNCTIONS

- to consult and coordinate, as needed, with the local government units within its jurisdiction in the implementation of the NHIA:
- to ensure the registration of population from all the areas within its jurisdiction;
- to ensure population register with accredited PHC facilities and providers within district
- to ensure that there is updating of the population list at district levels;
- to ensure that NHI ID cards are issued to all eligible persons.
- to establish referral systems and network arrangements, as may be necessary, and following the guidelines set by the NHIA
- to participate in information and education activities that are consistent with the government's priority programmes on disease prevention and health promotion;
- to raise awareness on national health insurance; and
- to prepare an annual report according to the guidelines set by the NHIA and to submit the same to the central office of the NHIA

CHAPTER 3: REVENUE COLLECTION AND POOLING FUNCTIONS

3.1. Introduction

The NHI policy aims to introduce a publicly-funded and publicly administered NHI which will provide all South Africans with access to quality health care that will be free at the point of delivery.

Through the NHI system, government aims to mobilise sufficient funds for improving the quality of health services and ensuring that the cost of care does not prevent people from receiving health services in time of need. This is consistent with underlying principles of an NHI policy – universal coverage and equity, amongst others.

To ensure universal coverage, three distinct but interrelated health financing functions for the delivery of health care services are key: (1) *revenue collection*; (2) *pooling of funds*; and (3) *purchasing* of services. Revenue collection refers to the process by which the health system collects money from the households, enterprises and possibly donors. Pooling refers to the accumulation *and* management of the revenue with the purpose of ensuring that the risk of having to pay for health is collectively shared by all in the pool and not by an individual. The purchasing function refers to the process by which pooled funds are paid to providers to deliver specified set of health services.

The revenue collection and pooling functions of the NHI are discussed in this Chapter and while purchasing functions are discussed in Chapter 15.

3.2. Revenue Collection

3.2.1 Sources of funding

The financial contributions to our country's health system are currently raised from the household and enterprises, principally in a form of general taxation and voluntary medical schemes. Out-of-pocket payments represent third largest form of health care funding and includes fees from co-payments by members of medical schemes, official user-fees for certain income groups in the public sector hospitals and fees paid by the low income workers for general practioners and pharmacies.

There are other revenue sources include social insurances schemes like RAF and COIDA and user-fees for non-residents – but they are not discussed here.

General tax revenue and *mandatory contribution (in a form of payroll levy)* are being identified in the NHI Policy as the main funding sources for the national health system.

3.2.2. Mandatory contribution

Mandatory contribution refers the specific contributions which will be collected from workers and employers – in a form of payroll levy – which will be pooled into the single national health insurance fund. The main rationale for introducing such mandatory contribution is to establish a link between contributions that individuals make to public funds and the health service benefits to which they will be entitled under the NHI. Importantly, it provides a mechanism for cementing social solidarity in the health system through income-related contributions to a single pool of funds that will benefit all. In essence both general tax and payroll revenues will be combined, with government contributing on behalf of those who cannot afford to pay themselves.

Given the massive income inequalities in South Africa in which more than 55% of the workers in the formal sector earn less than R2500 per month, the mandatory contribution would need to be *progressively structured* (i.e. the percentage contribution will be higher for higher income groups). *Everyone above the income tax threshold* would be required to make this contribution (i.e. no one may 'opt-out' of the NHI), which will be shared between employers and employees.

There are options for sharing the contribution: *contribution rates* could be set on a 50:50 split or employers' contribution could be set at a much higher level (e.g. at 60 percent). It is necessary to take account of the growing practice among private sector employers to pay employees on a total cost of employment basis. Under these conditions, the full NHI contribution will be passed on the employees.

While the precise contribution rate will be determined by the costing exercise of the health service benefit package, it is envisaged that the mandatory NHI contribution (or dedicated tax) should initially be set at a relatively low level. This will signal the initiation of the NHI while allowing adequate time to lay the foundation for purchasing a full range of high quality health services. As the purchasing and provision elements of the NHI are rolled out and it becomes evident that the NHI is able to ensure access to quality health care, the mandatory NHI contribution (or dedicated tax) can be gradually increased to more closely approximate the level of contributions currently paid by medical scheme members.

It is assumed that revenue collection mechanism will be limited to the formal sector and that the informal sector will be exempted. Consideration will need to be given to the inclusion of other categories, such as *pensioners*. The 2005 Old Mutual Survey noted that in 1995, that 89% of companies surveyed were providing funding for health care benefits for pensioners. By 2005, only 29% offered such benefits. The percentage of companies offering post-retirement benefits to new employees was estimated to be 85% to 95% in 2005.

3.2.3 Tax Revenue and Mandatory contribution

Government will contribute all those who cannot afford to pay NHI contributions – the unemployed, underemployed and low-income workers who are below the income tax threshold - through allocations from general tax revenue.

While the recent health budget allocations, calculated in real terms have tried to keep up with inflation, real public health expenditure as a percentage of the GDP has been declining (See table below). It is also important to recognise that the introduction of a progressive dedicated tax /mandatory contribution does not necessarily mean that funding from general tax revenue should stay stagnant or decline. Instead, *consistent real increases* in allocations to the health sector from general tax revenue in the next cycles of Medium-Term Budget Policy Statements (MTBPS) need to be sustained.

Table 3: Annual increases in public health expenditure (from 2005-2008) and medium-term estimates (2009-2011).

	2005/06	2006/07	2007/08	2008/09	2009/10	2010	2011	Annual Average 2005-2011
	Actual				Medium-Team Estimate			
Public health expenditure Rm (nominal)	48,770	56,433	68,169	80,809	86,945	97,632	105,351	82,556.5
Year-on Year growth rate (nominal)	*100.0*	*15.7*	*20.8*	*18.5*	*7.6*	*12.3*	*7.9*	*13.8*
Public health expenditure Rm(real)	48,770	53,951	60,811	64,647	65,718	70,239	72,656	64,670.4
Year-on Year growth rate (real)	*100*	*10.6*	*12.7*	*6.3*	*1.7*	*6.9*	*3.4*	*6.9*
Government expenditure Rm	460,649	529,077	632,532	721,052	834,336	899,744	953,069	761,635.0
Public Heath expenditure as % of government expenditure	10.6	10.7	10.8	11.2	10.4	10.9	11.1	10.8
CPIX (Average for year)	4.3	4.6	7.2	11.6	5.8	5.3	4.7	6.5
Real public health expenditure as % of GDP	3.2	3.1	3.1	2.9	2.7	2.7	2.5	2.8

Sources: *National Treasury (2009), MTBPS (2008), StatsSA on CPIX (2009)*

The current *tax deductibility of medical scheme contributions* will be removed. This will contribute to increasing tax revenue, which will facilitate the allocation of additional tax funds to the health sector through the NHI Fund. In addition, the current government *contributions to public servants' medical schemes* will be re-routed towards the NHI fund as part of the mandatory contribution.

3.2.4. Out-of-pocket contributions

Under the NHI system, *out-of-pocket payments* are not expected to be the dominant sources of funding in the NHI. They will be minimized or removed to ensure access to health care is free at the point of delivery. Numerous studies have shown that out-of-pocket payment is an inequitable and inefficient way of mobilising resources for health services and could also be a barrier for people access health care.

Overall the combination of the above government and mandatory contributions will enhance public health funding and the increase in government funding would be offset by reductions in private medical scheme contributions and out-of-pocket expenses.

3.2.5 Collection Mechanisms

Since mandatory contribution will be based on payroll tax and the NHI being a single-risk pool and single-purchaser mechanism, the collection of revenue will be centrally collected. The infrastructure of South African Revenue Service (SARS) and its efficient administration systems will be utilised for revenue collection.

3.3. Pooling functions

3.3.1. A single-risk pool

The contributions from general and payroll levy will be pooled into a *single NHI fund*, which will be publicly administered, with not role for intermediaries - to achieve the objectives of NHI. The creation of a central pooling of health funds to ensure income and risk cross-subsidies in the overall health system

By pooling both these contributions NHI is expected to have strong bargaining power to negotiate certain standards of care and level of prices with public and private health care providers. Therefore, the publicly-financed NHI will be in a strong position to encourage a cost-effective health care financing and integrated delivery system. The additional advantages of central pooling include the following:

- Pooling of resources for the entire population into one pool creates *maximum redistribution of income/financial burden* for health services allowing effective cross subsidies from the rich to the poor and from richer health districts to poorer districts.

- A big pool will *improve economies of scale* that will maximize benefits to the population. Similar schemes in Taiwan and Medicare in Canada have administrative costs as low as 3% of the total contribution revenues.

- The big pool or single payer will create *purchasing power relative to health care providers* that in the end will push health care costs down. The pooling of all funds allows redistribution of health care providers across geographic areas in a more equitable way.

3.3.2. Allocation of NHI resources

The resources pooled in the NHI fund (from general tax revenue allocations and dedicated tax / mandatory contributions) would be transferred to lower level organisations (e.g. provincial and district health authorities) that are responsible for purchasing health services for the NHI. This would be done on an equitable basis so that each purchasing organisation has adequate funds to meet the health care needs of the population that it serves.

It is necessary to reconsider the allocation of health care funds from national to provincial level via the current 'equitable shares' and conditional grants mechanisms. A proposal for the allocation of resources from the NHI fund to individual purchasing organisations according to their relative health care needs (e.g. size of population, age and sex composition of the population and levels of ill-health) is currently being developed.

A separate mechanism for allocating capital funds under the NHI must also be developed. The objective will be to redress historical inequities in the availability of health infrastructure and ensure that all are able to physically access the services to which they are entitled under the NHI.

CHAPTER 4: HEALTH SECTOR BUDGETING AND FUNDING FLOWS

4.1. Introduction

Funding for the South African public health system relies almost entirely on tax generated revenues, with some direct contributions from employers, households and donors. The total public health sector budget for 2007/2008 was an estimated R58 billion, translating into a per capita estimate of around R1, 400. Over the past ten years, the real per capita spending in the public health sector has risen steadily but still falls significantly below the private sector levels.

The private health sector is funded primarily from voluntary contributions. According to the Council for Medical Schemes, there were 122 medical schemes in 2007 with a total membership of 7 478 040 (principal members and beneficiaries). The total healthcare expenditure within the private sector during the 2007/2008 financial year was R64.7 billion (compared to R57.6 billion in the previous financial year). This translates into a per beneficiary per capita expenditure rate of around R8, 700.

Therefore, a total of about R122 billion was spent on the South African national health system in the 2007/2008 financial year, with an estimated 53 percent being spent in the private sector on approximately 7.5 million lives compared to 47 percent in the public system on 42 million lives.

The ability of the public system to effectively deliver care is always hampered by the limited availability of financial, infrastructural and human resources. In many countries around the world with a national health insurance system, particularly Scandinavian countries (e.g. Sweden, The Netherlands, and Belgium) and some Asian and Latin American countries (e.g. Taiwan, Thailand and Cuba) health systems are primarily funded through general tax revenues and some form of mandatory contribution. General tax revenues form a reliable source of funding which helps to ensure that services can be sustainably delivered to the national population over a given time period. Therefore, within the South African context, any move towards a national health insurance system would have to be financed through significant tax revenues with complementary mandatory contributions imposed primarily for those who are employed and earn above a given tax threshold.

4.2. Fiscal Federalism

By definition, fiscal federalism is concerned with "understanding which functions and instruments are best centralised and which are best placed in the sphere of decentralized levels of government" (Oates, 1999)[2]. It relates to the study of trying to understand how competencies (expenditure side) and fiscal instruments (revenue side) are allocated across different (vertical) layers of the administration. An important component of fiscal federalism is the system of transfer payments or grants by which a central government shares its revenues with lower levels of government.

In the South African health system fiscal federalism is enshrined in the Constitution. The National Department of Health makes two primary types of transfers to lower spheres of government namely, conditional (e.g. National Tertiary Services Grant) and unconditional (i.e. equitable share allocations). The principle behind the fiscal federalist system in South Africa is that the National level is primarily responsible for policy making and overall stewardship of the system while the Provincial and Local governments are more responsible for operationalising national policy.

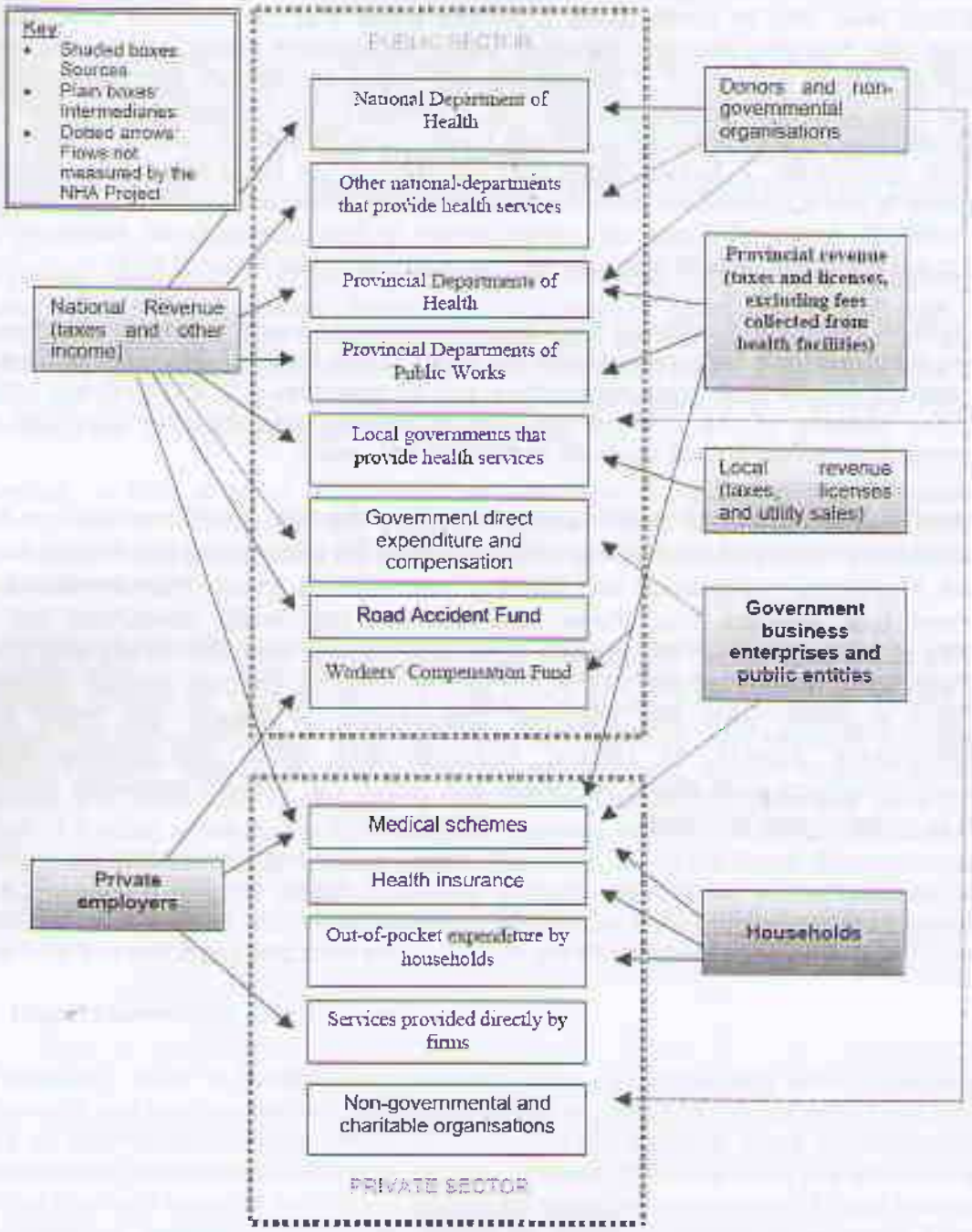
[2] Oates, W.E. 1999. 'An Essay on Fiscal federalism'. Journal of economic Literature, 37(3):1120-49 JSTOR

However, despite this division of responsibilities there are some paramount challenges to the system. While the National Department of Health is held accountable for the achievements and failures within the health system, implementation of many policies is not the preserve of the National level and in some cases provinces argue that the National level has no jurisdiction over how they allocate resources within the equitable share. Additionally, some provinces engage in some form of 'budget gaming' – they intentionally allocate conditional funds for non-conditional purposes with the knowledge that national government will automatically intervene by providing additional funds to ensure that the national priorities are adequately catered for. A further matter that complicates the fiscal federalism system in South Africa is that it significantly relies on the principle of cooperative governance. Because of this principle, some provinces can simply revert to their Constitutional autonomy and choose to act against a national mandate with no recourse for the National level.

Within the NHI system, the matter of fiscal federalism would have to be carefully addressed to ensure that there is a balance between the ability of the National and lower spheres of government to ensure that strategic priorities and programmes are implemented without eroding the capacity of the PHAs and DHAs to develop and implement policies and programmes most suited to their contexts and population needs.

The National Department of Health and assisted by the NHI Fund must always take the lead in the process of developing new strategies for addressing key health sector priorities. Resource mobilisation and funding mechanisms should then be structured in manner that ensures that these priorities are sufficiently resourced for the outcomes to be achieved in the agreed upon timeframes. Both the PHAs and DHAs will be expected to provide the NHI Fund with sufficiently justified budget requests. The Fund together with the National Department of Health will then have comprehensively assess all budget requests and make adjustments where necessary to ensure that these requests are within the fiscal framework and are aligned to government priorities.

4.3. Funding Flows in the South African Health System[3]



Fiscal federalism is the basis upon which resources are allocated from the National government to the sub-national spheres in the South African health system. The figure above shows that funding for the public health system is primarily divided into the three spheres of government: National, Provincial and Local. In the current national health system there are nine (9) Provincial Departments of Health, with 52 demarcated District Health Authorities and 263 sub-districts.

[3] South African Health Review, 2002, Chapter 2

4.5. Health Sector Budgeting Process

The South African constitution assigns roles and responsibilities to the different spheres of government and these are translated into practice through the Medium Term Expenditure Framework (MTEF) process and the rigorous accountability provisions of the Public Finance Management Act (PFMA). Despite this, sorting out national and provincial roles and responsibilities and identifying who is accountable for what should be an ongoing process that evolves around ensuring effective mechanisms are developed for the best resource allocation mechanism.

The allocation of roles and responsibilities across the spheres of government is complicated by a number of factors: firstly, the constitution requires the equitable division of nationally collected revenues between national, provincial and local government; and secondly, it assigns joint or concurrent responsibilities for a number of important functions to the national and provincial spheres. While there has been progress in clarifying these roles, more still needs to be done.

Within an NHI system in South Africa two key overriding factors must be kept in mind when deciding on the budgeting process namely:

The Constitution says:

The Constitution of the Republic of South Africa, 1996, requires an Act of Parliament to provide for—

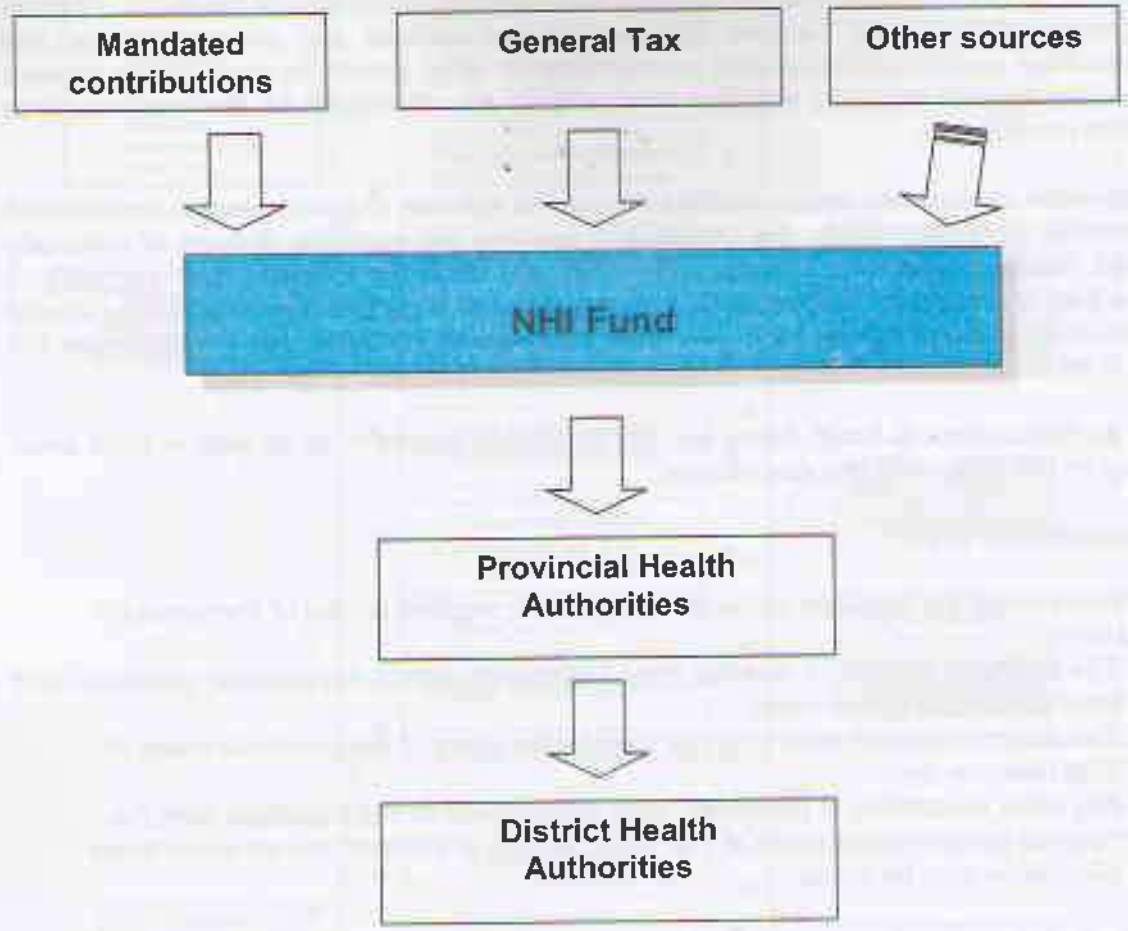
(a) The equitable division of revenue raised nationally among the national, provincial and local spheres of government;
(b) The determination of each province's equitable share of the provincial share of That revenue; and
(c) Any other allocations to provinces, local government or municipalities from the national government's share of that revenue, and any conditions on which those allocations may be made.

Additionally, the national, provincial and municipal budgets and budgetary processes must promote transparency, accountability and the effective financial management of the economy, debt and the public sector. **(Section 215)**

The constitutional imperatives for the state to give everyone a right to health care and an environment that is not harmful as discussed in Chapter 2 (**sections 24, 27 and 28** of the Constitution of the Republic of South Africa have to be addressed.

The implication of these factors is that appropriate and effective resource allocation mechanisms must be adopted to ensure that resources are properly aligned to meeting the needs of the people across the 9 geographical regions of the country. The NHI Fund will be the receiving end of the revenues that are collected by the National Treasury (via the South African Revenue Service) in the form of general taxation and mandated NHI contributions. Additional sources of funds will also be pooled from other sources such as donors and NGOs. It is important to note here that appropriate and national policy aligned mechanisms will have to be in place to ensure that funding that comes from external sources (i.e. bilateral and multilateral organisations) will have to form part of the funding that is intended to finance national, provincial and district priorities and programmes. The option that could be considered here could be that of "basket funding" – a concept that refers to the process where external stakeholders are allowed the opportunity to participate in determining healthcare priorities for funding if they agree to make their funding revenue part of the basket of funds intended to finance health service delivery. This is depicted in the figure below.

PROPOSED FUNDING FLOWS FOR THE NATIONAL, PROVINCIAL AND DISTRICT HEALTH AUTHORITIES



The critical aspect of this whole process is that there must be adequate capacity at the National, Provincial and District level to collect relevant population and related information which will be used in the budgeting and resource allocation process. DHAs will regularly collect information from their target populations and this information will have to be systematically collated to create a database that clearly indicates the risk profile of the each respective DHA's population. This population database will then be used in a needs-based resource allocation process (i.e. resource allocation based on the population risk profiles of the 52 DHAs) developed at the National level to ensure an equitable allocation of the pooled funds.

According to the provisions of the Division of Revenue Act No. 1 of 2007 (DORA), equitable share allocations of financial resources must be undertaken by the National Treasury for all spheres of government. The DORA also provides for the action that National Treasury should take in instances of shortfalls and excess revenue. The responsibility for deciding how much of the allocated equitable share will be spent on health in each province is purely that of the Provincial administration. This is a matter that has to be changed within an NHI system that is primarily based on developing a single-funder environment that is capable of reaping the economies of scale of a centralised purse. This implies that allocations for health will no longer have to go into the National Revenue Fund that is managed by National Treasury. Instead, allocations for health will have to go straight into the NHI Fund via the

National Treasury. All revenues collected by SARS as a mandatory contribution will be earmarked and allocated straight to the NHI Fund. Additional provisions to these allocations will have to be made to ensure that sufficient resources are available for infrastructural development and maintenance.

The NHI Fund will be responsible for making disbursement of funds to the PHAs and DHAs using the Risk-Adjusted Capitated Global Budget approach. The risk adjustment factors to be used in the allocation formula could include components like regional age distribution, gender profile, specified disease categories (i.e. HIV & AIDS, TB prevalence). Appropriate mechanisms will have to be developed and implemented to address some of the potential challenges that could emanate from adopting this mechanism e.g. district health authorities could start to refer patients to other regions to ensure that there resources remain intact. A key approach here would be to ensure that districts with high levels of cross-border patient movements are sufficiently compensated for the budget spent on such patients.

This matter is also important to consider in respect of portability of services for the covered members. Clearly it must be envisaged that members will not always access services only in the districts in which they are registered. To ensure effective portability of member entitlements, mechanisms for reimbursements across districts must be carefully developed. That is, DHAs must be able to recover funds from other each other for services rendered to members. There must be clearly stipulated rules indicating the rates at which these reimbursements should occur and the timeframe within which they should be effected.

An equally important matter that has to be considered carefully is the transition of the funding arrangements from the current 'multiple funder system' that includes the three spheres of government and the current medical schemes as financing intermediaries to the approved policy proposal of 'a single funder NHI system'. In practical terms, it is vital to plan for an intermediate phase in which there will be multiple funds disbursing resources to the PHAs and the DHAs. Within this environment the State (through the NHI Fund) will be the main source of funds for the system.

4.6. Allocation of funds between accredited and non-accredited providers

The NHI Fund will be responsible for making all annual funding disbursements to the PHAs and DHAs. In addition, the PHAs and DHAs will then reallocate these resources to the public and private accredited providers within their catchment population on needs-based resource allocation formulae. This will help ensure that equitable shares are allocated to the various provinces and districts.

As for the non-accredited public providers, the allocation of resources to these facilities will have to be retained at the National level. This is primarily to ensure that sufficient effort is directed at mobilizing the necessary additional resources needed for the facilities to attain accreditation in the shortest possible time. Alternatively, the PHAs and DHAs can retain control of allocating budgets to the non-accredited public providers while at the same time ensuring that these facilities are given sufficient support and resources so that they improved and achieve accreditation in the shortest possible time. Whatever mechanism is chosen as the most appropriate approach, strong linkages to the NHI Fund will have to be retained to ensure that once a facility achieves accreditation there is a smooth transition in the funding arrangements from National to NHI Fund.

With respect to the non-accredited private sector providers, the NHI Fund will not be obliged to provide any financial and/or related resources to ensure that they achieve accreditation in the shortest possible. This will be the sole responsibility of the private providers and the NHI Fund cannot enter into any contractual arrangements with these providers until full accreditation is achieved. These providers will, however, be in the position to charge for their

services on a fee-for-service basis (i.e. out-of-pocket and reimbursement from medical schemes).

CHAPTER 5: PROVIDER PAYMENT MECHANISMS FOR SERVICE PROVIDERS

5.1 BROAD OVERVIEW OF MECHANISMS

Provider payment mechanisms refer to the way in which funds are transferred from a purchaser to a health care provider. Through arrangements between providers and purchasers, such as incentives and risk sharing, payment mechanisms can bring a provider's behaviour more into line with the objectives of the purchaser. Payments are made either to an individual provider or to a health care facility, and in either case can be prospective, i.e. determined and/or made in advance, or retrospective, i.e. made after the service has been provided. The main forms of provider payment mechanism are as follows:

- To individual providers
    - salary: determined prospectively, paid retrospectively
    - fee for service: determined prospectively, paid retrospectively
    - capitation (i.e. a flat payment per person covered, who is then entitled to use all services covered in the benefit package offered by that provider): determined prospectively, paid prospectively
- To facilities
    - budget allocations: determined prospectively, paid prospectively
    - fee for service: determined prospectively, paid retrospectively
    - per diem (a flat payment per day of hospitalization): determined prospectively, paid retrospectively
    - case-based fee (a flat payment per treatment package, such as for normal childbirth services), sometimes adjusted for risk factors, such as age and co-morbidities (such as in Diagnosis Related Groups – DRGs): determined prospectively, paid retrospectively

Table 5.1 below summarizes the advantages and disadvantages of each of these payment mechanisms and suggests strategies to minimize the disadvantages. The most effective way of maximizing positive incentives and minimizing perverse incentives (incentives that have unforeseen, unintended, and/or adverse effects) is to use a mix of payment mechanisms

The more fragmented a health care financing system and the greater the number of independent purchasers, the more difficult it is to exert pressure on providers to contain costs. If there are only one or two large purchasers, they can use their combined purchasing power to negotiate lower fees with providers and to impose global caps on reimbursement claims (Normand & Weber, 1994). With a large number of small purchasers, providers can simply refuse to provide services to beneficiaries of purchasers who attempt to limit their profit margins and income levels. Alternatively, fee levels can be fixed by government regulation, but this may not necessarily limit practices such as over-servicing

Table 5.1: Advantages and disadvantages of different provider payment mechanisms

Payment mechanism	*Advantages*	*Disadvantages*	*Ways of minimizing disadvantages*
Salary	Predictable expenditure Low administrative costs	Possible under-provision and/or poor quality of care Little incentive for efficient behaviour and productivity unless linked to performance	Peer review of provider practices Link part of payment to performance
Capitation	Incentive for technical efficiency and preventive care Administration costs reasonably low	Incentive for under-service Possible cream-skimming (attracting low-risk patients) Possible cost shifting (referral to another provider)	Adjust payments to risk Monitoring and peer review of provider practices (including referral patterns) Patient choice of provider
Fee for service	Incentive for technical efficiency (where fee schedules are fixed)	Incentive for overprovision and cost escalation High administrative costs	Global caps and/or adjusting fee to keep within resource limits
Budget allocation	Predictable expenditure and tight control Low administrative costs	Limited direct incentives for efficiency unless linked to performance Can lead to under servicing and cost shifting	Link part of payment to performance Monitoring and peer review
Per diem	Some incentive for technical efficiency	Incentive to extend length of stay and/or increase number of admissions	Global caps/budget limits Lower fees for longer stays
Case-based (includes diagnosis related group payments)	Strong incentive for efficient operation	Unpredictable expenditure Relatively high administrative costs Incentive for cream-skimming	Adjust for case mix, i.e. by grouping people according to their use of resources

Reproduced from: (McIntyre, 2007); **Sources of information:** (Carrin & Hanvoravongchai, 2002; Kutzin, 2001)

5.2 OPTIONS FOR SOUTH AFRICA'S National Health Insurance

A distinction needs to be made between the proposed provider payment mechanisms for recurrent costs and infrastructural maintenance and development. The following sections describe payment arrangements for recurrent cost. Funding for infrastructure will remain a national and provincial responsibility through agreed annual budgets.

5.2.1 Objectives for provider payment mechanisms for SA NHI

The specific provider payment mechanism(s) adopted for the SA NHI should facilitate achieving the following objectives:

- To promote positive behaviour by health care providers (e.g. providing quality health care; adhering to treatment protocols; providing preventive and promotive services in addition to curative care; providing services efficiently);

- To discourage undesirable behaviour by health care providers (e.g. cream-skimming low-risk patients and refusing to treat high-risk patients; over-servicing or under-servicing of patients; and cost-shifting);
- To contain costs (administrative and health care) in the health system; and
- To promote predictability of revenue of existing health care providers (during the transition period) and predictability of total NHI expenditure.

Before considering alternative provider payment mechanisms for different types of service providers, it is important to note that fee-for-service as the primary provider payment mechanism would be the least desirable option to achieve these objectives (see Table 5.1). Within a commercial environment, it is standard practice to 'unbundle' services and pay for each service separately. It involves health care providers receiving a fee for each service such as an office visit, test, procedure, or other health care service. Fee for service offers rewards for seeing more patients, generating more services and upcoding procedures and diagnoses. Fee for service financing encourages providers to increase their income by providing unnecessary or redundant services.

The main disadvantage of fee-for service is that there are no deterrents to how many services are rendered. However, fee-for-service payments could be used in a limited way to complement other provider payment mechanisms which should predominate. For instance, for services not covered under the NHI package of services.

5.2.2 Provider payments to PHC providers

The proposed main reimbursement mechanism for accredited PHC providers in the NHI is that of capitation. Capitation is a fixed payment (usually per month) made to a PHC provider for each person registered to receive services from that provider. Cost containment is the principal motivation for implementing capitation in this instance. The capitation payment will be risk-adjusted, to take account of age and gender (a higher capitation for very young children and the elderly and possibly women of childbearing age). A 'cap' will be placed on capitation payments to each provider, mainly to ensure that each provider does not take on too many patients and then under-serve them. The cap can be expressed in terms of the total number of patients that a provider can have on their 'books' (e.g. 2,000 patients per general practitioner), and/or in terms of the total capitation payment they can receive.

The key challenges with adopting a capitation approach in South Africa are:

- Enormous administrative effort will be required - the entire population will have to register with a health facility and must be phased in over the implementation period of NHI (which will take considerable time and will require extensive public education);
- Strong mechanisms for the review of PHC provider practices need to be established (particularly to ensure that there is not excessive referrals and to avoid under-servicing); and
- Given that public sector PHC facilities are currently funded via budgets, a rapid move to capitation funding could seriously destabilise these facilities

At least for the foreseeable future, public sector PHC providers should continue to be funded via budgets until they are capacitated and NHI accredited. It should be recognised that budgets can be equated with a crude capitation payment approach, e.g. if there is only one PHC provider in a particular area, the budget can be set on the basis of the size of the population they serve and through applying the agreed capitation rate. If there are two accredited PHC providers in an area, one public and one private; the private provider will be paid on a 'pure' capitation basis (based on the number of patients registered with them)

while the public provider could initially be given a budget linked to capitation rates (total population in area less those registered with the private provider and apply the capitation rate). This could gradually be phased into a universal capitation approach for PHC services.

Careful attention needs to be paid to service provision arrangements for PHC services. In particular, the respective roles of public and private PHC providers must be considered and there must be a clear plan for how to reduce service differentials between the two sectors as rapidly as possible. Standards must be maintained in both public and private sector facilities and considerable effort should be devoted to improving public PHC facilities, particularly in relation to staffing levels, including through approaches such as sessional appointments with private GPs if inadequate numbers of salaried doctors can be attracted to work in public PHC facilities. If this does not occur, there is the risk that higher income groups will all immediately register with accredited private PHC providers and poorer groups will have to rely on currently under-staffed public sector PHC services. The strategic preference is to try and accredit public providers first and then look for private alternatives where public facilities worthy of accreditation may not immediately exist.

Payment arrangements will also have to be made to compensate PHC providers when a patient uses a provider with whom they are not registered (e.g. if they fall ill while travelling). This is necessary to ensure portability of benefits. While it may be necessary to pay for this on a fee-for-service basis, again caps should be placed the total value of fee-for-service payments per provider. In addition, careful public education of the need to use the provider with whom they are registered except under very specific conditions (patients should be able to move their registration to another provider if they are dissatisfied with their current provider, but this should generally only be allowed once a year).

5.2.3 Provider payments for hospital care

Universal health systems most frequently either use budgets or case-based (e.g. DRGs) reimbursement mechanisms. Diagnosis Related Groups (DRGs) are a classification system that groups patients according to their clinical characteristics and the consumption of resources required for their treatment. It classifies hospital cases who have a similar hospital resource use, and who are expected to use the same level of hospital resources (sometimes called iso-resource use groups). This simplifies the complexity of patient specific diagnoses by grouping similar diagnostic categories into clinically meaningful diagnostic clusters where resource use is also similar. This approach reduces the transaction costs of third party payment, and gives providers the incentives to provide care more efficiently because reimbursement is determined by the level of patient need, not the service intensity provided. The DRG system is developed as a part of the prospective payment system and is assigned by a grouper programme on ICD diagnoses, procedures, age, sex, and the presence of complications. Once again, considerable administrative capacity will be needed to effectively introduce case-based payments, the extent of which should not be underestimated. Part of the accreditation process will involve assessing hospital capacity to operate on the basis of DRGs and therefore what is required to improve the required capacity.

A global budget is a reimbursement mechanism used to reimburse providers for a range of health care services. It involves providing budget amounts determined prospectively and paid prospectively. Global budgets are best used with a large number of covered lives in order to spread risk. It is advisable that budgets continue to be the primary provider payment mechanism for public sector hospitals for the foreseeable future, particularly given the importance of restoring public hospitals to being the provider of choice for the majority of South Africans. A similar approach could be adopted for hospital care as for PHC, in that accredited private hospitals could be reimbursed on a case-based payment basis and public hospitals provided with budgets until such time as all payments can be made through means of case-based payments. It is important that the mechanism for reimbursing shareholder

hospital groups be supported by specific conditions such as annual reimbursement caps and zero tolerance to differential treatment between NHI and fee paying private patients.

An alternative approach is to explore the option of paying an all inclusive capitation fee to 'gatekeeper' PHC providers. These PHC providers then cover the costs of all specialists to which they refer a patient and for inpatient care. This could either take the form of the 'GP fund-holding' model adopted in the UK NHS, or the approach adopted in Thailand, where capitation payments are made to hospitals, with the hospital OPD providing PHC and specialist care as well as inpatient care.

The issue of how to pay specialists and allied professionals will require careful consideration. In the case of public hospitals, those in full-time employment would be paid on a salaried basis while those in part-time employment would be paid on a sessional basis. Capitation to primary care providers may also include cover for specialist clinical investigations such as pathology and radiology, which are some of the key cost drivers and cost containment will be the principal motivation for implementing capitation in these instances. Institutions such as the NHLS and accredited private sector laboratory services will be reimbursed at an agreed fee. The key issue that needs further consideration is how to draw on the specialist resources that are located in the private sector.

5.3 Pricing and Negotiation Mechanisms

The NHIA will set capitation levels and prices for reimbursement of both public and private providers. The prices and capitation levels will be negotiated nationally in accordance with the NHA and once agreed these will be used by all NHI accredited facilities in the country. What is critical is that prices and capitation levels set do not support profiteering and hence allow for cost containment and quality improvements.

In summary, the proposal is that accredited PHC facilities be reimbursed on a per capita basis (otherwise continue receiving budgets), hospitals continue to receive budgets unless accredited in which case they will be reimbursed on a case-based (or DRG) system, public doctors and specialists be salaried where possible otherwise private specialists and other allied professionals be paid on per case basis with caps. Fee-for service payments with caps in exceptional circumstances related to portability of services and voluntary private sector utilisations

CHAPTER 6:

ESTABLISHMENT DISTRICT HEALTH COUNCILS

6.1 Establishment of District Health Council structures in line with the new National Health Act (2004)

One of the major requirements of the National Health Insurance is the creation of functioning structures at a District level and local government level for health service delivery. The National Health Act (2004) has mandated the establishment of District Health Councils. This chapter addresses its establishment as well as challenges currently experienced with the district health system. It ends with plans for addressing these challenges.

6.1.1 Background and Context

The Alma Ata declaration on Primary Health Care (PHC) in 1978[4] and the World Health Organisation's[5] definition of a district health system provided the international context for health sector transformation in South Africa. In South Africa a White Paper for the Transformation of the Health System was published in 1997[6]. This White Paper set the framework for establishing a District Health System (DHS) and formed the basis for the National Health Act of 2004[7] (the Act).

The Act provides for the establishment of district health councils (DHC) whose boundaries coincide with the administrative structures of local government viz the six metropolitan and 46 district municipalities. The principles of the DHS are:

- overcoming fragmentation
- equity
- comprehensive services
- effectiveness
- efficiency
- quality
- access to services
- local accountability
- community participation
- developmental and intersectoral approach
- sustainability

In terms of the Act the Member of the Executive Council (MEC) for Health in each province must establish a DHC in each district under the chair of a person nominated by the relevant metropolitan or district municipality. These DHCs must promote cooperative governance, ensure that there is coordination of planning, budgeting, provisioning and monitoring of all health services in the health district and advise the MEC for health and the municipality on any health matter

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[4] Declaration of Alma Ata. International conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978

[5] Tarimo E. Towards a healthy district. Organising and managing district health systems based on primary health care. World Health Organisation, Geneva. 1991

[6] Department of Health. White paper for the transformation of the health system in South Africa, 1997. Notice 667 of 1997 in the Government Gazette no 17910

[7] National Health Act of 2004. Act 61 of 2003. Government Gazette Vol. 469, No. 26595. Cape Town 23 July 2004

Provincial legislation is required to provide for the functioning of the DHCs, the approval of the budget and setting performance targets for health services in the district.

The MEC for Health is required to ensure that districts are adequately managed while the municipality is required to ensure that municipal health services (a range of environmental health services) are effectively provided throughout the health district.

On an annual basis the health manager of the district must draw up a district health plan (in line with national and provincial health priorities and the integrated development plan of the municipality) which also contains a human resource plan for the district. The Minister and the MECs, together with the relevant District Health Manager discuss the plan. Once agreed upon the Minister will discuss the plan with the National Health Insurance Authority with a view to get it funded.

6.1.2 Key problems related to the DHS

6.1.2.1 Political governance, oversight and accountability

By the end of September 2008, no provinces had finalised legislation required by the Act although KwaZulu-Natal had published a draft health care bill for comment.[8] As a result the envisaged political accountability measures are not in place and the associated governance and oversight functions are consequently neglected. In many districts the district plans and budgets are not aligned with the provincial plans and targets are not monitored adequately.

The management structures of districts vary widely. Recent research highlights the fact that there is widespread lack of standardisation of the district management teams (DMTs) with regards to district organogrammes, job descriptions, roles and responsibilities, accountability and communication with provinces and relationships between DMTs and district hospitals.[9]

The districts vary in size from servicing a population of 50,000 in the large sparsely populated Northern Cape to servicing nearly four million people in the metropolitan municipalities. The management structures, roles and responsibilities in sub-districts are not uniform and vary considerably from district to district.

6.1.2.2 Integration

One of the principles of the Act is that fragmentation should be overcome. In August 2005 the National Health Council resolved that the fragmentation between local government and provincial health departments should be reduced through the consolidation of all health services (personal PHC)[10] into provincial structures that absorb municipal services and staff. Although this has happened in many provinces, at the time of writing there is still duplication of structures in the six metropolitan municipalities and many district municipalities in the Eastern Cape, Mpumalanga and

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[8] Hassim A, Heywood M, Honermann B. AIDS Law Project. The National Health Act 61 of 2003 – A Guide. Siber Ink 2008.

[9] Health Systems Trust. Review of structures, competencies and training interventions to strengthen district management in the national health system of South Africa. January 2009. In Press.

[10] The term personal PHC is meant to denote individual health care services. These include preventive, promotive, curative and rehabilitative services. In contrast non-personal PHC services include such things as environmental health services (e.g. water and air pollution).

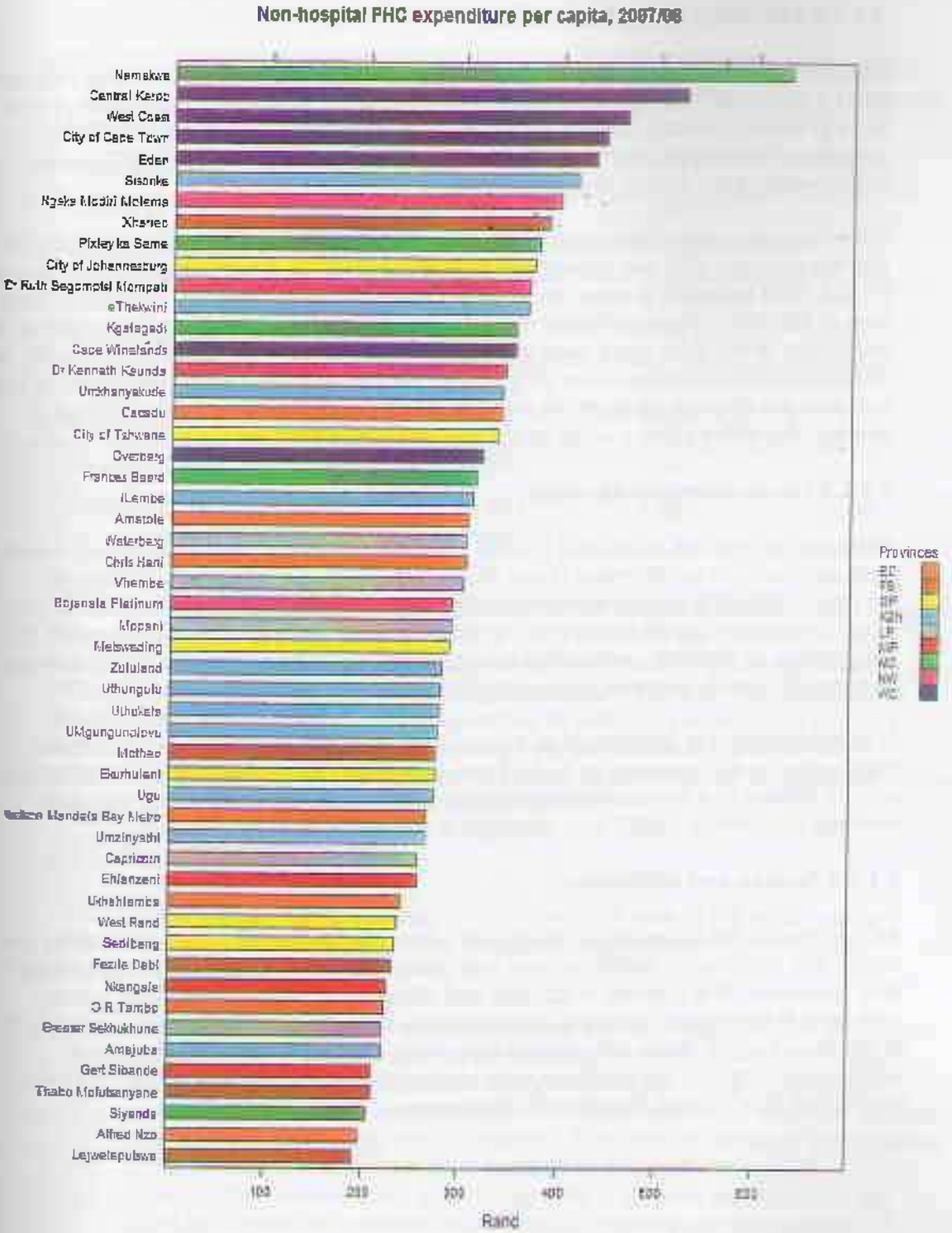
KwaZulu-Natal still deliver personal PHC. The Western Cape offers an example of successful phased implementation of the DHS in district municipalities.[11]

6.1.2.3 Equity

Although there has been much improvement in equity of resource allocation there is still a great deal of disparity. The figure below illustrates the per capita expenditure in 2007/08 by district. This ranges from the lowest per capita expenditure (PCE) of R191 per capita in Lejweleputswa in the Free State to the highest, R633, in Namakwa in the Northern Cape. The 3.3 fold difference between the district with the highest PCE and the district with the lowest PCE in South Africa is unchanged from 2006/07, although there has been a decrease from the 3.5 fold difference in 2005/06 and a large decrease from the nine-fold difference in 2001[12].

[11] Barron P. The Phased Implementation of the District Health System in the Western Cape Province - A case Study. Department of Health. Western Cape. 2008.
[12] Monticelli F, Day C, Barron P, Seoc E. The district health barometer 2007/08. Health Systems Trust in Press.

Figure 1; Non-hospital PHC expenditure per capita 2007/08



6.1.2.4 Efficiency and effectiveness

The DHS varies considerably in its effectiveness from district to district. For example the TB cure rate[13] ranges from districts in the Western Cape with cure rates above 80% to those in KwaZulu-Natal with cure rates of less than 40%.[14] Similarly the success of the prevention of mother to child transmission (PMTCT) of HIV varies considerably from district to district.

There are also wide differences in efficiency. An analysis of district hospitals shows that the average cost per patient day equivalent (PDE) in South Africa in 2007/8 was R1128. This conceals a wide range from a low of R744 in Chris Hani district (EC) to a high of R2 363 in Frances Baard district (NC). Even allowing for some deficiencies in the quality of the data there were wide intra-provincial differences among districts. As district hospitals consume over 40% of total district resources the wide ranges in this indicator are of great concern. At the high end it may indicate lack of efficiency or leakage out of the system while at the low end it may indicate poor quality of care.

6.1.2.5 Comprehensive services

Although districts are supposed to offer a comprehensive package of primary health care services[15] in reality many (if not most) districts do not offer the full range of services. Rationing occurs either explicitly, where services are not offered at all (e.g many community health centres do not do either medical or surgical termination of pregnancy), or implicitly, where the service is offered but not done comprehensively (e.g. mental health services, screening for cervical cancer).

In addition since the publication of this package in 2001, additional services have been added to the package (e.g. ART for people with AIDS; PMTCT services) which are not offered in a comprehensive way throughout the district facilities. The new package for primary health care package is comprehensive (see Chapter 8).

6.1.2.6 Access and utilisation

As is shown in the table below, the public sector DHS contains over 3 000 clinics and nearly 300 community health centres and district hospitals scattered throughout the nine provinces. The number of doctors and other professionals working at primary care level in the private sector is not accurately known and is discussed in section 12 of this report which deals with human resources. Generally there is reasonable access to clinics with the great majority of the population living within five kms of a facility and much closer than this in urban areas.

[13] The TB cure rate is used as marker of the effectiveness of the TB control progamme and measures the proportion of people who have infectious TB who are cured of this disease and is based on six months antibiotic treatment supported by objective laboratory diagnosis.
[14] Monticelli F, Day C, Barron P, Sello E. The district health barometer 2007/08. Health Systems Trust in Press.
[15] Department of Health. A comprehensive primary health care service package for South Africa. September 2001.

Table I: Numbers of primary level facilities by province

	Clinics	CHCs	Mobile Services	District Hospitals
Eastern Cape	683	32	140	61
Free State	231	35	112	25
Gauteng	307	33	50	9
KwaZulu-Natal	547	15	153	40
Limpopo	411	27	128	33
Mpumalanga	231	36	76	23
Northern Cape	118	20	32	24
North West	286	51	94	19
Western Cape	263	64	98	35
South Africa	3077	313	883	269

There has been little change in the utilisation rate of first level services over the past four years and it has fluctuated between 2.1 and 2.3 visits per person per year. This refers to people who are dependent on the public sector and generally refers to the 85% of the population who do not belong to medical schemes. This utilisation is thought to be well below the optimum number of visits for primary care which is estimated to be at least 3.5 visits per person per year. This is indicative of considerable unmet need for health services and has substantial implications for the planning of service delivery in a DHS under the NHI.

6.1.2.7 Quality of care

There are numerous reports relating to poor quality of care in the public sector primary care facilities. This quote from the 2006 South African Health review illustrates the problem:

> *"In addition to the type of service received and the quality of that particular service, there are also issues of communication and interaction between patient and provider.... Although many studies report that patients are generally satisfied with the quality of ANC [antenatal care] services, the same studies show that quality was a problem. This may be because expectations of service are generally low. At a national level, quality of care in contraceptive services has shown that 20% of women reported that the provider shouted or scolded the patient in the family planning setting."*[16]

Countrywide less than half of all clinics and CHCs received a satisfactory supervisory visit on a monthly basis in 2007/08. Supportive supervision is one of the critical factors contributing to continuous improvement in the quality of care.

[16] Beksinka M, Mullick S, Kunene B. Maternal Care: Antenatal, peri and postnatal. In Ijumba P and Padarath A editors. South African Health Review 2006. Durban: Health Systems Trust; 2006.

The private sector is not immune to quality of care issues. If brought into the DHS, private sector practitioners would have to undergo massive training in order for them to cope with standardised protocols for the management of illnesses, including the infectious diseases of TB and sexually transmitted infections including HIV.

6.1.2.8 Local accountability and community participation

The Act (section 42) requires provincial legislation to establish committees for clinics and CHCs. However, this section of the Act had by September 2008 not been proclaimed by the President nor had provincial legislation been passed. Therefore these committees, which are meant to include community representatives, have not been established in the manner intended.[17] It is important that the Act be proclaimed as soon as possible to make it possible for the National Health Insurance is established.

Under Section 41 of the Act the MEC must appoint a representative board for each district hospital and must prescribe the functions of such boards and the the procedure for meetings. Included in the board must be community representatives. Although no definitive research is available it is thought that in most instances these hospital boards are not working as envisaged in the Act.

6.1.2.9 Developmental and intersectoral approach

In most health districts, district health plans are drawn up largely by the district health managers employed in the provincial health departments. They are thus not integrated with the integrated development plans (IDPs) of local government municipalities.

There are few concrete examples where line departments work well together and with each other synergistically so that there is an intersectoral approach in tackling developmental issues. As many of the major issues facing the health sector in South Africa (e.g. HIV, TB, homicide, violence, motor vehicle accidents) have their roots outside the health sector it is imperative that an intersectoral approach be adopted to tackle the social and economic determinants of health.

6.1.2.10 Limited managerial capacity

In addition to the issues related to the principles of the DHS there are a range of other issues. These include challenges related to management and lack of management capacity to deal with the complexities of the DHS; issues related to HR including demotivation of staff; high turnover and attrition rates; overall shortage of certain categories of staff; lack of use of data for monitoring and evaluation and therefore for decision making. Ad hoc, unco-ordinated management and decision making by national and provincial health departments add to the difficulties of running the DHS optimally.

6.2 Priorities for investment in administrative and management capacity of DHCs.

The issues raised in the preceding section all need to be systematically and methodically dealt with. Strategies for doing this would include:

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[17] Hassim A, Heywood M, Honermann B. AIDS Law Project. The National Health Act 61 of 2003 – A Guide. Siber Ink 2008. Page 63.

- Section 5 of the Act (dealing with the DHS) needs to be legislated for at provincial level and implemented. Alternatively the Act needs to be amended to fit in with the priorities and policies of the NHI.

- There needs to be a political decision about the integration of personal PHC, especially in the metropolitan municipalities, and local and provincial health departments need to be merged.

- District management team structures need to be reviewed. There needs to be clarity of role, function, responsibility, accountability and communication. There needs to be standardisation throughout the 52 districts with the relationship between the CEOs of hospitals and the DMTs clarified as well as that between the DM and the province. The need for sub-districts and management structures in these also needs to be defined, clarified and standardised.

- It is important that every citizen is treated equitably and fairly. Currently there is a large mismatch between resource allocation and need. Generally the health districts with the best infrastructure and socio-economic circumstances ("least deprived") receive more resources per capita for health care than do those that are "most deprived". Under the National Health Insurance resource allocation per district needs to be first equalised and then progressively allocated according to need based on clear allocation formulae.

- Resources need to be used both effectively and efficiently. Clear norms and standards need to be developed at national level, benchmarked on best performance in the country. There needs to be a system of continuous performance improvement based on individual facilities. Managerial performance at every level needs to be assessed based on objective evidence linked to targets and adherence to norms and standards.

- The depth and breadth of the package of services to be provided in the DHS needs to be clearly and unambiguously defined so that every health provider and every citizen is aware of what services should be provided at what level of care. This applies to the community health worker working at community level through to district hospitals. This package needs to be as broad as possible (i.e. comprehensive) so that out of pocket expenditure is avoided. This matter is partially dealt with in Chapter 8.

- Issues around access to health services need to be looked at on a district by district basis and plans made for improvement to this. It will require different solutions dependent on population density, infrastructure and available transport systems. The utilisation of health services should be used as a benchmark to measure access.

- Utilisation is dependent on quality as well as access. Quality of care should be subject to continuous improvement through a range of initiatives. Included in these are that there should be clear clinical protocols for all conditions; there should be a system of clinical governance with periodic peer review; there should be regular supportive supervision of clinics and CHCs; mortality

and morbidity reviews need to be institutionalised. Patient satisfaction reviews should be independently conducted.

- As much of the improvement in health care is dependent on what happens at the individual and community level, (e.g. risky health behaviour, health seeking behaviour) it is important that the voice of the community is stronger. The role of health committees needs to be institutionalised (in the same way that school governing bodies have been institutionalised). The legislation provided for in the Act needs to be brought into effect.

- Municipalities as developmentally oriented institutions need to be revitalised. For example, a problem such as cholera should not be seen only as a clinical issue for the health services. Environmental services (e.g. water testing) and engineering services (e.g. water provision) should work intersectorally with health services for the well-being of the population

- As provision of health care is a service industry resting on the people working in the DHS, every aspect of human resources planning and management needs to be re-scrutinised and improved, including recruitment, induction, retention, training, supervision, support and career structuring.
- Information management and monitoring and evaluation needs to be given the prominence that it deserves so that there can be speedy review of implementation and remedial steps based on key indicators of performance at every level in the system can be taken swiftly.

6.3 Develop priorities for health services at the local level within the DHS

- There should be an incremental improvement in the delivery of health services over a five year period with a long term strategy to provide the full package of defined services. Clearly each district will be starting from a different baseline with a unique set of problems.

- The priorities initially would be based on the most commonly occurring health problems and for most districts these would include at least the range of HIV services, TB services, maternal and child health services and emergency services. Once these have been satisfactorily sorted, it is likely that many of the systemic problems will also have been sorted out and that incremental improvements in other components of the comprehensive package will come about. Facilities that meet the criteria for accreditation will be included in the National Health Insurance. Those unable to meet the accreditation criteria will be assisted to do so within five years of implementation of the National Health Insurance Plan.

- Incorporation of the private sector to work cooperatively with public sector facilities to deliver comprehensive PHC will need careful consideration and planning. Different models should be piloted and evaluated in different contexts so that there is clear understanding of what works and what doesn't in the South African context before any one model is taken to scale.

6.4. Develop district health plans to be used for financing health services

- Currently district health plans (DHPs) are based on an historical view of service delivery and historical budgets. Under the NHI, it will not be business as usual. DMTs will need a range of support to conceptualise and operationalise their plans so that these reflect the resources required to deliver the full package of services. It is likely that each district will need a roadmap five year plan (similar to a long term transformation plan) which will guide the annual operational/business plan on the way forward for the phased implementation of the NHI.

- This support will include at least finance, human resource and epidemiological input.

CHAPTER 7: REGISTRATION OF THE POPULATION PER DISTRICT AND CATCHMENT AREA

7.1 Introduction

The policy proposal for the National Health Insurance unequivocally states that NHI membership will be compulsory and in order to access NHI services people must be registered and hold an NHI card. Furthermore, it clearly states that accredited providers of the comprehensive package of services will largely be funded on a per capita basis and will thus be responsible for a defined population. Registration of the populations within defined geographical areas, and documentation of all existing private and public health facilities including professional groups such as general practitioners and specialists will be critical to the successful implementation of NHI. This section describes what needs to be done to ensure that potential beneficiaries are registered and linked to accessible health care facilities in their area. This involves three distinct phases: (i) providing a population and facility profile through geo-mapping (ii) defining the catchment population and (iii) assessing the functionality of each facility.

7.2 Defining District Population

The role of the District Health System (DHS) is critical to the delivery of NHI services and therefore the starting point in identifying beneficiary populations is to clearly identify the basic planning/ and administrative demarcations, that is, districts. The NHI refers to the District Health Authorities which are defined in chapter five in the National Health Act under the establishment of the DHS. It stipulates that each health district is required to be coterminous with Local Government (LG) district and metropolitan boundaries. Since interim health districts were established before LG finalized district boundaries in 2001, health districts were not necessarily contiguous with the administrative district boundaries as defined by the Municipal Demarcation Board for LG. Currently, most health districts have been aligned with LG jurisdictions as shown in Table 7.0. What is crucial is that the population profile is known and that the population covered is appropriately calculated.

First, most recent National Census data from STATS SA will be used to depict the national population broken down by province and district. This will provide an overview of potential beneficiaries in the districts, provinces and nationally. Second, in areas where the districts as defined by the census do not coincide with the DoH defined district health authorities, the population covered will be recalculated using enumeration area population figures. The idea is to make sure that correct coverage populations are established for planning purposes (namely, resource and infrastructure planning for NHI) (See Table 7.0)

Table 7.0: Population profile by Province and District

PROVINCE	DISTRICT Local Government	DISTRICT HEALTH	POPULATION 2001 SA citizens	Perm res	2008 Projected
Eastern Cape	Alfred Nzo	Alfred Nzo	390 754	589	
	OR Tambo	OR Tambo	1 674 070	973	
	Ukhahlamba	Ukhahlamba	338 451	1 512	
	Chris Hani	Chris Hani	807 912	826	
	Amathole	Amathole	1 655 398	5 467	
	Cacadu	Cacadu	383 825	2 350	
	Nelson Mandela Metro	Nelson Mandela Metro	992 072	9 233	
	6 districts & 1 metro		**6 263 432**		
Western Cape	Central Karoo	Central Karoo	60 143	158	
	Eden	Eden	446 752	5 275	
	Overberg	Overberg	200 017	2 271	
	Cape Winelands	Cape Winelands (Boland)	623 047	4 469	
	West Coast	West Coast	279 826	2 068	
	City of Cape Metro	City of Cape Town	2 802 991	55 318	
	5 districts & 1 metro		**4 482 355**		
Northern Cape	Frances Baard	Frances Baard	322 557	2 239	
	Siyanda	Siyanda	197 837	3 641	
	Pixley	Karoo	161 807	2 532	
	Namakwa	Namakwa	106 676	1 086	
	Kgalagadi	Kgalagadi	184 117	1 027	
	5 districts		**983 519**		
Free State	Fezile Dabi	Fezile Dabi	453 563	2 820	
	Thabo Mofutsanyane	Thabo Mofutsanyane	717 664	3 012	
	Lejweleputswa	Lejweleputswa	633 673	8 973	
	Motheo	Motheo	717 194	6 044	
	Xhariep	Xhariep	134 171	622	
	5 districts		**2 677 736**		
Gauteng	West Rand	West Rand	486 918	15 958	
	Metsweding	Metsweding	155 705	2 759	
	Sedibeng	Sedibeng	778 793	12 157	
	City of Tshwane Metro	City of Tshwane Metro	1 923 795	36 993	
	City of Jhb Metro	City of Jhb Metro	3 006 154	124 969	
	Ekhuruleni	Ekhuruleni	2 358 453	75 407	
	3 districts & 3 metro's		**8 978 061**		
Mpumalanga	Ehlanzeni	Ehlanzeni	1 374 804	46 223	
	Nkangala	Nkangala	1 006 105	9 108	

	Gert Sibande	Gert Sibande Bushbuckridge	888 343	6 571	
	3 districts	**4 districts**	**3 330 154**		

PROVINCE	DISTRICT Local Government	DISTRICT HEALTH	POPULATION 2001 SA citizens	POPULATION 2001 Perm res.	2007 Projected
Limpopo	Greater Sekhukhune	Sekhukhune	961 841	1 971	
	Waterberg	Waterberg	602 134	5 910	
	Capricorn	Capricorn	1 148 034	3443	
		Bohlabela			
	Vhembe	Vhembe	1 177 939	6 384	
	Mopani	Mopani	1 033 816	12 970	
	5 districts	**6 districts**	**4 954 442**		
North West	Southern	Southern	757 669	15 764	
	Bophirima	Bophirima	429 579	1 915	
	Central	Central	756 816	3 407	
	Bojanala	Bojanala			
	Platinum	Platinum	1 144 178	16 123	
	4 districts		**3 125 451**		
KWA-ZULU NATAL	Sisonke	Sisonke	455 143	728	
	iLembe	iLembe	557 068	2 056	
	Uthungulu	Uthungulu	879 220	3 914	
	Umkhanyakude	Umkhanyakude	570 863	1 243	
	Zululand	Zululand	776 966	1 335	
	Amajuba	Amajuba	465 154	1 718	
	Umzinyathi	Umzinyathi	479 138	640	
	Uthukela	Uthukela	653 740	1 691	
	Umgungundlovu	Umgungundlovu	913 192	9 152	
	Ugu	Ugu	698 354	3 532	
	Ethekwini	Ethekwini	3 032 759	37 813	
	10 districts 1 metro		**9 545 419**		

Source: Municipal Demarcation Board and Dept of Health
Projections for 2007 will be done before plan is finalized

7.3 Establishing a National Database of Health Facilities and Professionals

7.3.1. Health Care Facilities

The main purpose of this exercise is to establish, as far as possible, the existing stock and distribution of health facilities in South Africa both public and private. An understanding of available health facilities in the country will facilitate the implementation of the proposed per capita resource allocation mechanism under NHI to designated and accredited providers. Most importantly, knowing the geographic location of these facilities and the populations they cover is vital information for proper planning of the service delivery model for NHI. An understanding of what facilities exist and where, will amongst other things, inform the accreditation process, alternative contractual arrangements (e.g. having PPP where public

facilities do not exist), infrastructural development and human resource redistribution strategy.

The database will be the first of its kind in that it will attempt to provide a consolidated record of most, if not all, facilities by type and level. These are stipulated by the National Department of Health with definitions provided in appendix 1. The following is an outline of the criteria / data items per district:

- Ownership: public; private (for profit / not-for-profit)
- Level: Primary (ambulatory / referred / day care)
  - Secondary (acute care / step down or sub-acute / chronic care)
  - Tertiary (provincial / national referral / central referral / specialist referrals
- Type: Clinic / satellite clinic / mobile / CHC / General practitioner / specialist consulting / convalescent unit/ rehab unit / hospice etc

Information to construct this facility profile was received from a variety of sources, for example, the Department of Health, Private Hospitals Association (PHA), Department of Social Development (DSD), Board of Health Care Funders BHCF), local municipalities).

Additional information on the type of hospital services and number of beds for private hospitals is also available. Information on general practitioners, group practices, private pharmacies and other allied independent providers and who are registered with the Board of Health Care Funders will be integrated into the data base per district

7.3.2. Health Professionals

In addition to the facility database, a database of all critical professionals starting with doctors, nurses and specialists with details of their physical location (where possible) by district and provinces will be developed. The main objective is to understand the spread of critical human resources and therefore design human resource recruitment and deployment policies and procedures under NHI that will address inequities where they exist. This database of existing human resources is integral to the human resources planning process (See Chapter 12)

Data on public sector professionals will be obtained from the National and Provincial Health Departments, and that of private Specialists will be gleaned from the Health Professional Councils, Board of Health Care Funders, local municipalities, and any other sources identified during the data collection excise.

The concentration ratios and geo-mapping of professionals will be done to show the spread of critical health professionals across the country. This is very important in assessing service availability and most importantly capacity to provide NHI services.

7.4 Health Facility Accessibility Modelling

Accessibility modelling is about establishing location of facilities (by level of care) and their accessibility to the population and the key parameter of geographical access is distance to the facility. A distinction can made between geographical access and workplace access. Since access is primarily conceived in terms of residential access to health care providers, the reality of employees who live away from home and to be closer to their workplace, has to be taken into consideration. It may be necessary to include both approaches in the process of accessibility modelling. The facilities data base will be used to geo-map all the facilities according to the criteria stated earlier.

This exercise will show clearly which facilities are located where; however, it does not tell us anything about which facilities are functional or not. The Department of Health will then assist in reviewing all facilities in terms of functional preparedness (See Section on Infrastructure and accreditation) to provide NHI services. The presence of a non-functional facility is as good as having no facility and therefore cannot, for practical purposes be used to determine access.

The Department of Health norms and standards of what type of facility should exist within what radius (walking or travelling distance) and for what size of the population are important in identifying service access and gaps, and more specifically will inform the processes of identifying facilities to consider for accreditation and inclusion in the NHI system.

7.5. Catchment Area Exercise Modelling

Whilst accessibility modelling will assist in identifying facilities and people's access to these health care facilities (population coverage), it does not show which facilities are best located for which population (catchment population). Catchment area analysis will show which populations use which facility and all this is a function of the following factors, amongst others:

- Location of the facility versus covered population
- Population density
- Topography
- Transport networks
- Common mode of transport
- Type of Facility
- Perceived Quality of care
- Continuity of care
- Burden of disease per district / province
- Migration patterns of general population

Public sector utilisation data will be collected from the routine health information system and any other utilisation studies done by the National and or Provincial Departments of Health (e.g. SSCBIA study), from the Council of Medical Schemes, Board of Health Care Funders, Private Hospitals Association of South Africa and others. Using flow-maps it will be possible to model facility utilisation patterns and hence the actual catchment population for each facility.

7.6 Design of a National Health Insurance Card

The Department of Home Affairs currently provides Identification Documents (ID) for all South African citizens and permanent residents. The plan is that the existing infrastructure, systems and procedures for getting an ID be used to register everyone who resides in specific geographical areas. The existing challenges of getting an ID which might negatively affect the acquisition of the NHI card will obviously need to be streamlined if there is going to be massive (or phased) registration of people once implementation begins. Eligibility of the population for registration with the NHI will be clearly defined and in line with international practice. The approach will depend on the assumed strategy for implementing NHI over the next five years.

The Department of Health will be responsible for the actual design of the card in terms of what it will look like and most importantly the information that it will contain. In this regard, the NHI must be designed in such a way that it interfaces with the proposed NHI patient

record system and existing national identification system. This will not only ensure that there s no fraud in the NHI system but also that service benefits are portable to the card holder.

Given the challenges of transiting from the current system to the NHI, it is important that the current National Identification Document be the main document used for identifying NHI beneficiaries, until such time that the smart NHI card can be given to people. The Smart Card requires significant improvements in information capacity and technology and the associated costs need to be established. This will ensure that no one is denied access to services at the beginning of the process. The key issue is that of registering people by district and most importantly by designated facility.

7.7 Strategy for Registration of the population for NHI

Getting everyone eligible for NHI registered and more so linked to specific health care facilities presents logistical and practical challenges. Important parameters to consider in deciding on a population registration strategy are:

- The proposed implementation period — 5 years
- Existing national infrastructure and databases to facilitate registration of people
- The annual target of 25% NHI coverage
- The need to ensure that current contributors receive uninterrupted service and those currently able to contribute but are not contributing get on board early
- The role of different government agencies in ensuring rapid registration of people
- The pace of accreditation of facilities in relation with increasing expectations as people register

The proposal is that the NHI be phased in over a five year period with a target of increasing coverage by 25% each year. It is important that the accreditation process be aligned to the registration process to avoid raising expectations as more people register and get the NHI card and not being able to deliver quality services. Linking beneficiaries to facilities can effectively be done at higher coverage levels for NHI, for example, at 75% in year three and thereafter.

For practical purposes, registration of people for NHI should be done at the same time in all districts using the Department of Home Affairs' platforms, that is, infrastructure and processes. However, it is important that registration be preceded by massive public education on the requirements for registration, what NHI is, its benefits, portability of services and pheses through which it will be implemented including how people will be assigned to specific primary care facilities closest to them (first points of entry into the health care system) and the referral system. The interim measure as more facilities get accredited will be that people continue to use public facilities with or without accreditation.

The Department of Home Affairs is key in the registration process for two main reasons: First, as aforementioned it already has the capabilities and systems in place to register people in all the districts, and secondly, it has updated databases of people with IDs (and residential addresses) which are important for checking the peoples' eligibility for NHI and their NHI registration district. In addition, 90% of birth registrations are done by it and these are a significant part of the dependent population (those under 16 years without an ID). Worth highlighting is that whilst this segment of the population does not have IDs, the Department of Home Affairs allocates them an ID number that is then used ex post. Starting with this cohort of the population will ensure that at the majority of the people are targeted for registration right from the beginning.

In addition, a workplace based approached will be used to register people and their dependents. Those that currently contribute to medical insurance and their dependents can be registered through their employers after negotiations with the respective trade unions. The challenge is to make sure that those who are not contributing to some form of health insurance but are able to so, are registered through their workplaces. This will ensure that the critical mass of employed people who are able to contribute begin to do so under NHI and hence improve the revenue stream for NHI. With is approach an estimated 30 million people (contributors and at least 3 dependants) will be rapidly registered for NHI. The next task would then be to register those in the informal economy and the unemployed in the priority geographical areas.

Before the registration can be rolled out, it is critical that the registration process is robustly pilot tested so that any pressure points can be identified and addressed.

7.8 Pilot Testing the Registration Process

The plan is to establish a sub-task Team that will be responsible for pilot testing the registration process in a selected district between May and June 2009. The pilot study team will be made up of people from STATS SA, Department of Home Affairs, Independent Electoral Commission, Local government, Department of Labour and other relevant stakeholders.

The pilot test will be designed in such a way that it uses a combination of approaches: district-based population registration using the Department of Home Affairs and Independent Electoral Commission platforms and processes, and workplace based approaches.

The team will be responsible for developing the population registration model that will then be rolled out by the relevant implementing agencies for NHI as soon as the Bill is passed in Parliament.

CHAPTER 8: COMPREHENSIVE PACKAGE OF HEALTH SERVICES TO BE COVERED UNDER THE NATIONAL HEALTH INSURANCE SYSTEM

8.1. INTRODUCTION

Many countries, at different levels of economic growth, have instituted a number of health system reforms. These reforms have endeavoured to transcend the key areas of their health systems; namely funding, pooling, purchasing and provision of health services for the population. The primary objective that has been driving these reforms is the 'humanitarian drive' and or 'social solidarity' principle that is targeted at ensuring that every household's economic, social and health security are properly and adequately catered for to ensure and improve health outcomes through the provision of financial risk protection. The consensus among policy makers, academics, researchers, economists and international organizations is that this can be effectively realised by creating the essential institutional and organizational structures that guarantee long term sustainability for social and human security. Adopting a framework for the health system that is based on the principle of universal coverage offers a promising opportunity to provide people with social security and also helps to ameliorate the unsustainable, cost ineffective and inefficient use of the limited resources.

A key element that has to be adequately addressed if universal coverage is to become a reality in any given context is the clear definition of the package of services that any given citizen will be entitled to once the system is reconfigured. Within the sphere of service provision, particularly in countries that are pursuing the objective of universality through some form of mandatory health insurance system, the clear definition of the benefits package has been central to clearly determining the scope of services that the state will cover, either at public or private provision of services.

NHI enrolments and medical benefit payments for the package of services will be administered by National Health Insurance Authority through its network of provincial health authorities and district health councils offices and other information claiming services.

Therefore, the clear definition of the benefit package is a key step in ensuring that the principle of universal coverage is fully realised and that all citizens irrespective of their ability to pay for services will have access to the needed care. It is important to note that the determination of the package must be based on consistent consideration of the principles of affordability (i.e. are the services being covered cost-effective and getting the best value-for-money, including outcomes) and sustainability (i.e. Is the ensuing cost of the covered services sustainable in the medium to long term and does it allow for system success).

Additionally, the quality of health care that is provided must be acceptable and appropriate. Services in need that are covered under the comprehensive package are usually reimbursed using a defined reimbursement mechanism which is usually not the fee-for-service method. Fee-for-service method is typically prevalent in the private sector and considered unaffordable and inappropriate in the public sector.

Equity here means that those with a greater need for services should be accorded sufficient opportunity to ensure that they access and benefit from services as demanded by their needs and those with less need for services should actually benefit to that same extent. This implies that people should benefit purely based on their need for services, irrespective of their socio-economic status or any other factor. Obviously the debates around 'need' and 'equity' lead to the unavoidable debate of whose perspective should be taken when considering the need and determining what is most equitable.

A simplistic, yet acceptable approach, is to agree that need can never be universally described and that the context (i.e. the legal and political space, economic circumstances, cultural values and the society) will impact significantly on the agreed upon definition of need and how it is going to be addressed.

8.2. DEFINING A PACKAGE OF SERVICES

The expansion of health services that a given population is entitled to should not be the only factor that is considered when deciding the package of services to be offered under a universal health insurance system. This implies that not each and every service should automatically be made part of the service. It is important that decision-makers consistently look at identifying cost-effective interventions that are results-based, provide holistic approaches to health system integration and development, and to the long term sustainability of the system. In defining the package of services that should be offered within a given context, three separate and interrelated matters must be adequately considered:

- Breadth of Coverage: The size of the population that will be entitled to the package as defined
- Depth of Coverage: The number and type of services to be covered
- Impact on health outcomes: Impact of services included in the package on key indicators like Infant Mortality Rate, Maternal Mortality Rate, Immunization Rate, New HIV infections, TB cure rates, Burden of Disease, etc

Taking the above three factors into consideration, it therefore implies that in determining the nature and type of services to be covered sufficient consideration must be taken of the:

- Population demographics (e.g. age and gender profiles at the regional and national levels)
- Epidemiological profile of the population (e.g. communicable and non-communicable diseases)
- Health services utilisation (e.g. utilisation rates for primary, secondary, tertiary and quaternary services)

- List of health services available in the country (i.e. national capacity for service provision and expansion)
- The scope of the services to be covered in the package (i.e. is it all levels or care or not)
- Sustainability and affordability of the entire benefit package

Reforming the health system in a manner that effectively, efficiently and equitably leads to the realisation of the principle of universal coverage should involve providing individuals and households with a package of healthcare services that is designed to improve health outcomes and prevent catastrophic healthcare expenditures. However, as indicated earlier, this does not in any way imply that any given service should be included on the package irrespective of whether it is based on need or want. Preference should always be given to need. The need should be informed by the population's epidemiological and other relevant profiles (e.g. age, gender, etc.).

Lists 1 and 2 below provide the scope of the nature and type of services that should be covered in a package of services at the primary and secondary levels of the health system that are aimed at realising universal coverage within a national health insurance system for South Africa.

8.2.1 List 1: PRIMARY HEALTH CARE SERVICES

- Women's Reproductive Health Services
- Management & Prevention of Genetic Disorders & Birth Defects
- Integrated Management of Childhood Illnesses
- Prevention, Management & Treatment of:
  - HIV/AIDS
  - Asthma
  - Dysentery
  - Helminths
  - STIs
  - Tuberculosis
  - Malaria
  - Leprosy
  - Rheumatic Fever & Rheumatic Heart Disease
  - Chronic Diseases (i.e. Hypertension & Diabetes) & Geriatrics
  - Cholera & Diarrhoeal Diseases
  - Management of Communicable Diseases

- Immunisation services
- Adolescent & Youth Health
- Trauma & Emergency
- Oral Health Services
- Mental Health (Psychiatric & Psychology)
- Sexual Abuse, Domestic and Gender Violence
- Substance Abuse

8.2.2. List 2: HOSPITAL HEALTH CARE SERVICES

- Paediatrics
- Obstetritcs & Gynaecology
- General surgery
- Orthopaedics
- Selected other Surgical Sub-Specialties:
    - Ophthalmology
    - Ear Nose & Throat Surgery
    - Urology
    - Reconstructive Surgery
    - Oral / Maxillo-Facial Surgery
    - Neurosurgery
- Day Surgery Service
- General (Internal) Medicine
- Psychiatry
- Oncology
- AIDS Management
- Family Medicine:
    - OPD : General
    - Specialist
    - Casualty/ Emergency Service
- Forensic Service
- Community Health / Occupational Health Service
- **Clinical Support Services:**
- Anaesthesiology / ICU (Intensive Care Unit) / High Care / Theatres

- Radiology & Diagnostic Services
- Rehabilitation

- **General Support Services:**
- Pharmacy
- Laboratory: Pathology Services
- Blood Bank

PAEDIATRIC SERVICES	RANGE: **Neonatal** ♦ Premature infant (> 1 000g) including: 1. Respiratory distress (Hyaline Membrane Disease, Pneumonia, Meconium Aspiration Syndrome) 2. Convulsions 3. Septicaemia ♦ Short-term ventilation (< 5 days) ♦ Pneumonia ♦ Hyaline Membrane Disease ♦ Meconium Aspiration Syndrome ♦ Convulsions ♦ Septicaemia ♦ Patent Ductus Arteriosus (medical closure) ♦ Anuria ♦ Abdominal obstruction including Necrotising Enterocilitis not requiring surgery ♦ Neonatal jaundice – (< 24 hrs after birth) ♦ Prolonged jaundice – (>10d in Full-term infant and >14 d in pre-term infant unresponsive to phototherapy) ♦ Persistent hypoglycaemia ♦ Macrocephaly ♦ Congenital abnormalities **Paediatrics** ♦ Persistent/severe airway obstruction – upper & lower ♦ Complications of /persistent/ recurrent pneumonias ♦ Severe croup (> grade III) / Bronchiolitis ♦ Complications of Asthma ♦ Complications of TB ♦ Cardiac disease & murmurs ♦ Hypertension ♦ Complications of Acute Rheumatic Fever ♦ Abdominal mass ♦ Resistant diarrhoea ♦ Malnutrition severe metabolic derangement ♦ Renal disease such as glomerulonephritis ♦ Complications of nephritis ♦ Nephrotic syndrome ♦ Prolonged jaundice ♦ Complicated seizures ♦ Complicated CNS infections ♦ Severe persistent movement disorders ♦ Development regression /Growth disorders ♦ Haematological disorders ♦ Disabilities requiring multidisciplinary team ♦ Diagnostic dilemmas/therapeutic failures at district hospitals ♦ Shared care: malignancies, Diabetes mellitis ♦ Child abuse (complicated cases) ♦ HIV / AIDS management

Gynaecology

- Management of pre-malignant conditions
- Infertility – initial investigations
- Abnormal uterine bleeding
- Post menopausal bleeding
- Recurrent vaginal discharges
- Fibroids
- 2nd trimester Termination of Pregnancies (TOP)
- Complicated Abortions
- Severe Pelvic inflammatory disease
- Uro-gynaecology
- Uterine prolapse +/- urinary incontinence
- Endocrinology: initial investigation
- Endometriosis
- Colposcopy
- LLETZ (Large Loop Excision of the Transformation Zone)
- TAH (Total abdominal hysterectomy)
- BSO (Bilateral Salpingo-oopherectomy)
- Vaginal hysterectomy
- Colpo suspension / repairs
- Diagnostic laparoscopy
- Ovarian cystectomy

Obstetrics

Indications:

- 2 previous first trimester abortion
- Previous mid-trimester abortion, cong. Abnormality
- Previous neonatal death, IUD (Intra-Uterine-Death), preterm labour
- Previous hypertension/pre-eclampsia/eclampsia
- Previous Caesarian Section (C/S) >2
- Inductions
- Severe cerebral malaria
- PIH (Pregnancy Induced Hypertension), PET (Pre-eclampsia), Chronic hypertension, Eclampsia

Labour:

- Preterm labour (< 37 weeks)
- DVT (Deep Venous Thrombosis) / PE (Pulmonary Embolism) – current pregnancy
- Multiple pregnancy (> twins, abnormal lie, previous C/S
- Extra-uterine pregnancy
- Uncomplicated abruptio
- Uncomplicated severe hypertension and Eclampsia

GENERAL SURGERY	♦ Complicated general surgical cases that are referred from the district hospital ♦ Complicated and severe trauma ♦ Laparotomy / management of acute abdomen ♦ Resection & re-anastomosis of bowel (trauma, tumour/masses, obstruction/gangrene) ♦ Repair of viscera ♦ Iliostomy & colostomy ♦ Cholesystectomy (open & laparoscopic) ♦ Peptic ulcer disease: omentopexy for perforated ulcers, gastrectomy ♦ Complications of pancreatitis ♦ Anorectal surgery: fistulectomy & sphincterotomy ♦ Splenectomy/nephrectomy / ureteric injuries ♦ Repair genito-urinary injuries – ureter, bladder, and urethra ♦ Endoscopy (oesophagoscopy, gatroscopy, sigmoidoscopy, colonoscopy) ♦ Resection of tumours/masses: thyroid, breast, parotid, soft tissue, pancreas ♦ Primary Biliary Cirrhosis ♦ Sclerosing Cholangitis ♦ Auto-immune Hepatitis ♦ Infections/abscesses/masses ♦ Elective hernias/ groin surgery ♦ Amputations ♦ Vascular surgery – arterial embolectomy, femoral-popliteal bypass, repair of aneurysms (aortic, infrarenal, traumatic) ♦ Exploration of stabbed vessels and repair there-of ♦ Repair of laryngeal, tracheal injuries ♦ Sternotomy for stabbed heart ♦ Basic thoracic surgery- decortication, lobectomy, pneumonectomy ♦ Palliative surgery for Ca oesophagus ♦ Burns involving joints, face and > 40% of surface burns ♦ Wounds requiring small grafts ♦ Subdural haemorrages ♦ Ventriculo-Peritoneal (V-P) shunts

ORTHOPAEDICS	♦ Reduction of fractures (closed) ♦ Open reduction & internal fixation ♦ Tendon repair & tendon transplant ♦ Draining of Osteomyelitis ♦ Nerve repair & transplant (excluding microsurgery) ♦ Carpal and De Quervain's Syndrome ♦ Spinal surgery 1. Discectomy 2. Treatment of spinal fractures (stable) ♦ Joint replacements: hip, knee, occasionally shoulder ♦ Correction of clubfeet ♦ Hand surgery ♦ Hallux valgus correction ♦ Arthroscopies – both investigative and operative ♦ Complicated fractures & dislocations ♦ Multiple trauma
OPTHALMOLOGY	♦ Tertiary eye care provided by general opthalmologists or opthalmic medical officers (general opthalmology service, with emphasis on the provision of cataract and glaucoma surgical services) I. Anterior segment Cataract extraction ♦ Uncomplicated extracapsural surgery plus intraocular lens implant ♦ Phaeco-emulsfication possible in the future ♦ Uncomplicated corneal graft ♦ Optical iridectomy II. Glaucoma ♦ Trabeculectomy for open angle glaucoma ♦ Strabismus ♦ Uncomplicated paediatrics squints, e.g. congenital esotropia ♦ Oculoplastic surgery ♦ Entropian/ectropion III. Diagnostic ultrasound IV. Argon Laser to retina (PRP) for diabetics V. Refraction by optometrists if available (Refractive errors) VI. Diabetic Retinopathy VII. Trauma Management VIII. Blindness prevention and Management related to Childhood, Cataracts and Glaucoma

EAR, NOSE & THROAT	♦ Uncomplicated emergencies e.g. foreign body in throat, peritonsillar abscess, mastoiditis and acute sinusitis ♦ Minor elective surgery such as tonsillectomy and myringotomy ♦ Removal vocal cord nodules ♦ Tympanoplasty ♦ Tracheostomy ♦ Fronto ethmoidectomy ♦ Micro laryngoscopy ♦ Pan-endosopy ♦ Antral Irrigation ♦ Mastiodectomy ♦ Head and Neck Trauma ♦ Preliminary investigations needed for diagnosis other conditions requiring tertiary care ♦ Post-tertiary care follow-up
SURGICAL SUB-SPECIALTIES:	**UROLOGY** ♦ Orchidectomy ♦ Torsion of testes ♦ Cystoscopy – biopsy strictures ♦ Injuries to bladder, kidneys ♦ Infertility & Andrology: initial investigations ♦ Uncomplicated infectious diseases **RECONSTRUCTIVE SURGERY** ♦ Skin flaps & grafts ♦ Removal of keloid **ORAL / MAXILLO-FACIAL SURGERY** ♦ Wiring of mandible ♦ Removal of teeth – especially in the case of mental retardation where anaesthetic risk requires specialist anaesthetist input **NEUROSURGERY** ♦ Burr holes ♦ Identification of neural tube defects such as Hydrocephalus and myelomeningocele ♦ Temporary management of neuro-surgical emergencies for stabilization purpose until Level III transfer is possible such as Reduction of intra-cranial pressure (Medical management with steroids / Mannitol / Lasix

DAY SURGERY	♦ Breast surgery (definitive breast cancer surgery not requiring immediate breast reconstruction procedures) ♦ Reduction mammoplasty ♦ Varicose veins ♦ Hernia repairs ♦ Cataracts ♦ Tonsillectomy and adenoidectomy ♦ Hysteroscopic surgery for endometrial ablation ♦ Cone biopsies ♦ Therapeutic abortions ♦ Arthroscopic Knee surgery ♦ Hand surgery – De Quervain's/ Carpal tunnel release

GENERAL MEDICINE	***RESPIRATORY*** ♦ Non-resolving / complicated pneumonia ♦ Asthma: non-responsive, status asthmaticus ♦ COPD (Chronic Obstructive Pulmovary Disease) – moderate – severe ♦ Extra-pulmonary Tuberculosis / complications of Tuberculosis (e.g. fistula), Multi-Drug-Resistant Tuberculosis, MiliaryTuberculosis ♦ Pleural Diseases / non-resolving pleural effusion ♦ Carcinoma Lung ♦ Complicated Empyaema/ lung abscess ***CARDIO-VASCULAR*** ▪ Severe & complicated hypertension ▪ Unstable angina/Ischemic heart disease, arrythmias ▪ Myocardial infarct – streptokinase (not in district package) ▪ Moderate-severe cardiac failure ▪ Valvular heart disease ▪ Cardiomyopathies ▪ Pericardial effusion ▪ DVT (Deep Venous Thrombosis) work-up ***RHEUMATOLOGY*** ♦ Rheumatoid arthritis initial Diagnosis & periodic review) ♦ Gout ♦ Osteoarthritis ♦ Psoriatic arthritis and other spondyloarthropathies ♦ Fibromyalgia ♦ Soft tissue rheumatic syndrome ***DIABETES/ ENDOCRINOLOGY*** ♦ Type 1 Diabetes Mellitis ♦ Acute metabolic complications: diabetic ketoacidosis, hyperosmolar hyperglycemic coma, severe / prolonged hypoglycemia = after initial stabilization ♦ Type 2 diabetics with non-metabolic complications e.g. pneumonia, pyelonephritis ♦ Endocrine Disorders ♦ Uncomplicated hypothyroidism & other endocrine disorders ***GASTROENTEROLOGY*** ♦ Ulcerative Colitis, Crohns disease ♦ Severe Constipation, Fecal Impaction ♦ Complicated cases of diarrhoeas & dysentries ♦ Peptic Ulcer Disease ♦ Peritonitis ♦ Reflux Oesophagitis ♦ Liver Abscess ♦ Upper GIT(Gastro-Intestinal-Tract) bleed ♦ Viral Hepatitis ♦ Liver Failure ♦ Portal hypertension and Ascites

	HAEMATOLOGY ♦ Anemia ♦ Congenital and Acquired hematological disorders ♦ Hematology malignancies initial Management **INFECTIOUS DISEASES** ♦ Referred cases from district hospital **NEPHROLOGY** ♦ Complicated renal disease ♦ Obstructive uropathies ♦ Renal failure
	NEUROLOGY ♦ Meningitis ♦ Migraines/headaches ♦ CVI (Cerebro-Vascular-Incident): younger person, possible reversible cause ♦ Other infectious and non-infectious conditions requiring further diagnostic and therapeutic procedures that are referred from the district hospital level including toxoplasmosis, cryptococcus ♦ Epilepsy / status epilepticus ♦ Seizures with fall-out ♦ Post-ictal confusion
	DERMATOLOGY ♦ Any skin disease where a diagnosis has not been made ♦ Severe Acne ♦ Complicated Eczema, Psoriasis, Scabies ♦ Syphillis and Sexually Transmitted Diseases unresponsive to the Syndromic management ♦ Disseminated Herpes ♦ Cutaneous manifestations of HIV ♦ Superficial and deep fungal infections ♦ Granulomatous skin diseases ♦ Autoimmune Skin Disease ♦ Severe Drug Reactions including Stevens-Johnson Syndrome and Toxic Epidermal Necrolysis ♦ Benign Skin Tumours and Naevi ♦ Pigmentary and Inherited Skin Disorders ♦ Disorders of Nail and Hair ♦ Photodematoses ♦ Pruritus where no cause is obvious ♦ Skin cancers

	POISONING / OVERDOSE: More complex such as: ▪ Tricyclics ▪ Theophylline ▪ Digitalis ▪ Organophosphates ▪ Phanaxathine
PSYCHIATRY	♦ Medical support to primary level and mental hospitals i.e. screen for organic condition ♦ Emergency management of psychiatric presentations ♦ Prolonged / Severe Depression ♦ Depression with suicide tendencies ♦ Severe psychosis/neurosis ♦ Management of suicide attempts ♦ Management of substance-induced intoxication and withdrawal states ♦ Puerpurial Psychosis (in co-ordination with Obstetrics)
ONCOLOGY	♦ Diagnosis & Management of uncomplicated cases – not requiring DXT ♦ Screening: cancer of the cervix ♦ Clinical diagnosis and subsequent referral for confirmation of diagnosis and initial treatment (pooled at some regional hospitals depending on access to tertiary care and patient workload) ♦ Follow-up of patients referred back from higher care level ♦ Management of associated, independent and treatment induced complications of mild to moderate severity ♦ Emotional support and rehabilitation ♦ Terminal care and pain management ♦ Health education targeting cancer prevention and control ♦ Additional: 1. Screening for other common cancers like breast cancer 2. Follow-up may include chemotherapy for patients not in need of radiation or further surgery even before remission is established 3. Management of some of the malignancies like leukemia and lymphoma in case of relapse
AIDS MANAGEMENT	Management of HIV and AIDS will be according to guidelines contained in the Comprehensive Plan

FAMILY MEDICINE:	**OPD** ♦ General outpatients ♦ Co-ordination of linked Specialist clinics **CASUALTY** ♦ 24 hour accident and emergency services of complicated cases
FORENSIC SERVICE	♦ Advanced crisis care for adult and child abuse ♦ Rape case management ♦ Other medico-legal services
COMMUNITY HEALTH / OCCUPATIONAL HEALTH	♦ Diagnosis and treatment of occupational related diseases ♦ Occupational hygiene ♦ Information and referral services ♦ Employee Assistance Program Support NB: needs National Expertise Workgroup discussion to determine core package based on proposed Regional Health Care service range.

CLINICAL SUPPORT SERVICES	
ANAESTHETICS / HIGH CARE / ICU	**Anaesthesia:** * ASA = American Society of Anaesthetists ♦ Pre-operative: 1. Higher risk patients: ASA III-V 2. Medical conditions: hypertension, diabetes, asthma, obesity ♦ Intra-operative: 1. Interventions requiring specialist anaesthetist supervision 2. Anaesthesia for children < 2yrs / 10kg (except for minor surgery such as Incision & Drainage superficial abscesses and circumcisions which are manageable at district level) ♦ Post-operative: 1. No post op ventilation lasting > 48 hours required 2. Post-op epidural pain control **HIGH CARE / ICU** ♦ Range of proposed services necessitates the provision of a high care facility that provides post-operative care and more intensive monitoring than in a general ward. ♦ Adults & children ♦ Short-term ventilation (3-5 days) ♦ Total Par-enteral Nutrition (PTN) ♦ Acute dialysis

RADIOLOGY	♦ Due to proposed services range, a specialist radiologist should be either part-time or full-time available ♦ Ultrasonography ♦ CT scanning (pooled at certain regional hospital depending on accessibility to tertiary care services and patient workload) ♦ Arteriography various contrast studies (pooled at certain regional hospital depending on accessibility to tertiary care services and patient workload)
REHABILITATION	♦ National Clinical Rehabilitation standards

GENERAL SUPPORT SERVICES	
PHARMACY	♦ Standard Treatment Guidelines and the Essential Drug List for Secondary Care ♦ NB: need discussion by National Clinical Expertise Workgroup to accommodate current gaps identified by proposed Regional Health Care Package Range
LABORATORY / PATHOLOGY SERVICES	• Standard national guidelines will apply
BLOOD BANK	• Standard national guidelines will apply • Compliance with South African National Blood Service quality standards

NB: A summary of the types of hospitals at which the services indicated in the above table will be offered is provided in the attached annexure.

It is important to emphasize here that appropriate mechanisms must be developed to ensure that there is efficient and effective delivery of the covered services. This implies restricting the number of visits that each covered individual or household is entitled to in relation to GPs, specialists, optometrists and dentists. A key element that will ensure cost-effective and efficient use of the available resources is to ensure that adequate "gate keeping" mechanisms are in place to ensure that individuals are accessing the needed services at the right level and are given the most effective treatment. This implies that the roles of the various providers have to be clearly defined, especially at the primary care level as that is where the patients first come into contact with the system. An example of these restrictions is provided in the **Table 1** below:

Table 1 Example of consultation benefits restrictions in terms of provider visits (for the purposes of costing)

Provider category	Benefit
General Practitioner consultations	• Graduated patient limits depending on the size of the family e.g. 3 visits for a single member household to 12 visits for a 4 member household. • Additional visits allowable for members with specific, clearly determined need
Specialists consultations	Highly restricted using a managed care approach with GPs acting as "gatekeepers" • High co-payments for non-referrals • Number of visits kept as low as can be with recourse to appropriate and evidence-based clinical practice guidelines

A similar argument holds for the medication that is to be prescribed within such an environment – the primary recommendation here is that all chronic and acute medications be based on the Essential Drug List ("EDL"). Appropriate mechanisms must be developed to ensure that as new and more effective drugs become available the EDL is revised to incorporate these drugs and ensure that existing and future health needs are sufficiently catered for. This section will be re-done for the purposes of operationalisation.

The package of services will have exclusions. These will be determined according to the principles of need. For instance, health services or procedures like cosmetics will be excluded except if appropriately motivated by a healthcare provider with independent verification by a team of health professionals with relevant expertise in the particular field. However, reconstructive surgery with silicon breast post cancerous mastectomy is a special case that needs attention, so are some dental operations. The premise upon which the comprehensive package of healthcare services is determined is that de facto all necessary health services are included as part of the package subject to the principles of evidence-based clinical practice, cost-effectiveness, patient safety and need. The exclusion list will remain a dynamic list to cater for changes in technologies and knowledge, resource endowment and acceptable ethics. A Benefits Advisory Committee will be established as key institution under the National Health Insurance Authority with responsibilities to alter and/or modify the list of included and excluded services depending on emerging evidence and evolving clinical practices.Unless otherwise clearly stated all benefits are universally accessible in NHI facilities and service providers, subject to the referral processes that will be implemented. In those categories where exclusions and or limits apply, the Benefits Advisory Committee (see Chapter 2) will have clear guidelines to determine such. The Committee will have the power to obtain referrals or second opinions with regard to illnesses of a protracted nature or procedures / treatments that may be excluded. The latest clinical protocol and guidelines will always be applicable in consideration of the exclusions and inclusions.

A detailed example of comprehensive inclusion and an exclusions list is included in the annexures.

8.3 Portability of Health Services

The ability for patients to be able access and utilise the services they require in different locations provides a key aspect of the capacity of the NHI system to effectively realise the principle of universal coverage. Individuals and households must have the ability to access services in other Provinces and Districts despite not being registered. There must be mechanisms that are developed by the NHIA that allow for the inter-provincial and inter-district disbursement of funds to ensure portability of services for the population. A supporting mechanism that will be essential to the realisation of the principle of portability of services is the creation of an integrated health information system that allows for ease of access to patient information to ensure effective and continuous care.

8.3.1 The Electronic Health Records

The electronic health record helps to keep track of people medical histories no matter where the patients are located when the health intervention is required. The benefits of electronic health records are:

- Improve health outcomes by increasing opportunities for coordinated and continuous of care with the health care system;
- Provide health providers with access to a more comprehensive patient history and improve clinical decision making;
- Portability and ease-of-access to patient information;
- Reduce the reliance on the patient's own memory to provide a medical history.

The electronic health records has potential benefits to citizens like better and expanded access to needed health services, shorter delays in service availability, greater continuity and accessibility, and improved efficiency in resolving health problems.

Health professionals will benefit from electronic health records because improved information flow makes it easier to obtain better quality information and measure results, thus supporting better informed and simpler clinical decision making and could potentially result in an increasing level of productivity for health providers. For government, electronic health records improve the lives of general population, quickly and quantifiably and with added benefit of freeing additional budget for other health care initiatives. The electronic health records have a further benefit of ability to track disease trends within broad population thereby enabling government to develop proactive, targeted health strategies.

The electronic health record also has the risk associated with it. The risks involved with the electronic health record include:

- The threat to the confidentiality provided by the doctor/patient relationship;

- Sensitive data could be accessible to a wider range of health providers, thereby increasing risk of unauthorised disclosure;

8.3.2 Experiences with the Portability of Health Services in Canada

The portability requires provinces to cover insured health services provided to their citizens while they are temporarily absent from their province of residence or from Canada. The payment for insured health services provided in another province is made at the rate negotiated by the governments of the two provinces.

Residents who are temporarily absent from their home province must continue to be covered for insured health services during their absence. If the patients get the services out of Canada the amount paid will be equivalent to the amount the province would have paid for similar services rendered in that province.

Residents moving from one province to another must continue to be covered for insured health services by the home jurisdiction during any waiting period imposed by the new province of residence.

The waiting period for eligibility to a provincial health care insurance plan must not exceed three months. After the waiting period the new province assume responsibility for health care coverage.

The portability of health services does not entitle a person to seek services in another province, but it is intended for a person to receive necessary services in relation to emergency need when absent on a temporary form a business or vacation.

8.4 Current Measures for Ensuring the Portability of Services in South Africa

8.4.1. National Health Information System in South Africa

The South African government had established a committee to develop the policy for Health Information System for South Africa in 1995. The government has achieved some success in the area of health management information and in particular the District Management Information System. However, some challenges exist with the current system. A major challenge is that most of the provinces have implemented their own hospital information system which was focusing on administrative data not clinical data. This has resulted in a lack of progress in achieving a uniform, national patient information system which enables the system to track patients and easily access their clinical history regardless of where they present themselves. A further challenge is that some provinces implemented different information systems and technology only in some selected facilities, resulting in the inability to track patients who use public health facilities within and across provinces and districts.

The National Health Insurance Authority will establish an integrated National Health Information System that is based on an electronic patient record platform. This will enable any person who visits a health facility in any province to be allocated a unique identifier and have their medical history recorded and stored electronically in

a health record. This system will be crucial for the implementation of the NHI system and the portability of services for the population.

8.4.2. National Electronic Health Record in South Africa

The objectives of the Electronic Health Record for South Africa are to:

- Integrate health records systems in the country by bringing together the existing health information systems, facilitating access to health records at the national, provincial and district levels;
- Develop a population-based national health database;
- Improve and enhance administration and managerial decision making abilities at the national, provincial and district levels;
- Improve evidence-based decision making at the national, provincial and district levels;
- Improve the efficiency of health service delivery; and
- Enable national, provincial and district level monitoring and evaluation of health trends.

The electronic health record must provide the minimum up to date patient record structured across different levels of operations, clinical care and management. The use of smart Health Cards will assist the introduction of portability of health services in South Africa. The national, provincial and district levels need to develop an integrated policy on portability of services which will give guidance to all three spheres of government on how best they can make health services portable.

CHAPTER 9: INCREASE AUTONOMY AND EFFICIENCY OF PUBLIC HEALTH CARE PROVIDERS, INCLUDING HOSPITALS

(CHAPTER STILL BEEN DEVELOPED)

It will cover the following

- Review the Hospital Reform Strategy
- Investigate mechanisms for increasing managerial autonomy of public health care providers.
- Investigate shifts from global budgets to capitation fees or other transitional payment systems
- Hiring of managers with experienced and /or private sector experience in the short term, and creation of apprenticeship/shadow management arrangements to build capacity in the public sector and change management culture generally

- Decentralise authority to allow them to take decisions and be accountable for meeting the goals using resources allocated based on their plans

CHAPTER 10: ACCREDITATION OF HEALTH SERVICE PROVIDERS

1.1. Introduction

Healthcare facilities provide a wide spectrum of services: from complex high-tech interventions to save the lives of severely ill patients conducted by a multi-disciplinary team of staff with advanced skills in an urban academic hospital to equally important preventive immunisations administered by competent nurses in a rural clinic.

The range of levels of healthcare facilities in South Africa should be seen as a necessary gradation of increasingly sophisticated services, each designed to manage the patient's journey from settings of promotive, preventive care to necessary high-risk interventions when they reach a stage of critical illness.

The challenge of ensuring the quality of these diverse services is great but follows well-tried and tested quality assurance and improvement methods. Fundamental to this process is the setting and implementation of standards that meet the needs and expectations of patients, staff and citizens. This process includes the evaluation of the degree to which standards are met and the introduction of quality improvement activities designed to address identified areas of non-compliance to the required standards.

This chapter outlines how this challenge can be met through setting of standards, training of facility, local, district, provincial and national staff to understand the intent of the standards and their evaluation and monitoring in healthcare facilities using a "train-the-trainer" approach. An essential component of the proposal is the recognition of gains made through a graded recognition programme that certifies facilities according to levels of achievement attained, leading ultimately to substantial standards compliance and the awarding of full accreditation status to facilities that meet accreditation requirements.

All types of facilities will be subject to a standard set of accreditation norms, varied according to whether the facility is a hospital, clinic, ambulance services and ART sites. The same process of standard setting, evaluation and quality improvement followed by accreditation awards is followed in each of these facilities. The implementation of the standards and their monitoring at facility, local, provincial and national levels is supported by a web-based Information System that:

- provides continuous access to current standard compliance data;
- allows facilities to input their own data and monitor their own performance;
- supports ongoing quality improvement programmes;
- enables management at all levels to make informed decisions;
- assists facilities to reach and maintain accreditation standards;
- is a tool for the ongoing monitoring of performance indicators.

This Information System is the foundation of the quality improvement, monitoring and accreditation activities and it is essential to the success of the programme.

10.2 Overview of Accreditation of Health Service Providers

Accreditation is the assessment of a service provider's compliance with pre-established performance standards. It is a process linked to incentive systems and part of a more comprehensive quality improvement and assurance effort. Accreditation focuses on continuous improvement strategies and achievement of optimal quality standards. The main issue with accreditation is to ensure that providers, both institutions such as hospitals and health centres provide good quality care.

Accreditation is an external review of quality with four principal components:

- It is based on written standards;
- Reviews are conducted by professional peers;
- The accreditation process is administered by an independent body; and
- The aim of accreditation is to encourage organisational development.

The accreditation can be granted to the individual providers and to one type of health facilities with the health system. Accreditation processes are widespread in health service delivery. The goals of accreditation are regulation, establishing barriers to entry, and providing evidence of quality assurance for individuals and the wider groups.

The purposes of accreditation of health service providers include:

- To improve the quality of health care, by establishing optimal achievement goals in meeting standards for health care organisations;
- To stimulate and improve the integration and management of health services;
- To establish a database of health care organisations;
- To reduce health costs by focusing on increased efficiency and effectiveness of services;
- To provide education and consultation to health care organisations, managers, and health professionals on quality improvement strategies and best practice in health care;
- To strengthen the public's confidence in the quality of health care, and
- To reduce risks associated with injury and infections for patients and staffs.

Some of the accreditation focuses on inputs and process standards, on outcomes standards or on combination of both types' standards. Accreditation developing countries may be restricted to one sector of health care provision.

The potential benefits of participation in accreditation programmes include:

- Assistance in improving organisational quality;
- Increased reputation among end-users;
- The right to participate in reimbursement programmes;
- An approved supplier status for some clients;
- Higher reimbursement from payers; and
- Information about competitor's relative quality.

The costs of participation in accreditation programmes include:

- New instrumentation needed to meet standards;
- Cost of survey and membership;
- Risk to staff morale if not accredited;
- Risk that purchases/ clients will shift away from a facility if a low grade is given; and
- Stress associated with compliance efforts.

The accreditation process for all health facilities in South Africa will be according to set norms and standards. These will be influenced by the following themed objectives or goals associated with quality improvement achieved at different facility types and sustained through accreditation processes, namely:

Goal 1: Hospitals

To provide the technical expertise to enable the National Department of Health and Provincial Health Services to bring about an internationally accredited quality improvement and accreditation programme for hospitals.

Goal 2: Primary Healthcare

To provide the technical expertise to enable the National Department of Health and Provincial Health Services to bring about an internationally accredited quality improvement and accreditation programme for its clinics and community health care centres.

Goal 3: Ambulance Services

To provide the technical expertise to enable the National Department of Health and Provincial Health Services to bring about an internationally accredited quality improvement and accreditation programme for its ambulance services.

Goal 4: Increasing Access to HIV Treatment to meet the 2011 NSP goals.

To focus on meeting the treatment gap, improving quality of care, and addressing bottlenecks in the accreditation process that occur at the provincial, district and facility level to ensure that quality is maintained in a sustainable manner. Since

public ART rollout commenced 4 years ago, 363 service points have been accredited up to December 2007. Both the pace of accreditation and the number of treatment points must rise to meet the 2011 NSP goals. An estimated 800 additional ART service points are needed to manage the one million more patients needing treatment by 2011.

Goal 5: Patient Safety – Advanced Incident Monitoring System

To provide a system for the collection, classification and analysis of incidents that occur during the delivery of healthcare services, adverse events and near-misses that will enable learning which will lead to the reduction and prevention of incidents and thus improve the safety of patients and staff in healthcare facilities.

Goal 6: Disease Management

To provide the technical expertise to enable the National Department of Health and Provincial Health Services to deliver effective services for conditions such as HIV and AIDS, TB and other long-term conditions at all levels of health service delivery.

A. **HIV / AIDS:** To deliver the most effective care and management of HIV /AIDS in all sectors, improving the quality of care. To ensure that quality is maintained in a sustainable manner and treatment is managed and delivered consistently against agreed standards and clinical protocols.

B. **TB:** To deliver the most effective care and management of TB in all sectors, improving the quality of care and to focus on the particular needs of patients with the Multi Drug Resistant and Extensively Drug Resistant mutations of the disease. To ensure that quality is maintained in a sustainable manner and treatment is managed and delivered consistently against agreed standards and clinical protocols.

C. **Diabetes:** To deliver services to the growing number of patients with diabetes in the primary care and secondary care sectors. To ensure that quality is maintained in a sustainable manner and treatment is managed and delivered consistently against agreed standards and clinical protocols.

10.3 Core Indicators for Cross-Country Comparisons of Health Facility Readiness

An important requirement of a facility-based information system is that definitions of indicators and data elements should be defined and collected the same way, regardless of the approach used in different systems for collecting the data. A standardised approach enables facility-based data comparisons across surveys, provinces and countries, providing a snapshot view of health facility readiness to provide services and facilitate resource mapping. Core indicators also allow surveys to note and measure change and/or progress over time.

Such a core set of indicators for assessing health facility performance should:

- cover the critical components of system capacity to provide essential services - these components include: infrastructure, availability of communication and transportation equipment for emergency care, staffing, support for quality information, and infection control;
- apply broadly to all areas of the health system, while focusing on components necessary to support quality services regardless of the service (i.e., each indicator should be cross-cutting, reflect outcomes of health systems development and provide a snapshot view of health systems functionality and/or performance);
- be simple, measurable, attributable, reliable, and time bound;
- be relevant at primary, secondary and tertiary levels of health systems and simple enough to be collected both through routine program monitoring as well as using special evaluation surveys; and
- if possible, be comparable to information that one or more of the emerging cross-country assessment approaches produces.

10.4 Assessing Accreditation Standards Compliance

At the facility level, healthcare organisations (hospitals, primary health clinics, ambulance services and community health services) are surveyed against the appropriate standards to obtain a baseline assessment of the organisation. Deviations from the standards are prioritised according to the impact they have on quality and patient and staff safety. Based on the detailed analysis of prioritised deficiencies, an integrated quality improvement programme for the organisation is developed with input from the multidisciplinary team.

All quality improvement interventions are formally monitored. Timeframes and responsible people are identified. A database identifies when timeframes are not met and remedial actions are taken to re-establish the quality improvement programme's objective of achieving facility-wide standard compliance and accreditation.

At the end of the standard implementation phase, organisation-wide surveys are carried out against the standards and facilities are awarded certificates according to the level of standard compliance achieved. Facilities that achieve substantial compliance with the standards are awarded an accreditation certificate, valid for two years.[18]

This means that all services should score at least 80/100. There should not be any non-compliant standards or criteria that could result in serious harm or injury

18 There is a possibility that this two-year award can be extended to three years, depending on whether facilities maintain compliance with standards over time.

to patients or staff or contravene critical laws and regulations and there should be no serious administration, organisational and/or managerial problems.

Facilities that do not achieve accreditation are encouraged to continue their efforts towards achieving overall standard compliance through a Graded Recognition certification programme. There are four levels of graded recognition: Progress, Entry, Intermediate and Intermediate with a Focus Survey, each of which is determined by an algorithm based on specific standard compliance scores. When a facility reaches the level of an Intermediate Award with a focus survey, the implication is that it is not far from achieving full accreditation status.

A common problem after any quality improvement or accreditation activity is that of sustaining improvements over time. To ensure that this does not happen, all accredited facilities will be required to continue their facility-wide quality improvement programmes after their external surveys. Interim surveys, focusing on high-risk systems, will be routinely carried out every nine months to ensure that standards are maintained. Accreditation awards lapse after two years for first time accreditation or after three years for re-entries that have maintained their standards. At that stage a further successful external survey will be required to retain accreditation status.

A key focus of this chapter is training and development to ensure knowledge and skills transfer at all levels of the health care system. Mentoring to transfer quality improvement methodology and evaluation skills has to be an integral component of the QI National Plan. A web-based quality improvement system information system will be used at all levels of health service management to monitor and compare standard compliance of individual facilities or grouped by sub-district, district, province and across the country. Where common deficiencies are identified, swift action can be taken at the appropriate level to rectify these in all facilities.

10.5 International Experiences with Accreditation of Health Services Providers

Most international experience in accreditation is from OECD countries and the number of developing countries with accreditation is increasing. The experience in Canada is similar to South Africa, with the government contracting with CCHSA, an independent body, for accreditation of federal hospitals.

Accreditation programmes in programmes in Brazil and Zambia had significant problems due to overdependence on government involvement. Accreditation provided at the request of government bodies, with international assistance, but has not achieved the independent status before the government decreased support provided to the organisations.
In countries where government operates all or some hospitals the relationship between government and assessment organisation is more complex. France,

Belgium and Scotland governments mandated accreditation of hospitals and creating independent accreditation organisations to implement the process. Because the government owns the hospitals, they are the purchasers of accreditation services, and this has worked.

In the developing countries, for accreditation programmes to be effective, they must have support of government licensing and health services bodies. Department of Health commitments to paying for accreditation of facilities is a common and probably key to the acceptance of accreditation in countries where health facilities are commonly government operated.

10.6 Accreditation of health services providers in South Africa

South Africa began to institute accreditation processes for various health services and facilities in the 1990s. The various provincial Health Departments have opted to engage different health facilities accreditation organisations. These organisations accredit different facilities, but in most provinces the focus has been primarily on district and provincial hospitals. The direct costs of participation are borne by either the province or district, making participation more attractive to the hospitals. The fragmentation in terms of the organisations used to undertake the accreditation exercises and the focus on a specific type of facility is something that has to be addressed. There is need to develop a national framework of standards and guidelines that all Provincial and District Authorities must adhere to and more importantly the accreditation strategy must be developed and implemented in a manner that addresses facilities at all levels of the national health system, irrespective of whether they are private or public facilities.

A decision has been made that South Africa will be implementing the National Health Insurance from 2009 onwards. The National Health Insurance Authority will have to enter into defined contractual arrangements with various providers for the provision and delivery of health services. A key aspect of these arrangements will be the requirement that the contracted facilities attain the minimum accreditation norms and standards for health service providers as determined in the national framework agreement drawn up by the National Office of Standards Compliance. This office will be responsible for coordinating activities that will be undertaken with participation and cooperation from existing local and international organisations that have relevant and proven experience in the accreditation of health facilities.

Using the accreditation status received by a provider to the level of reimbursement would provide an incentive mechanism for strengthening quality improvements in hospitals. This could be achieved by rating accredited facilities and the care they provide as good, average and poor. Facilities, especially private providers would then have an incentive to compete with other providers on the basis of quality.

10.7 Roles and Responsibilities of Stakeholders

The following is a high level outline of the roles , responsibilities and stakeholders that will have to be strategically engaged with to ensure success of the accreditation processes:

I. Government

- Establishment of the National Office of Standards Compliance
- Set the long term policy agenda
- Set the policy framework and associated regulations
- Identification of the impact of the burden of disease and shortfalls in health service delivery resulting in, for example, long waiting lists – e.g. 150 000 people awaiting cataract surgery
- Support the initiative and monitoring progress nationally
- Delegate responsibility for programme and accreditation process to external agencies drawing on local and international expertise
- Implementation of timetable
- Identify and support national champions for activities
- Coordinate and provide support to the National leadership Task Force (comprising different stakeholders)

II. Provincial Authorities

- Identify priorities in the province
- Set up Quality Assurance units
- Agree on local implementation plans with recourse to the national framework as determined by government
- Resource allocation
- Monitor performance, acknowledge success, motivate strugglers, identify local champions and task teams

III. District Teams

- Identify implementation teams
- Resource distribution
- Implement programme according to identified priorities
- Monitor progress and provide local support
- Introduce district-wide interventions as appropriate
- Support local champions

IV. Facility Managers

- Lead local implementation and monitoring
- Resource utilisation
- Introduce performance-based initiatives for departments
- Identify facility champions
- Facility level training
- Inter- facility cooperation

V. **Facility staff**
- Implement programmes
- Train the trainers
- Local knowledge sharing and skills transfer

VI. **Quality Improvement provider**
- Coordinate the overall programme
- Provide technical knowledge and assistance
- Provide training on all aspects of the programme using "train-the-trainer" methodology
- Monitoring and evaluation
- Accreditation

Accreditation will be done by the Office of Standards Compliance (OSC), established in accordance to an amended National Health Act (sections 77, 78 and 79) Act. The amendments to the National Health Act will include establishment of the OSC as a statutory body separated from the Department of Health to make sure that there is clear separation between the inspectorate/compliance functions and providers (both public and private). Secondly, the Act will need to be amended to provide NHI specific responsibilities, over and above those that relate to the whole health care system; particularly the private for-profit and not-for profit facilities that are not part of the NHI.

According to Section 78. (1) The Director General (amendment would say, the Minister of Health) must establish an Office of Standards of Compliance within the National Department (outside of the Department of Health and establish a public entity under PFMA) which must include
A person who acts as an ombudsperson in respect of the complaints in terms of this act (not essential because of the responsibilities listed below; the complaints rather go to the health facility committees or Boards)

The Office of Standards Compliance must do the following in line with the requirements of the National Health Insurance)---

(a) Keep the Minister informed of the quality of the health services provided by facilities that provide services under the NHI as measured against prescribed health standards;

(b) Advise the Minister on norms and standards for quality in health services that are paid for by the National Health Insurance;

c) Advise the Minister on norms and standards for the certificate of need processes;

(d) recommend to the Minister any changes which should be made to the

prescribed health standards;

(e) recommend to the Minister new systems and mechanisms to promote quality of health services;

(f) monitor compliance with prescribed health standards by health establishments, health care providers, health workers and health agencies;

(g) monitor compliance by a health establishment, health agency, and health worker and health care provider with any condition that may have been imposed on such establishment, agency, worker or provider, as the case may be, in respect of certificates of need issued in terms of this NHA Act;

(h) report to the Minister any violation of a prescribed health-standard where such violation poses an immediate and serious threat to public health and make recommendations to the Minister on the action to be taken in order to protect public health;

(i) prepare an annual report to the Minister concerning its findings with regard to compliance with prescribed standards and with conditions imposed in respect of certificates of need;

(j) institute monitoring activities and processes for quality assurance in health establishments;

(k) provide advice to the national Department of Health and to provincial departments on quality of care provided by health establishments, health agencies, health workers and health care providers;

(l) inspect a health establishment or health agency in order to determine level of compliance with prescribed health standards and conditions imposed by certificates of need; and

(m) instruct a Health Officer or person designated by the National Commissioner of the South African Police Service in terms of section 80(3) to inspect health establishments and health agencies in order to-

(i) investigate any complaint, allegation or suspicion relating to the complaint, and;

(ii) report to the Minister on the findings of any investigation observation of prescribed health standards; and contemplated in subparagraph (l).

Conclusion

The accreditation of health service providers will improve the quality of health services under the National Health Insurance. There is need for an integrated approach at all levels of the health system to ensure that the quality improvements achieved through this process are sustained over time.

CHAPTER 12: A HUMAN RESOURCES FOR HEALTH PLAN FOR THE NATIONAL HEALTH INSURANCE

12.1. Introduction

A workable and comprehensive Human Resources for Health (HRH) Plan is an essential ingredient of the National Health Insurance Plan. Success of the NHI depends on availability and support of professionals across the entire health sector and the strengthening of the physical and human resources of the public sector, in particular, the district-based system on which our Primary Health Care (PHC) approach depends.

The transformation of the South African health system has at its core the implementation of district-based system driven by the Primary Health Care (PHC) approach. This system should provide an appropriately resourced, adequate and affordable health care at all levels of the service. This transformation requires a more equitable distribution of services between the private and public health sectors, rural and urban areas as well as between wealthy and poor areas. Sufficient numbers of health workers, from professional to mid-level to community-based, must be recruited to sustain the service delivery.

The fiscal austerity measures introduced in the latter half of the 1990's resulted in the stagnation of the remuneration packages of health care workers, gross under-staffing, a significant reduction in production and retention of skilled health professionals. Hence, health services at all levels of care, from community clinics to tertiary hospitals, face a serious human resources crisis. More than one third of public sector posts remain vacant, and substantial numbers of health professionals are not renewing their registration with the Health Professions Council (HPC). There are also growing concerns about the health status of health workers themselves. Indications are that health workers are not always sufficiently protected from infection risks, particularly from TB and HIV, leading to illness and death, and further lowering staff morale (Shisana, Hall et al. 2003)

This chapter outlines a framework and plan for the development of human resources for the NHI. Thus in this chapter, we outline the challenges to the development of an HRH plan, discuss key human resource issues in the health sector and propose measures to strengthen the public sector workforce. It is expected that the framework offered here will be developed and expanded in the final implementation plan.

12.2. CHALLENGES TO THE DEVELOPMENT OF A HRH PLAN

There are a number of challenges which have been taken into account in the development of this plan:

1) Over the past 15 years, government introduced a number of pieces of legislation and policies geared at the transformation of the health care system, including the White Paper on the Transformation of the Health sector, the National Health Act, the new Nursing Act, the Human Resources for Health: A Draft National Strategy Task Team ("Pick Report") published 2000; the DOH's Human Resources for Health Planning Framework

published in 2006 and more recently the Occupation-Specific Dispensation (OSD). Lack of systematic and critical engagement with the developments and lessons of the past 15 years must be corrected urgently to lay the basis for the development of a new implementation plan.

2) Lack of necessary statistics across the health care system for both the private and public sector, for example:

   - The HPCSA figures do not distinguish between those working in the public or private sector nor those in the country and those who are inactive (e.g. retired, overseas, etc).
   - PERSAL data has proven to be not sufficiently accurate for planning and research purposes, as it recently became evident in the implementation of the OSD for nurses.
   - Labour Force Surveys provide some indication of the total active workforce. However, since their classifications of occupations do not always correspond directly with the titles and descriptions of particular occupations as indicated in professional registers, the integration of the information is difficult.
   - Even where one can find sufficient figures to quantify public vis-a-vis private, those individuals who work across both systems: e.g. private doctors who do sessions in public facilities and public doctors who also have private patients are not captured.
   - Available data on the demographics of health professionals that distinguishes race and gender.

3) There is a need for comprehensive projections of human resource requirements based on service requirements (packages). Broomberg and Shisana (1995) provide a model based on data from health centres in Alexandra and Soweto. This methodology can be used to make projections for future HR requirements but needs to be updated to take account of all service levels (not only PHC services), the introduction or expansion of new services (eg. VCT and treatment support), and the introduction of new cadres such as Community Health Workers and various mid-level cadres. (See Appendix A for Broomberg and Shisana's projections and estimates of gaps between demand and supply in certain key health professions).

12.3. KEY HUMAN RESOURCE ISSUES IN THE HEALTH SECTOR

While South Africa's private health sector is of such high quality that it attracts foreign medical tourists, the public sector is overburdened, under-resourced and understaffed. In this section we consider some of the major problems affecting the health system and those measures introduced by government to address them.

d) Maldistribution between public/private, rural/urban.

It is estimated that about 60 per cent of nurses and 40 per cent of doctors work in the public sector serving about 85 per cent of the population. The rest of the nurses and doctors work in the private sector serving 15 per cent of the

population who have medical insurance. However, it is increasingly recognised that private sector professionals are also serving uninsured patients who, for various reasons, choose not to make use of public facilities. Some of these patients will have been deterred by the long queues in the public sector which often mean the loss of a day's income, the distances they might have to travel and the quality and type of care they receive when attended to in the public sector. The Hospital Association of South Africa (HASA) (2008:4) quotes the Statistics South Africa's (StatsSA) General Household Survey of 2005 as reporting that nearly 1,1 million non-medical scheme members visited a private sector facility in June 2005.

A number of factors make the public sector unattractive for health professionals: poor physical infrastructure despite some improvements, the location of many public facilities in rural or inhospitable areas that are often difficult and dangerous to access, staff shortages, the extent of the disease burden, fear of contracting HIV or TB, heavy work loads and low salaries.

There have been numerous policies designed to alleviate these problems and there is some evidence that they have had some positive effect. In this regard, government introduced the rural and scarce skills allowances; increased the nurses' salaries through the implementation of the OSD; provided scholarships/bursaries for rural school leavers on the proviso that they return to these areas to work; community service; the certificate of need and the importation of doctors through bilateral agreements with the Cuban and other governments to serve in rural areas and teach at the Walter Sisulu University's Medical School.

Further measures such as the creation of study and career progression opportunities, improvement of must be developed across all service levels rural hospital management, the provision of transport allowance and educational assistance to children of professionals servicing in rural areas, must be considered.

b) Staff shortages

Doctors and nurses

Data on the employment of health professionals indicate that there has been growth in professional registrations across most health professions (See Appendix for Chapter 12, Table 12.1) and fairly substantial increases in public sector full-time permanent appointments that are probably a reflection of some of the improvements mentioned above. (See Appendix for Chapter 12,). However, these increases conceal the fact that in many categories South Africa is undersupplied and is facing a huge challenge in the medium to long-term:

Table 12.1 Growth in professional registrations, 2002 to 2008

	2002	2003	2004	2005	2006	2007	2008	%change
Medical practitioners	29,903	30,578	31,214	32,198	33,220	34,324	34,687	16.0%
Professional nurses	94,948	96,715	98,490	99,534	101,295	103,792		9.3%
Enrolled nurses (staff nurses)	32,495	33,575	35,266	37,085	39,305	40,582		24.9%
Enrolled nursing assistant	45,426	47,431	50,703	54,650	56,314	59,574		31.1%
Dental practitioners	4,505	4,500	4,514	4,620	4,815	4,937	5,110	13.4%
Dental therapists	364	381	390	417	443	450	455	25.0%
Student dental therapists	92	102	143	123	131		166	80.4%
Pharmacists		10,629	10,891	10,824		11,547	11,905	12.0%
Dental assistants	not yet	not yet	not yet	16	131	375	2,147	13318.8%
Oral hygienists	851	885	933	929	952	953	946	11.2%
EMS practitioners	18,242	23,899	28,937	31,346	36,496	41,831	46,888	157.0%
Environmental Health Officer	2,215	2,307	2,513	2,540	2,607	2,602	2,567	15.9%
Medical technicians	1,001	1,095	1,193	1,214	1,276	1,271	1,378	37.7%
Medical physicist	88	82	84	83	88	86	93	5.7%
Medical orthotist prosthetist	292	294	323	344	345	342	351	20.2%
Orthopedic footwear technicians	39	37	39	34	50	52	52	33.3%
Nutritionists/ Dieticians	1,322	1,433	1,592	1,575	1,687	1,795	1,844	39.5%
Occupational Therapists	2,465	2,511	2,819	2,808	2,922	3,159	3,189	29.4%
Optometrists	2,146	2,218	2,401	2,516	2,633	2,733	2,882	34.3%
Physiotherapists	4,196	4,400	4,785	4,760	4,915	5,240	5,372	28.0%
Physiotherapy Assistants	283	269	275	272	257	249	263	-7.1%
Occupational	495	501	511	506	527	519	475	-4.0%

therapy assistants									
Psychologists	5,302	5,401	5,774	5,878	6,130	6,391	6,598	24.4%	3.7%
Radiographers	4,669	4,789	5,221	5,237	5,433	5,624	5,757	23.3%	3.6%
Speech therapists and audiologists	1,282	1,345	1,397	1,391	1,396	1,441	1,294	0.9%	0.2%
Speech therapy assistants	7	7	6	6	5	5	4	-42.9%	-8.9%

Sources: Health Professions Council of South Africa (HPCSA), SA Nursing Council (SANC), South African Pharmacy Council (SAPC).

South Africa has approximately 69 doctors per 100 000 people, while countries such as the US enjoy around 550 doctors per 100 000 people. South Africa's rural public service has as few as 2 or 3 doctors per 100 000 people in places – a situation comparable to some of the worst-off nations worldwide.

- A recent International Organization for Migration (IOM) report estimates that South Africa loses 1000 doctors per annum. This is ominous given that the country only produced 1122 doctors in 2007 (see Chapter 14 for details of the production of doctors).
- There is also a concern about the slow take-up of female graduates in the medical profession. Although females have outnumbered men in medical schools since 2000 (in 2007 they formed 56 per cent of graduates), the rate of growth in female professional registrations is so slow such that it will take about two more decades for women to reach parity with men in the profession itself.
- There are also concerns about attrition in nursing. The increase in registrations each year falls far short of the number trained. Attrition rates over a ten year period ranged from 66 per cent for professional nurses to 72 per cent for Enrolled Nurses and Enrolled Nurse Assistants. Although we have a greater percentage of nurses in the public sector than doctors, this figure is dropping. In 2001, 62.7% were employed in the public sector. By 2005 the figure had dropped to 60.4%. The figures for professional nurses are particularly low. Of the 99 534 professional nurses on SANC's register in 2005, only 44% were in the public sector, according to the Health Systems Trust (2007).

Table 12.2. Numbers of professionals employed in the public sector, 2002 to 2008

	2002	2003	2005	2006	2007	2008	%change 2002 - 2008	Annual av. Growth 2002 - 2008
Medical practitioners	7287	7645	8747	9527	9959	10653	46.2%	6.5%
Professional nurses	40318	41563	43660	44071	45102	47834	18.6%	2.9%
Enrolled nurses (staff nurses)	20590	20683	20582	20806	21379	22707	10.3%	1.6%
Enrolled nursing assistant	28661	29052	31006	31850	33219	34030	18.7%	2.9%
Dental practitioners	602	613	651	715	744	762	26.6%	4.0%
Dental therapists	123	126	143	146	150	149	21.1%	3.2%
Pharmacists	1238	1222	1617	1746	1830	1853	49.7%	7.0%
Occupational therapists	419	546	605	667	736	785	87.4%	11.0%
Dental specialists	57	30	43	41	3	32	-43.9%	-9.2%
Environmental health practitioners	537	786	890	682	868	814	51.6%	7.2%
Medical specialists	3685	3446	3499	3695	4000	4026	9.3%	1.5%
Physiotherapists	462	628	724	783	850	903	95.5%	11.8%
Psychologists	267	317	399	405	419	433	62.2%	8.4%
Radiographers	2009	2033	2048	2103	2100	2141	6.6%	1.1%

Source: PERSAL data reported in Health Systems Trust (2005,2006, 2007, 2008

- Our ratio of nurse to population (4.1 to 1000 population) is relatively high in relation to our immediate neighbours in Sub-Saharan Africa which are among the poorest countries in the world but far lower than the ratios of countries that recruit from our nurse workforce, including England (12.1 to 1000 population), US (9.4), Australia (9.1), New Zealand (8.2), Canada (10.0). Stakeholders argue that South Africa has a shortage of nurses but disagree about how many and what kind of nurses are needed. Academic researchers have identified a desired Professional Nurse (PN): Enrolled Nurse (EN) / Enrolled Nurse Assistant (ENA) ratio of 1:3. In 2007, the ratio was 1.04:1. However, many health workers and experts have argued for more professional nurses with the four-year comprehensive training

and, ideally, also community health specialisation, in order to support the primary healthcare system and facilitate the administration of anti-retrovirals.

Other categories

Although this chapter highlights shortages of medical doctors and nurses as they are the backbone of service delivery in the health care system, it is essential to note that shortages occur in many occupational categories at all levels. And these other categories play a critical role in the overall health care system. With the specific focus on the first level of care, shortages in secondary, tertiary and quaternary services are often not highlighted. In addition, many of these shortages occur in non-health professional categories and amongst support service staff categories but they nevertheless compromise service delivery levels.

d) Effects of the HIV/AIDS pandemic on the health workforce

Research shows that the HIV/AIDs and TB epidemics are a major factor contributing to disillusionment with the public sector (see Breier et al, in press) and also that many health workers are themselves infected with HIV.

Shisana et al (2003) found 15.7 per cent of 1922 health workers employed in public and private health facilities in the Free State, Mpumalanga, KwaZulu Natal and the North West province were HIV positive. The prevalence in the age group 18 to 35 years was 20 per cent. Furthermore 28 per cent of the patients in the public and private health facilities surveyed in these provinces were HIV positive and the prevalence rate in hospitals alone was 46 per cent. The study concluded that the HIV and AIDS epidemic will impact on the health system through 'loss of staff due to illness, absenteeism, low staff morale and the increased burden of patient load'. (2002:131)

Veriava et al (2005) tested 1444 health workers at two public hospitals in Johannesburg and found a prevalence rate of 11.8 percent in general. Nurses had the highest prevalence (13.7 per cent in general and 3.8 per cent among student nurses). The researchers predicted about five deaths among professional nurses and three among staff nurses out of an estimated 52 and 32 HIV positive staff in each of these categories respectively. The researchers concluded that hospitals should aim for '100 per cent VCT uptake for staff' in order to reduce the risk of opportunistic infections, especially TB, among HIV positive staff.

Progress has been made in the fight against HIV and AIDS and infected health workers are better placed to receive the care necessary to keep them relatively healthy and working for a long time. However, research by Breier et al (in press) suggests that there is a particularly endemic stigma associated with HIV infections amongst health workers; and for this reason they are actually less likely than the rest of the population to come forward for testing and treatment, despite their access to such services.

c) Employment Practices

The 2007 public sector wage agreement included that measures must be undertaken by government to ensure that vacant posts are funded and filled, as part of the necessary improvements of the working conditions of both the nursing and support service staff in the public health facilities. But the current through-put of comprehensively trained nurses is far below the required level to improve the conditions of work experienced by nurses in the public sector. There is also evidence that a key factor is attrition – the gap between numbers trained and growth in registers. In addition, the implementation of the Service Transformation Plans in various provinces has led to the down-grading of some hospitals, hence the reduction of hospital beds and staff.

The situation pertaining to the support service staff in the public health sector is particularly precarious:

- Significant amounts of the support services staff have been outsourced and in some provinces this trend continues. Outsourcing has significantly affected the moral of the support services staff, given the fact that where it has been introduced the wages and benefits of those affected have been cut an estimated 40%.
- Many public health facilities lack adequate support service staff, leading to situations where the nursing staff performs some of the functions of the support service staff, thereby undermining quality care of patients.
- There have been no career-pathing programmes for the support service staff.
- The widening of the wage-gap in the public health sector has been at the expense of the support staff in particular.

Addressing the above and strengthening the human resource capacity calls for:

- Ending outsourcing and the reintegration of the support service staff into the public service.
- Addressing the wage-gap particularly in relation to the support service staff and developing a career-pathing programme as part of the human resource development plan.

Given the inadequate number of nurses joining and retained by the public health sector, the introduction of the Community Health Workers (CHW) appear to be seen as a substitute for the filling in of vacant posts. Certainly, the growing cadre of CHWs is an important development in the strengthening of the human resource capacity of the public health sector. However, as part of endeavours to improve the Expanded Public Works Programme:

- More CHWs must be directly employed by the government.
- Government needs to develop standardised conditions of work applicable to those employed by non-governmental organizations, in particular.
- Given their precarious status, there is a need for the introduction of a minimum wage regime in consultation with trade unions organising in the sector.

d) Emigration and Foreign workers

One of the defining features of globalisation is the migration of labour, in particular scarce and skilled labour such as health professionals – particularly doctors and nurses but not confined to these. South Africa has been a target of concerted recruitment programmes by developed countries and these health professionals emigrate in significant numbers per year. Government must develop a comprehensive programme geared at bringing back these skilled professionals to South Africa, as part of the homecoming revolution.

At the same time, there has been some immigration of doctors and nurses from other parts of Africa, especially the SADC into South Africa. Many of these professionals have found themselves being unable to work in South Africa, due to our government's policy stance – which sought to avoid a situation where the South African health care system benefits at the expense of other poor countries in the region. However, some of these professionals continue to live in poverty and are forced to take up any kind of job they can find in South Africa even when their desperately required skills could be utilised in our health care system. A review of this policy must be undertaken especially with regard to those whose presence in South Africa is properly documented and legal.

Research evaluating the Cuban Doctors Programme, a product of a bilateral agreement between the South African and Cuban governments, which in 1996 led to the recruitment of Cuban doctors to work in South Africa and subsequently the training of scores of South African doctors in Cuba testify to its success. The programme aimed at strengthening the provision of health care in the areas of greatest need, i.e. townships and rural areas whilst at the same time helping South Africa in the production of more highly trained doctors to strengthen capacity in public health care. Despite the fact that the programme has demonstrated tangible success, since the Cuban doctors are mostly brought in to provide curative care to the exclusion of preventative services, the full potential of the programme is not realised. In addition, the number of Cuban doctors still involved in the programme is declining in various provinces. Hence there is a need for a comprehensive national review of and recommitment to the programme, with a view of expanding its scope.

e) Recruitment and retention

The continued concentration of medical doctors in the private health sector, despite the introduction of public sector incentives such as scarce and rural skills allowances, indicates the need for further measures to attract and retain doctors in the public service. In this regard, a mechanism for rapid identification, assessment, advertising and filling of vacant posts must be created.

Inefficiencies around processing time in filling of posts and the payment of salaries, particularly for community service professionals must be addressed. Recruited staff should have access to an orientation and ongoing support programme that addresses clinical, cultural and logistical integration into working in health care facilities and South Africa in general.

There are other South African health professionals who have moved out of the health care system into different fields in the private sector, amongst whom there are those who have acquired some relevant managerial skills. Improving the conditions of work and infrastructure will be key in successfully recruiting many of this cadre back into the public health care system.

f) Increase the number of medical staff working on a sessional basis in the public health care system.

Attention needs to be paid to the workload of doctors working in the public sector, particularly rural areas. The introduction of medical assistants could alleviate some of this workload in the future. In the meantime, more private doctors could be recruited into offering their services on a sessional basis.

Strategies also have to be developed to ensure that the specialist capacity residing in the private sector is utilised effectively. In the public sector however, doctors would have opportunities for research and personal development which such work might offer and the personal satisfaction of working for the benefit of the poor.

g) Task-shifting

Task-shifting has been presented as a possible solution to the shortage of skilled professionals in developing countries, particularly in the context of meeting the challenge of HIV and AIDS. Task-shifting in health care involves the delegation of tasks to workers with lower qualifications or from trained to lay health workers (Philips, Zachariah and Venis, 2008:1).

Nurses

The major area of task-shifting for nurses is in the context of administration of ARVs which was initially confined to medical practitioners. Here task-shifting needs to be seen in relation to the scope of practice and associated legal implications. Salaries of nurses who routinely do the work that is above the usual scope of practice of a nurse should be reconsidered adjusted accordingly. Already, there is considerable resentment about the ways in which nurses are required to do the work of doctors without the pay that doctors earn. Nurses' unions and professional associations must be meaningfully consulted on all initiatives in this regard particularly with regard to the scope of practice and professional indemnity.

There are particular concerns about the position of Clinical Nurse Practitioners (CNP) which are seen as a means to address the shortage of doctors in poor and rural areas. There are no available actual numbers of CNPs trained to date, but they are generally understood to be low, particularly in the Western Cape. Kapp and Mash (2004) have shown extensive underutilisation of CNPs' capacities in Cape Town for numerous reasons. Yet the provincial government plans to increase the number of CNPs six fold from 71 posts to 466 while reducing the number of professional nurses from 698 to 340. (PGWC, 2007:22).

Mid-level Workers

A major portion of the task-shifting occurs with Mid-level Workers (MLWs), i.e. health care providers who are not professionals but who render health care in communities and facilities. As a result of shortage of various categories of health professionals in South Africa, MLWs work under the direct or indirect supervision of professionals. Their accredited training means that they are registered with professional councils though their scope of practice is limited. As a result of vacancies in the public services, in most instances they do not work under the direct supervision of professionals. Instead, they work independently and even lead health care teams, particularly in primary and community care.

The most common MLWs are nurse auxiliaries/assistants and pharmacist assistants. However there are further categories namely Dental Assistants, Nutrition Assistants, Physiotherapy Assistants, Occupational Therapy Assistants and Ophthalmological Assistants.

The draft national policy on MLWs is silent on those involved in health promotion and preventative care. These cadres of workers could take responsibility for local management of 'mid-stream interventions' particularly patient support groups, health promotion campaigns and transversal programme coordination across facilities and CBS.

Community Health Workers

Community Health Workers (CHW) programmes have a role to play that cannot be fulfilled by either the health services or the communities alone. Ideally the CHWs combine service functions and developmental/promotional functions that go beyond the field of health. Perhaps the most important developmental or promotional role of the CHWs is to act as a bridge between the community and the formal health services in all aspects of health development. The bridging activities of CHWs may provide opportunities to increase both the effectiveness of curative and preventive services and perhaps other important, community management and ownership of health-related programmes. CHWs may be the only feasible and acceptable link between the health sector and the community that can be developed to meet the goal of improved health in the near term (Kahssay, Taylor & Berman, 1998)

CHWs are in the main employed by NGOs who receive funding from Provincial Departments or from donors (often via the DOH). Payment of CHWs is based on stipends and the rationale for such low pay is that CHWs are paid for half day work although this is often not the reality of their working hours. This low level of payment means that the turnover of CHWs is high as they leave for better paid work – quite often into the private hospitals and hospices. It is also socially unjust and unacceptable to expect members from poor and vulnerable communities to work for, at best, the equivalent of minimum wages and to forego opportunities for development.

The need for career progression and training opportunities for CHWs and MLWs

12.4 TOWARDS A HUMAN RESOURCES FOR HEALTH PLAN

Most initiatives listed below must be implemented in the short-term. However some of the outcomes would be medium to long-term. The time-frame referred to in the table speaks to the expected date of outcome rather than initiation and it is defined within the context of a five-year-period of the implementation of the NHI plan.

PROPOSAL	TIME FRAME
Commission a comprehensive review of national and provincial health legislation and policy documents.	Short-term
Strengthen and extend current initiative by the DOH to develop a Comprehensive Human Resources Information Systems to link all aspects of human resource management and development in both the public and private sector with immediate effect.	Medium-term
Conduct a national staff survey to gather baseline information to ascertain distribution of personnel by district and facility, level of care, age, gender and qualification. This information or data must be integrated with PERSAL.	Medium-term
Review and alignment of tasks and staff configurations with service packages.	Short-term
Improvement of conditions of service for health professionals in rural areas.	Short-term
Delivery of induction and orientation programmes.	Short-term
Determination of actual shortages and vacancy rate within all categories of workers in the service.	Short-term
Complete the Comprehensive Human Resources Information System.	Short-term
Address wage-gaps particularly in relation to the support service staff..	Medium-term
Development of career-pathing programme for the support service staff	Short-term
Integration of CHWs into the service with the introduction of a minimum wage.	Short-term to medium-term
Outsourcing within all categories of personnel ended and the support service staff reintegrated into the public service	Short-term
Review policy on registration of health professionals from SADC countries who are legal immigrants.	Medium-term
Undertake research on health professionals other than doctors and nurses.	Short-term to medium
Undertake comprehensive national review on the Cuban Doctors Programme with a view to extend and escalate it.	Short-term
Investigate the importation of specialist clinicians and other scarce health professionals from other countries - who brought into a programme for training and skills transfer to South Africans.	Short-term to medium-term

12.5. Proposals for addressing the human resource challenges

12.5.1. Introduction

This chapter deals with the development of HR capacity in the public sector through increasing production of health professionals and in-service training, which includes reorientation through Continuing Professional Development (CPD) and skills development of personnel, particularly managers. The chapter will not address all production and training needs but reflects areas of critical importance.

Despite numerous training initiatives aimed at supporting district development, planning management skills of middle and senior managers in many areas remain weak and working environments are not conducive to change and

12.5.2 Trends In The Production Of Health Professionals

d) Decline in production of doctors and other health professionals

Comparison of trends in the production of key categories of health professionals between 2002 and 2007 shows that many of the targets set in the National Human Resources for Health Planning Framework (DOH, 2006) are unlikely to be met.**[See Table 12.1]**

Table 12.1 Targets proposed by the NHRH Planning Framework (DOH, 2006) vs. actual production, 2002 to 2007

Category	Proposed annual national production (Doha, 2006)	Actual production							
		2002	2003	2004	2005	2006	2007	% change	Annual av. growth
Medical practitioners	2400 by 2014	1212	1296	1399	1511	1196	1122	-7.4%	-1.5%
Professional nurses	3000 by 2011	1652	1553	1716	1533	2027	2342	41.8%	7.2%
	[2 years bridging] [1]	679	1841	2103	2352	2364	2093	208.2%	25.3%
Enrolled nurses (staff nurses)	6000 by 2008	2771	2308	4273	4565	4816	4758	71.7%	11.4%
Enrolled nursing assistant	10000 by 2008	3076	4390	6698	6754	5422	6136	99.4%	14.8%
Dental practitioners	Reduce to 120 by 2008	175	244	168	239	268	206	17.7%	3.3%

Dental therapists	Increase to 600 by 2009	38	36	33	22	27	29	-23.7%	-5.3%
Dental technicians	Maintain current levels	75	78	78	77	116	99	32.0%	5.7%
Dental assistants	300 by 2008	108	55	113	99	120	141	30.6%	5.5%
Oral hygienists	150 by 2009	18	64	53	62	34	45	150.0%	20.1%
Pharmacists	600 by 2010	385	463	696	590	540	511	32.7%	5.8%
Pharmacy Assistants[2]	900 by 2008								
EMS practitioners	*	24	22	26	53	77	64	166.7%	21.7%
Environmental Health Practitioners	Maintain current levels	356	269	308	501	450	440	23.6%	4.3%
Medical physicist	80 by 2010	49	114	97	76	93	86	75.5%	11.9%
Medical orthotist prosthetist	50 per year until 2010	18	18	19	20	39	49	172.2%	22.2%
Nutritionists/ Dieticians	250 by 2010	73	75	83	86	66	89	21.9%	4.0%
Occupational Therapists	350 - 500 by 2010	190	226	204	254	241	258	35.8%	6.3%
Optometrists	100 by 2010	169	145	118	156	190	123	-27.2%	-6.2%
Physiotherapists	500 by 2010	258	312	290	297	343	318	23.3%	4.3%
Occupational therapy assistants	300 by 2010	11	19	26	30	10	18	63.6%	10.4%
Clinical Psychologists[3]	150 by 2009	[396]	[329]	[338]	[333]			-15.9%	-5.6%
Radiographers	600 by 2010	232	281	229	321	336	359	54.7%	9.1%
Social Workers	*	700	724	630	622	823		17.6%	4.1%
Speech therapists & audiologists	500 by 2010	115	117	159	175	135	162	40.9%	7.1%

Sources: Figures in column 2 from DOH (2006); remaining figures from the DOE HEMIS (2008)

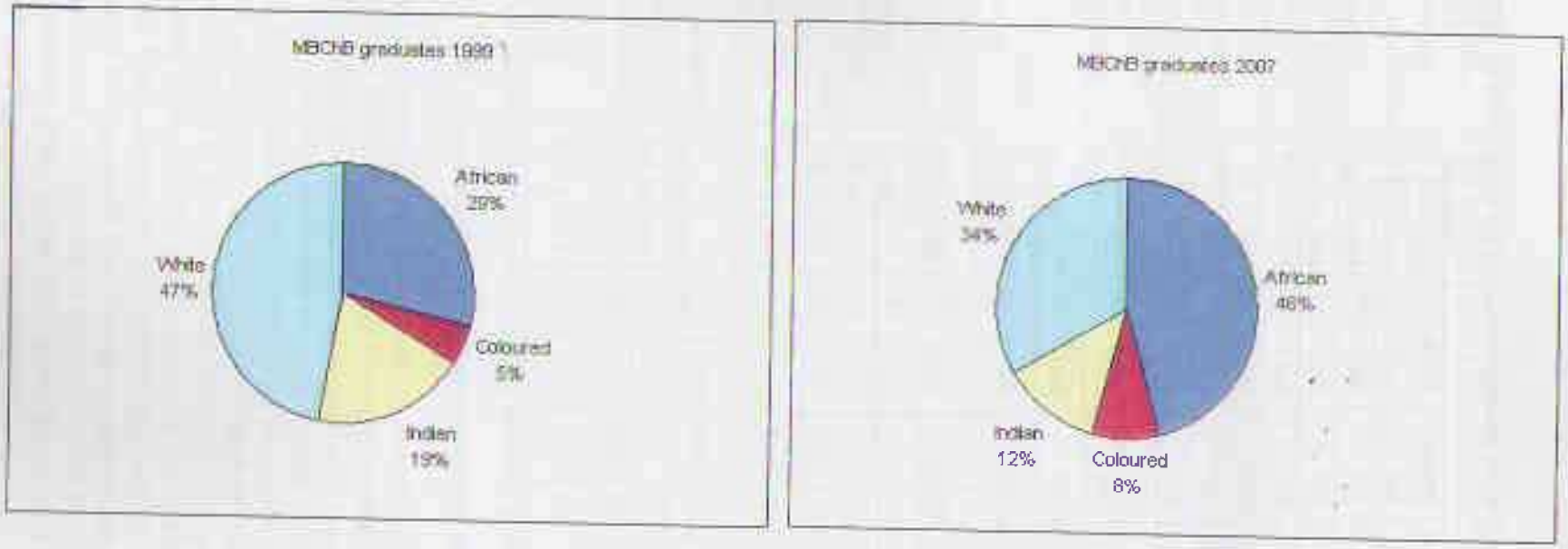
Note: the shaded areas indicate that no figures were available for that category or year.

A major concern is that the output of medical practitioners has dropped seven per cent since 2002 with an annual average decline of 1,5 %. In 2007 there were only 1122 medical graduates from all eight medical schools in the country. Yet the DOH plan of 2006 proposed that the annual production of doctors should double (from 1200 to 2400 per annum) by 2014. There are many possible explanations for the actual decline, including a shortage of medical academics which is related to the shortage of specialists who are willing to practice in the public sector. This decrease could also be associated with the changing medical schools' admission criteria. Medical schools are increasingly admitting students from disadvantaged and rural backgrounds that are less academically prepared than previous intakes and often take more years to complete their degrees than those from privileged backgrounds. **[See Table 12.2, and Figure 12.1 for details of the transformation of medical schools.]**

Table 12.2 MBChB graduates from all eight medical schools, by race, 1999 to 2007

	Year	African	Coloured	Indian	White	Total
	1999	379	64	244	622	1309
	2000	293	53	219	566	1131
	2001	350	67	247	565	1229
	2002	394	76	241	501	1212
	2003	422	115	233	526	1296
	2004	487	69	309	534	1399
	2005	598	88	309	516	1511
	2006	527	98	152	419	1196
	2007	511	93	139	379	1122
	Change N	132	29	-105	-243	-187
	Change %	34.8%	45..3%	-43.0%	-39.1%	-14.3%
Totals	Average annual growth	3.8%	4.8%	-6.8%	-6.0%	-1.9%

Figure 12.1 Proportions of MBChB graduates by race, 1999 and 2007



In 2008, government put aside an extra R900 million for the eight medical schools with the view of inducing them to increase the admission and thereby the production levels. However, according to the Deans of these medical schools these funds are insufficient. At the same time, there have been strong calls for the establishment of private medical schools, although there are concerns that such a move lead to the further depletion of capacity in the public sector. Given this shortages and bottlenecks in the supply of required numbers of doctors, the bi-national programme between South Africa and Cuba through which there are young South Africans training in medicine in Cuba must be strengthened and extended beyond medical officers.

b) Decline in the role of the public sector in the training of nurses

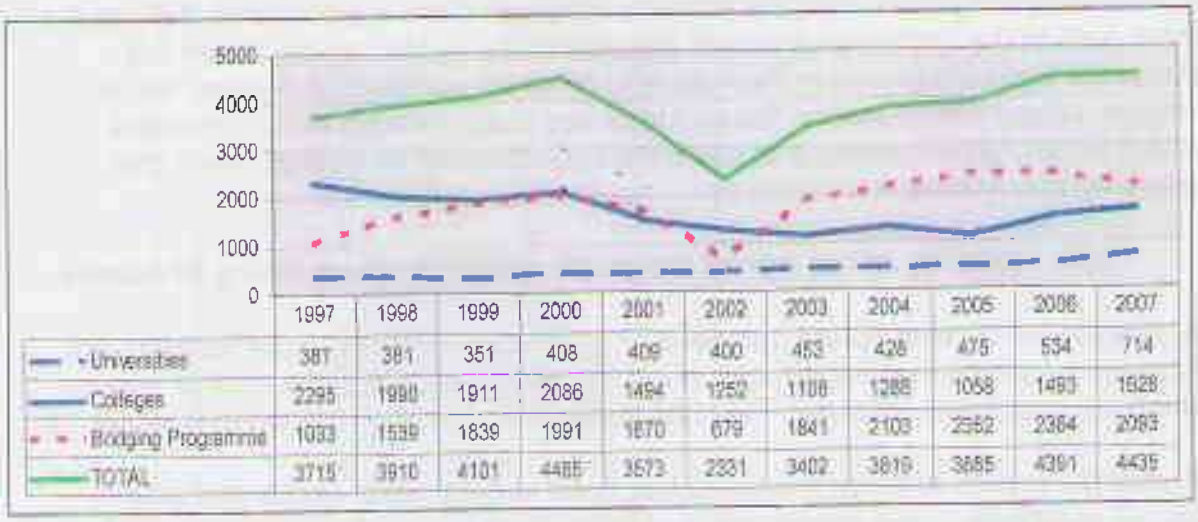
In contrast the nursing output has already exceeded the DOH target for 2011 but there are concerns that the education system is not producing the type of nurse which the country needs most. This has been extensively discussed in Chapter 13.

Most of the growth of nursing training has been in the private sector and little of this will contribute to the development of capacity in the public sector. For various reasons the role of the public sector in the training of nurses has declined dramatically.

Breier et al (in press) found that the public sector continues to be the sole provider of the four-year professional-nurse programmes, which include community, psychiatry and midwifery. However, as a result of this, as well as the fact that many nursing colleges were shut down during the restructuring of the sector, the output of nurses considerably declined, viz. in 2007 the public sector produced 340 fewer professional nurses than in 1997. Nonetheless, the new nursing qualifications as prescribed by the Nursing Council in 2008 suggest a 3 year diploma and a four year degree. In general, there should be a caution against grade creep – where professionals are required to have higher qualifications than are necessary for the job.

Most professional nurses are now trained through the bridging programme, which does not include much-needed midwifery, psychiatric and community-nursing skills; and the private sector is also assuming an increasingly significant role in bridging training. [See Figure 12.2] The application of the Recognition of Prior Learning will be particularly important, as it has proven to be relatively successful in other sectors of the economy.

Figure 12.2 Output of professional nurses, 1997-2007

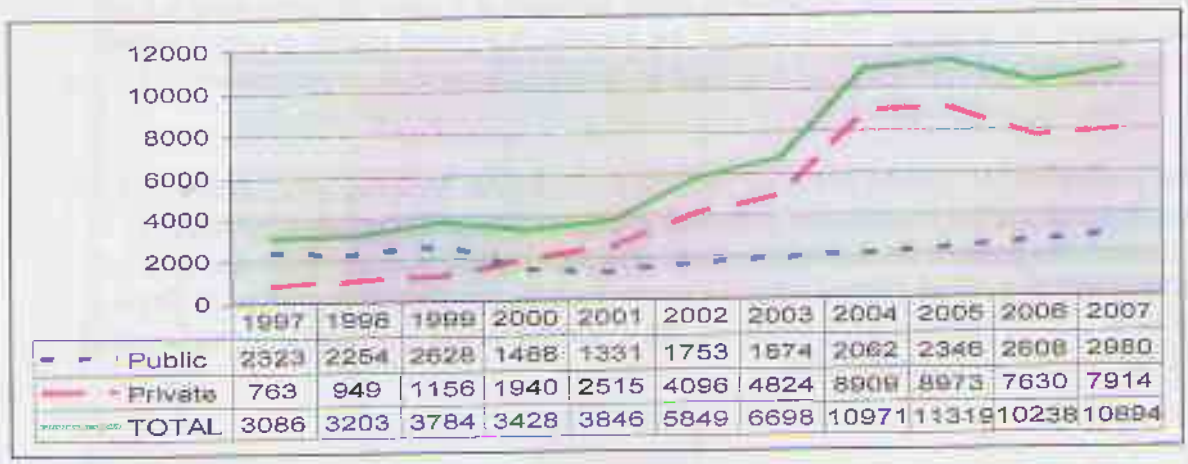


	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Universities	387	381	351	408	409	400	453	428	475	534	714
Colleges	2295	1990	1911	2086	1464	1252	1108	1288	1058	1493	1628
Bridging Programme	1033	1559	1839	1991	1670	679	1841	2103	2552	2364	2093
TOTAL	3715	3910	4101	4485	3573	2331	3402	3819	3885	4391	4435

Source: SANC (2007)

The private sector now also trains the vast majority of enrolled nurses and ENAs [see Figure 12.3]. While many trainees gain high level training offered by the major hospital groups or reputable independent colleges, there are also many those who receive training of dubious quality in private colleges that are not always able to provide appropriate clinical experience.

Figures 12.3 Output of sub-professional (ENA and EN) nurses, 1997 – 2007



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Public	2323	2254	2628	1488	1331	1753	1674	2062	2346	2608	2980
Private	763	949	1156	1940	2515	4096	4824	8909	8973	7630	7914
TOTAL	3086	3203	3784	3428	3846	5849	6698	10971	11319	10238	10894

Source: SANC (2007)

The high attrition rate of nurses was noted in Chapter 13. Qualitative research reported in Breier et al (in press) indicates that much of the attrition appears to be occurring immediately after graduation. They found that many nursing students enrolled in four year programmes do not actually want to be nurses but are attracted to the programmes because of the bursaries or salaries offered or because they think that the training will be a stepping stone towards other programmes with higher entrance criteria in the universities. Many others who would have actually wanted to become nurses, are put off by the current appalling conditions in the public hospitals which they experience in the course of their training. Those who complete the training are likely to emigrate.

c) Development opportunities for community heath worker cadres

CHWs in particular are presently being kept outside the health system, with no, or very limited, career opportunity. If CHWs are likely to provide essential health services in the medium- to long-term however, then they need to be encouraged to take up available opportunities for training. Lack of career or development opportunity will act as a disincentive and demotivator.

Historically the training of CHWs was done through the medium of non-accredited short courses. With the advent of the current education, training and development framework, four levels of community health workers training have been accredited via the South African Qualifications Authority. A fully qualified CHW could take four years of study. However this process does allow for the development of permeable, portable and laddered career structures, similar (and linked) to the structure of the National Qualifications Framework within bands of health care professions. In addition after completion of Level 3 and 4, CHWs could be recruited for mid-level worker training (particularly pharmacist assistant and nursing assistant) with the advantage of depth of knowledge and experienced gained whilst working as a CHW.

There are plans to introduce a category of community based workers known as Community Care Givers who would be employed by NGOs and whose training would be based on skills set.

d) Development opportunities for mid-level worker cadres

Career paths and progression and the integration of MLWs into the staffing structures of the formal health system have not been addressed satisfactorily, a fact that contributes to their continued lack of legitimacy and acceptance within health services. Nor do the current qualifications allow for career pathing into either professional categories.

There is a particular need for government to undertake an extensive training programme for lay HIV/AIDS counsellors - who are currently largely employed by NGOs - although they are usually facility-based. They therefore have the same uncertainties regarding stability of employment and access to career pathing as do CHWs.

e) Development opportunities for emergency services

The training of emergency services personnel is of crucial importance. It is estimated that only about one quarter of those trained are working in the public sector and many have emigrated.

At present the training of the emergency services personnel is divided into two streams, namely the modular and tertiary streams. However, the modular stream which covers the Basic Ambulance Course, the Ambulance Emergency Assistant Course and the Critical Care Assistant Course is set to be stopped. The tertiary model is actually a midlevel worker course i.e. it produces Emergency Care Technician (ECT). The first intake will graduate this year with National Diplomas and the B Tech degrees.

At present there are only 4 colleges in the country that are accredited (though not fully) to provide the ECT training and 4 University of Technology providing national diplomas (NDip) upwards. There will be approximately 20 ECTs graduating in April 2009 but this will still not be adequate in terms of what is required relative to the shortage. A University of Technology can only produce about 15 graduates per year which again is clearly not enough for the country. The modular courses were producing a substantial amount of graduates and now since it has been terminated the challenges have been compounded.

f) Development opportunities for support worker

Other health workers such as cleaners and porters also do not have a clearly defined career-pathing programmes. Career-pathing programmes in areas such as administration and procurement/ordering should be considered.

12.6 In-Service Training And Skills Development

The devolution of authority as envisaged by the NHI will require changes in management culture towards decentralised and empowered management and a renewed focus on the strengthening of management skills at all levels of the system, including skills in financial management and procurement, people and programme management and monitoring and evaluation.

The need to train healthcare professionals for the needs of the country in terms of epidemiology in the population must be recognised.

The development of norms and standards and the alignment of staff and service norms referred to in Chapter 13 will also facilitate the review of training provisions and capacity and the development of training and development plans.

Appropriate in-service training and skills development of employees – particularly management training and maintenance of competencies through Continuing Professional Development (CPD) training – must be expanded and made sustainable. Sources of funding are directly from the National Skills Fund and efficient utilisation of Skills Development levies within each Department.

There needs to be a specific training programme for the support service staff, addressing issues such as procurement, in order to ensure efficiency in National Health Insurance Authority. This is illustrated by the current situation in the public sector in the procurement process whereby the support service staff or procurement officers do not have adequate knowledge of the health sector. This results in procurement of incorrect and inappropriate material, further compromising service delivery.

So, there a number of in-service and skills development programmes that must be undertaken:

a) Maintenance of health delivery competencies

This training should not be limited to health professionals, but must also include support service staff. However, the maintenance of competencies is not prescribed for the associates/mid-level workers by the HPCs and this remains a priority in the health system.

b) Management training

The devolution of authority as enviseged by the NHI will require changes in management culture towards decentralised empowered management multi-disciplinary teams and a renewed focus on the strengthening of management skills at all levels of the system.

Managers in the health care sector seldom have appropriate management qualifications. The predominant profile is that of a healthcare professional that has migrated into management with no formal management qualifications.

Management training must cascade down to supervisory level. It is well established and accepted that careful and regular supervision impacts profoundly on quality of service delivery.

In a series of research articles, Pillay (2007, 2008) surveyed competencies of hospital managers and nurse managers in both the public and private sector. Results of this survey are included as Appendix A and the following two sections on key findings drawn from Pillay's research reports.

12.7 Key findings in research on hospital managers

Both the public sector and private sector hospital managers rated competencies related to 'people management', 'self management' and 'organising skills' highest and in the same order of importance, followed by 'strategic planning' and 'health delivery', respectively. Public sector managers rated the importance of all the competencies significantly higher than the private sector managers, except for 'people related skills' where there was no significant difference in the level of importance.

Demographics of respondents suggest that the transformation and equity objectives of the public sector are being met and that females are not precluded from occupying senior management positions. Although it is understandable in terms of government's transformation policy, it is of concern that the majority of public sector hospital managers are vastly inexperienced having been in management positions for less than five years.

The use of current public sector managers who are highly experienced could be utilised through an in-house mentoring model in a broader career management and succession planning initiative to develop individuals with management potential. This programme would provide for future sustainability and stability of public sector institutions.

Pillay found that generally, formal management development programmes made no significant difference to competency levels. This is corroborated by the lower self-assessed proficiency levels among managers who attended formal programmes, as well as the lower proficiency rating of public sector managers, the majority of whom admitted to some form of formal training.

Informal approaches significantly improved competency levels in all facets of health management. This implies that the current approach to the development of health managers which is focused on a predominantly formal and didactic approach is having minimal impact on management capacity. Instead, managers are more likely to improve their skills and competencies by informal means based on an experiential approach which may include mentoring and coaching, networking with colleagues and in-house programmes.
This approach has the benefit of tailoring training to practices and issues relevant within an institution, of exploring issues in a non-threatening environment, of increased acceptability and convenience to participants and of facilitating and enhancing senior manager's contribution to management development.

12.8 Key findings in research on nurse managers

Nurse managers who received some form of informal training (mentoring/coaching, in-service training and non-certified programmes) were significantly more likely to perceive themselves as being more competent in planning, organising and legal-ethical competencies than their colleagues who received no informal in health care management. This is especially pertinent given that it correlates with the findings in the survey on health managers.

The fact that there is a significant difference in competency levels of managers between the different sectors with private sector managers rating themselves significantly higher on all of the competencies, except for health services delivery where there was no difference, may partly explain the differences in performance between the sectors. Plausible explanations for this discrepancy may be that the emphasis and scope of professional development within the private sector may be better and broader within the private sector (Mediclinic, 2008; Netcare, 2008; Life healthcare, 2008), the migration of more experienced managers from the public to the private sector (Matsebula and Willie, 2007; Goudge et al 2002), and the difficulty of managing in a public sector milieu characterized by understaffing, poor

resource endowment and higher nurse-patient ratios (Harrison et al., 2007; Padarath et al., 2003).

Ninety-five (95) percent of public sector nurse managers reported having some kind of formal training in health management.

An indication of outcomes from management training is attached as Appendix B

Management qualifications

The need for management qualifications is also acknowledged by the Department of Public Service and Administration, which is an absolutely key requirement of a management qualification for all public sector managerial positions from directorship upwards. Deputy Directors are not required to have formal management qualifications but need to prove substantial managerial experience in the absence of such qualifications. However it does not appear that this requirement has been applied to public sector health care management appointments. The need for health managers to have formal management qualifications is further supported by organisations such as the World Health Organization that has identified the need to develop managerial competency as critical to achieving the Millennium Development Goals.

Training on the PFMA would have to be delivered by accredited specific training institutes with specialist training competencies.

Management training providers

Universities offer a number of out-service and in-service programmes of varying durations. The providers of management training include a large number of higher education institutions that historically provided generic management training and are systematically beginning to offer generic management training linked to health sector specific management training.

It could be argued that few health care managers require masters level management qualifications such as MBA degrees. There is a benefit in promoting management qualifications that are customised to the needs of the health care sector.

Changing the culture of management for the NHI

The devolution of authority as envisaged by the NHI will furthermore require changes in management culture towards decentralised and empowered management and a renewed focus on the building of a multi-skilled and multi-facetted team within districts and institutions.

There is a growing concern that despite numerous training initiatives aimed at changing the attitudes of staff to the patients there is still a long way to go before the results yield changes.

The inclusion of training on self-mastery, ethics and diversity within customised curricula specifically to address situations peculiar to working in a public health system will be included.

12.9 Towards A Human Resource For Health Plan for National Health Insurance

Most initiatives listed below must be implemented in the short term. However some of the outcome would be medium to long term. The time-frame referred to in the table speaks to the expected date of outcome rather than initiation and the timeframe is defined within the context of a five-year period.

PROPOSAL	TIME FRAME
Address decline in production of doctors	Medium-term
Re-assessment of public sector nurse training - continue opening nursing colleges	Short-term to Medium-term
Reprioritisation in provincial and hospital budgets so that public sector resumes its role in the production of enrolled nurses and enrolled nurse assistants.	Short-term to Medium-term
Re-assess projected health professional production totals in the light of the HIV, AIDS and TB epidemics	Short-term
Address career progression of community and mid-level cadres particularly the need for HIV/AIDS lay counsellors.	Short-term
Address training of emergency care practitioners with attention to the implications of stopping modular training.	Short-term
Allocation of more resources to public institutions of higher education including strengthening responsive institutions such as Medunsa.	Medium-term
Establishment of additional tertiary institutions and/or satellites in each province and/or at community level such as in Cuba.	Short-term to Medium-term
Strengthen teaching, training and research capability of the tertiary institutions awarding scholarships for training of specialists and super-specialists	Medium-term
Extend internship and community service programme to all health professionals	Short-term
Address Continuing Professional Development for mid-level workers	Medium-term
Extend training and development programme in Cuba to other health professionals and support workers	Short-term to Medium-term
Review the efficacy and efficiency of current management development programmes	Short-term
Undertake audit of management qualifications of all National and Provincial Health Care managers	Short-term
Integrated generic management training with specific material related to health care management	Short-term
Introduce specialised courses on the PFMA	Short-term
New and creative training approaches that combines formal instruction with informal practices to be on team-building interventions to create synergy amongst	Short-term

managers in a particular district/institution	
Base formal instruction on an experiential approach and include case studies drawn specifically from the experience of the participants	Short-term
Include mentoring and coaching, networking with colleagues and in-house programmes in management training programmes	Short to Medium-term
Monitor and evaluate performance of managers on courses	Short -term to Medium-term
Formal training courses to be provided by accredited providers – public bodies (universities) or private organisations	Short -term to medium

CHAPTER 13 GENERAL INFRASTRUCTURE INVENTORY AND DEVELOPMENT

The success of the NHI system hinges on significant improvements in the public health care infrastructure on one hand and the equitable distribution on the other. Public sector facilities should strategically constitute a significant part of the service delivery model for the National Health Insurance and therefore a plan that focuses on maintaining and refurbishing the current stock of health facilities, construction of new facilities where they are needed and entering into public –private partnerships for public purposes is essential for the attainment of the principle of universal coverage. This chapter outlines what needs to be done in order to ensure that the physical capacity of the health care system is enhanced over the five year implementation period for the NHI system.

13.1 Audit current infrastructure, building and equipment

A comprehensive evaluation of the current stock and status of existing public health care facilities at all levels (primary, secondary, tertiary and quaternary including specialist hospitals) is vital for developing a comprehensive infrastructural refurbishment and expansion plan. Tables 13 and 13.1 show the current stock of both public and private health facilities that are available in the country by level of care.

Whilst this data is an important indicator of the structural availability of services, it does not say much about the functionality and hence potential access to quality health services by the catchment population. The distribution of facilities by district , provincial and national is critical for the National Health Insurance System. Therefore the following activities have to be undertaken as both precursors and concurrent activities towards strengthening the health care system to deliver the envisaged comprehensive package of services:

1. An infrastructure audit of both public and private sector facilities - this will entail collecting data on the numbers, location, size, ownership, level and type of facilities.
2. An equipment audit by level of facilities - this will entail collecting data on essential equipment required (according to the norms and standards) to provide primary, secondary, tertiary and quaternary (including specialist) services in the country.

An updated inventory with additional information on the general level of functionality of the facilities will form the basis for designing an infrastructure expansion programme for the entire sector. Linking the results of this exercise to established norms and standards by the National Department of Health and the World Health Organisation will allow for the identification of existing gaps and the areas that need to be urgently addressed. It is important that the level of physical preparedness of the sector (in terms of infrastructure, buildings, equipment and others) be aligned to the NHI comprehensive package of services. Furthermore, the accreditation strategy of the existing health facilities for NHI will be informed by their level of preparedness and in cases where further refurbishments are required; the critical areas will be identified through this exercise.

Table 13 Public and Private Health Care Facilities by Province and Level

Province	Private Hospitals		Private Facility Beds		Clinics	Public Health Facilities, 2007**							
Province	2007 *	2008 *	2007 *	2008 *	Clinics	CHC	Mobile Services	District Hospital	Regional Hospital	Provincial Hospital	National Central Hospital	Specialised hospitals	Useable Beds Public Sector, 2005
Eastern Cape	14	14	1 488	1 488	683	32	140	61	9			19	13 421
Free State	12	14	2 016	2 119	231	35	112	25	5	1	1	3	4 970
Gauteng	82	82	13 558	13 454	307	33	50	9	12		4	10	15 317
KwaZulu-Natal	32	32	3 827	3 865	547	15	153	40	14	2	1	19	23 833
Limpopo	7	7	455	454	411	27	128	33	5	2		4	8 431
Mpumalanga	8	8	1 021	1 058	231	36	76	23	3	2		6	5 040
Northern Cape	4	4	325	335	118	20	32	24	1	1		3	1 988
North West	17	17	1 922	2 165	286	51	94	19		4		2	4 849
Western Cape	35	34	4 222	4 042	263	64	98	35	5		3	18	10 021
South Africa	211	212	28 834	28 980	3 077	313	883	269	54	12	9	84	87 870
ISRDP average	8		455		752	26	169	74	8	0	0	11	14072
Metro average	117		18970		516	90	68	19	20	1	8	33	30208

Data sources: * Wilbury and Claymore data bases, 2007 and 2008; ** DHIS facilities data 2007

13.3 Determine cost of refurbishment

The inventory of facilities of public health care facilities will identify existing facilities in both the public and private sectors (for-profit and not-for-profit) that require refurbishment in a variety of ways for them to assume an accreditation status. The costs of refurbishment will be influenced by the following parameters:

- The number of facilities
- The level of health care facility in the referral hierarchy
- The degree of dilapidation and the ensuing improvements required to bring the facilities to a situation where they meet the required accreditation norms
- The norms and standards as defined by the National Office of Standards Compliance for registration and hence accreditation for NHI
- The geographical location of the facilities

The annual costs of refurbishing facilities will be established by looking at the quantities of inputs (materials and labour) and current prices in the construction industry. This programme needs to be seen within the context of a broader public sector spending programme on social infrastructure.

13.4 Develop a plan for refurbishment

The expansion and refurbishment programme cannot be implemented over a short period of time given the huge financial investments and most importantly the existing capacity to deliver. Once the number and the location of the facilities to be refurbished is concretely established, a phased programme in which facilities are rehabilitated over the five year NHI implementation period needs to be developed. Each province and district health council will be required to develop detailed plans for refurbishing specific facilities with specific timelines for deliverables and penalties for non-delivery. The National Department of Health will be responsible for ensuring that refurbishment of facilities is part of a national master plan on infrastructure, buildings and equipment that is monitored very closely. The plan should aim to deliver at least 25% of the refurbishments required each year in line with the NHI transitional targets. It is worth noting that 31 hospitals are currently under construction, 18 of which are expected to be completed over the next three years. This will significantly enhance the capacity of sector to provide the much needed quality of services.

13.5. Continuation of expansion of current clinic upgrading and building programme

At the core of health system strengthening is the continued expansion of primary care facilities particularly in those areas that are currently underserved which are largely classified as rural and stable informal settlements.

The expansion programme needs to be supported by a nation-wide inventory of PHC facilities in the country. The National Department of Health will commission such a study in the context of broader infrastructure, buildings and equipment inventory mentioned earlier.

The investment priorities to be determined at provincial level and district level in order to ensure that appropriate resources are mobilised and construction services are effectively and efficiently procured. The expansion programme needs to be guided by the key transitional principles, namely: equity, efficiency, effectiveness and appropriateness. What this means, is that facilities must be built first where there are needed the most, and that all this be done at least cost and aligns to beneficiary expectations.

Table 13.1 Summary Inventory of Facilities by District (2007-2008)

District	Private hospitals		Private facilities beds		Public health facilities - number of facilities, 2007								Useable beds public sector
	2007	2008	2007	2008	Clinic	CHCs	Mobile Service	District Hospital	Regional Hospital	Provincial Tertiary Hospital	National Central Hospital	Specialised Hospital	2005
District (MDB)	Pvt_fac		Pvt_beds		Clinic	CHCs	Mobile Service	District Hospital	Regional Hospital	Provincial Tertiary Hospital	National Central Hospital	Specialised Hospital	Pub_bed
Cacadu	5	5	393	393	58	2	27	10				5	1 164
Amathole	1	1	30	30	213	7	42	14	2			5	4 243
Chris Hani					136	3	29	14	1			1	1 438
Ukhahlamba	1	1	110	110	44	1	14	8				2	575
O.R. Tambo					143	10	13	10	3			1	3 280
Alfred Nzo	7	7	955	955	46	2	6	4				1	629
Nelson Mandela Bay Metro					43	7	9	1	3			4	2 092
Xhariep	6	8	820	923	17	1	21	4					80
Motheo	3	3	1 017	1 017	69	5	20	4	1	1	1	3	2 705
Lejweleputswa	1	1	107	107	45	1	25	5	1				751
Thabo Mofutsanyane	2	2	72	72	67	1	21	8	2				888
Fezile Dabi	7	7	697	709	33	27	25	4	1				536
Sedibeng	1	1	43	43	31	5	10	2	1				1 057
Metsweding	4	4	643	643	9	1	3					1	298
West Rand					27	2	7	1	1			1	1 500

Ekurhuleni	15	16	2 331	2 410	78	9	7	1	5			1	2 812
City of Johannesburg	30	29	5 743	5 540	107	9	15	1	3		2	4	5 108
City of Tshwane	25	25	4 101	4 109	55	7	8	4	2		2	3	4 542
Ugu	2	2	146	146	51		15	3	1			1	1 353
uMgungundlovu	5	5	435	447	51	4	15	2	1	1		5	3 795
Uthukela	1	1	98	100	37		18	2	1				950
Umzinyathi					41		10	4					1 170
Amajuba	1	1	90	90	21		7	1	2				1 421
Zululand	2	2	37	37	60	1	15	6				4	1 741
Umkhanyakude					52		15	5					1 114
Uthungulu	2	2	301	301	49	1	14	5	3				2 151
iLembe	1	1	117	119	27	2	10	3	1				834
Sisonke	2	2	52	68	36	1	11	5				1	1 151
eThekwini	16	16	2 551	2 557	122	6	23	4	5	1	1	8	8 153
Mopani	1	1	64	64	86	7	26	8	1			1	1 619
Vhembe					113	8	21	7	1			1	1 954
Capricorn	1	1	186	186	88	4	31	6		2		1	2 566
Waterberg	5	5	205	204	52	2	31	6	2			1	890
Greater Sekhukhune					72	6	19	6	1				1 402
Gert Sibande	3	3	285	285	60	9	27	8	1			3	1 350
Nkangala	3	3	466	503	65	15	21	7		1		1	879
Ehlanzeni	2	2	270	270	106	12	28	8	2	1		2	2 811
Kgalagadi	1	1	25	25	34	1	6	2					278
Namakwa	1	1	26	26	17	8	6	6					121
Pixley ka Seme					27	2	3	9					287

Siyanda	1	1	40	50	12	6	13	3	1			1	276
Frances Baard	1	1	234	234	28	3	4	4		1		2	1 026
Bojanala Platinum	5	5	512	512	114	14	24	5		1			1 227
Ngaka Modiri Molema (Central)	1	1	93	93	82	16	25	5		1		1	577
Dr Ruth Segomotsi Mompati (Bophirima)	1	1	40	40	44	13	23	6					547
Dr Kenneth Kaunda (Southern)	10	10	1 277	1 520	46	8	22	3		2		1	2 498
City of Cape Town	24	23	3 289	3 106	111	52	6	8	2		3	13	7 501
West Coast	1	1	44	46	27	2	24	8				1	405
Cape Winelands	4	4	447	448	55	3	24	4	2			2	1 025
Overberg	1	1	45	45	31	1	14	5					193
Eden	5	5	397	397	33	5	24	6	1			1	703
Central Karoo					6	1	6	4				1	194

12.5. Proposals for addressing the human resource challenges

12.5.1. Introduction

This chapter deals with the development of HR capacity in the public sector through increasing production of health professionals and in-service training, which includes reorientation through Continuing Professional Development (CPD) and skills development of personnel, particularly managers. The chapter will not address all production and training needs but reflects areas of critical importance.

Despite numerous training initiatives aimed at supporting district development, planning management skills of middle and senior managers in many areas remain weak and working environments are not conducive to change and

12.5.2 Trends In The Production Of Health Professionals

a) Decline in production of doctors and other health professionals

Comparison of trends in the production of key categories of health professionals between 2002 and 2007 shows that many of the targets set in the National Human Resources for Health Planning Framework (DOH, 2006) are unlikely to be met.**[See Table 12.1]**

Table 12.1 Targets proposed by the NHRH Planning Framework (DOH, 2006) vs. actual production, 2002 to 2007

Category	Proposed annual national production (Doha, 2006)	Actual production							
		2002	2003	2004	2005	2006	2007	% change	Annual av. growth
Medical practitioners	2400 by 2014	1212	1296	1399	1511	1196	1122	-7.4%	-1.5%
Professional nurses	3000 by 2011	1652	1553	1716	1533	2027	2342	41.8%	7.2%
	[2 years bridging] [1]	679	1841	2103	2352	2364	2093	208.2%	25.3%
Enrolled nurses (staff nurses)	8000 by 2008	2771	2308	4273	4565	4816	4758	71.7%	11.4%
Enrolled nursing assistant	10000 by 2008	3078	4390	6698	6754	5422	6136	99.4%	14.8%
Dental practitioners	Reduce to 120 by 2008	175	244	168	239	268	206	17.7%	3.3%

Dental therapists	**Increase to 600 by 2009**	38	36	33	22	27	29	-23.7%	-5.3%
Dental technicians	**Maintain current levels**	75	78	78	77	116	99	32.0%	5.7%
Dental assistants	**300 by 2008**	108	55	113	99	120	141	30.6%	5.5%
Oral hygienists	**150 by 2009**	18	64	53	62	34	45	150.0%	20.1%
Pharmacists	**600 by 2010**	385	463	696	590	540	511	32.7%	5.8%
Pharmacy Assistants[2]	**900 by 2008**								
EMS practitioners	*	24	22	26	53	77	64	166.7%	21.7%
Environmental Health Practitioners	**Maintain current levels**	356	269	308	501	450	440	23.6%	4.3%
Medical physicist	**80 by 2010**	49	114	97	76	93	86	75.5%	11.9%
Medical orthotist prosthetist	**50 per year until 2010**	18	18	19	20	39	49	172.2%	22.2%
Nutritionists/ Dieticians	**250 by 2010**	73	75	83	86	66	89	21.9%	4.0%
Occupational Therapists	**350 - 500 by 2010**	190	226	204	254	241	258	35.8%	6.3%
Optometrists	**100 by 2010**	169	145	118	156	190	123	-27.2%	-6.2%
Physiotherapists	**500 by 2010**	258	312	290	297	343	318	23.3%	4.3%
Occupational therapy assistants	**300 by 2010**	11	19	26	30	10	18	63.6%	10.4%
Clinical Psychologists[3]	**150 by 2009**	[396]	[329]	[338]	[333]			-15.9%	-5.6%
Radiographers	**600 by 2010**	232	261	229	321	336	359	54.7%	9.1%
Social Workers	*	700	724	630	622	823		17.6%	4.1%
Speech therapists & audiologists	**500 by 2010**	115	117	159	175	135	162	40.9%	7.1%

Sources: Figures in column 2 from DOH (2006); remaining figures from the DOE HEMIS (2008)

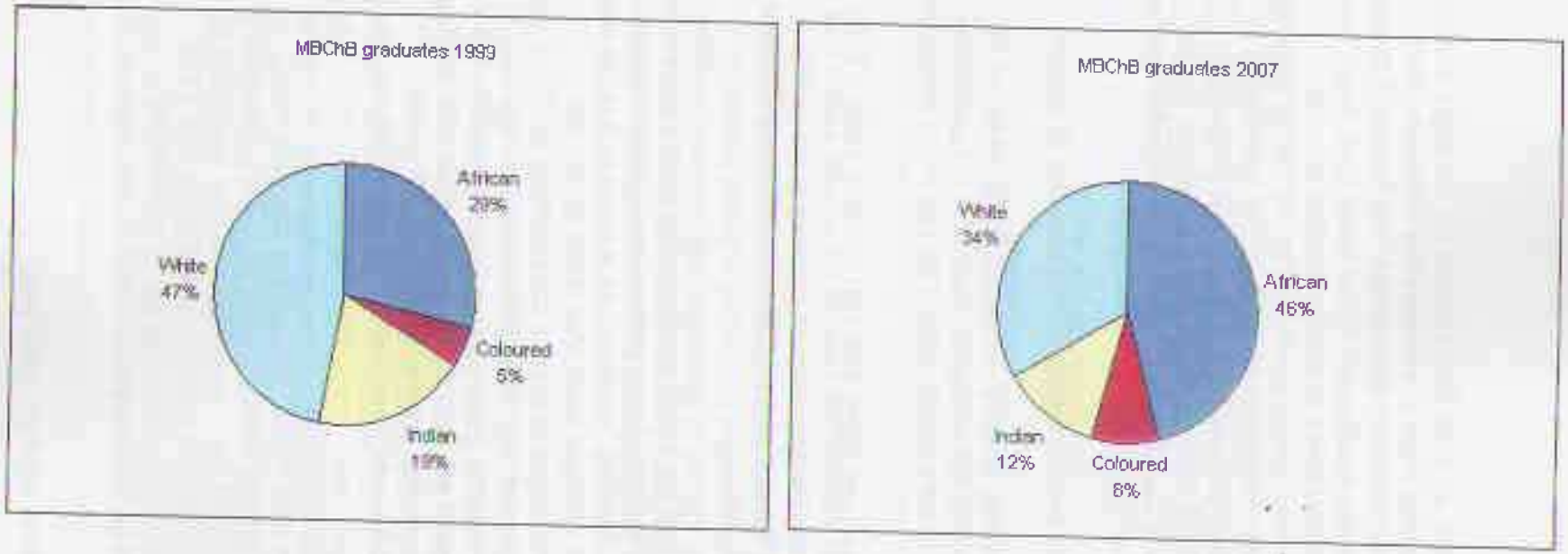
Note: the shaded areas indicate that no figures were available for that category or year.

A major concern is that the output of medical practitioners has dropped seven per cent since 2002 with an annual average decline of 1,5 %. In 2007 there were only 1122 medical graduates from all eight medical schools in the country. Yet the DOH plan of 2006 proposed that the annual production of doctors should double (from 1200 to 2400 per annum) by 2014. There are many possible explanations for the actual decline, including a shortage of medical academics which is related to the shortage of specialists who are willing to practice in the public sector. This decrease could also be associated with the changing medical schools' admission criteria. Medical schools are increasingly admitting students from disadvantaged and rural backgrounds that are less academically prepared than previous intakes and often take more years to complete their degrees than those from privileged backgrounds. **[See Table 12.2, and Figure 12.1 for details of the transformation of medical schools.]**

Table 12.2 MBChB graduates from all eight medical schools, by race, 1999 to 2007

	Year	African	Coloured	Indian	White	Total
Totals	1999	379	64	244	622	1309
	2000	293	53	219	566	1131
	2001	350	67	247	565	1229
	2002	394	76	241	501	1212
	2003	422	115	233	526	1296
	2004	487	69	309	534	1399
	2005	598	88	309	516	1511
	2006	527	98	152	419	1196
	2007	511	93	139	379	1122
	Change N	132	29	-105	-243	-187
	Change %	34.8%	45.3%	-43.0%	-39.1%	-14.3%
	Average annual growth	3.8%	4.8%	-6.8%	-6.0%	-1.9%

Figure 12.1 Proportions of MBChB graduates by race, 1999 and 2007



In 2008, government put aside an extra R900 million for the eight medical schools with the view of inducing them to increase the admission and thereby the production levels. However, according to the Deans of these medical schools these funds are insufficient. At the same time, there have been strong calls for the establishment of private medical schools, although there are concerns that such a move lead to the further depletion of capacity in the public sector. Given this shortages and bottlenecks in the supply of required numbers of doctors, the bi-national programme between South Africa and Cuba through which there are young South Africans training in medicine in Cuba must be strengthened and extended beyond medical officers.

c) Decline in the role of the public sector in the training of nurses

In contrast the nursing output has already exceeded the DOH target for 2011 but there are concerns that the education system is not producing the type of nurse which the country needs most. This has been extensively discussed in Chapter 13.

Most of the growth of nursing training has been in the private sector and little of this will contribute to the development of capacity in the public sector. For various reasons the role of the public sector in the training of nurses has declined dramatically.

Breier et al (in press) found that the public sector continues to be the sole provider of the four-year professional-nurse programmes, which include community, psychiatry and midwifery. However, as a result of this, as well as the fact that many nursing colleges were shut down during the restructuring of the sector, the output of nurses considerably declined, viz. in 2007 the public sector produced 340 fewer professional nurses than in 1997. Nonetheless, the new nursing qualifications as prescribed by the Nursing Council in 2008 suggest a 3 year diploma and a four year degree. In general, there should be a caution against grade creep – where professionals are required to have higher qualifications than are necessary for the job.

Most professional nurses are now trained through the bridging programme, which does not include much-needed midwifery, psychiatric and community-nursing skills; and the private sector is also assuming an increasingly significant role in bridging training. [See Figure 12.2] The application of the Recognition of Prior Learning will be particularly important, as it has proven to be relatively successful in other sectors of the economy.

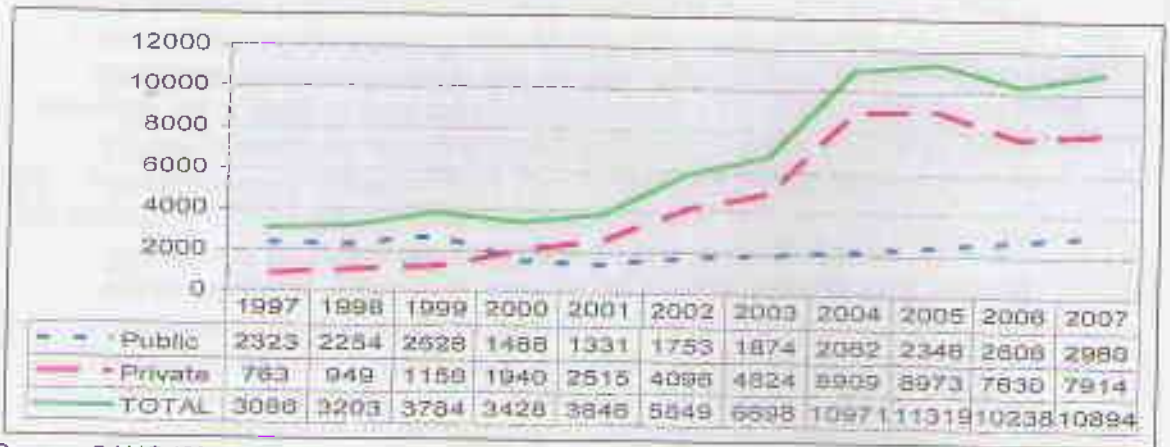
Figure 12.2 Output of professional nurses, 1997-2007

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Universities	387	391	357	408	409	400	453	428	475	534	714
Colleges	2295	1990	1911	2086	1494	1252	1108	1288	1058	1493	1628
Bridging Programme	1033	1539	1833	1991	1670	679	1841	2103	2352	2364	2093
TOTAL	3715	3910	4101	4485	3573	2331	3402	3819	3885	4391	4435

Source: SANC (2007)

The private sector now also trains the vast majority of enrolled nurses and ENAs [see Figure 12.3]. While many trainees gain high level training offered by the major hospital groups or reputable independent colleges, there are also many those who receive training of dubious quality in private colleges that are not always able to provide appropriate clinical experience.

Figure 12.3 Output of sub-professional (ENA and EN) nurses, 1997 – 2007



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Public	2323	2254	2628	1488	1331	1753	1874	2082	2348	2608	2980
Private	763	949	1156	1940	2515	4096	4824	8909	8973	7630	7914
TOTAL	3086	3203	3784	3428	3846	5849	6698	10971	11319	10238	10894

Source: SANC (2007)

The high attrition rate of nurses was noted in Chapter 13. Qualitative research reported in Breier et al (in press) indicates that much of the attrition appears to be occurring immediately after graduation. They found that many nursing students enrolled in four year programmes do not actually want to be nurses but are attracted to the programmes because of the bursaries or salaries offered or because they think that the training will be a stepping stone towards other programmes with higher entrance criteria in the universities. Many others who would have actually wanted to become nurses, are put off by the current appalling conditions in the public hospitals which they experience in the course of their training. Those who complete the training are likely to emigrate.

c) **Development opportunities for community heath worker cadres**

CHWs in particular are presently being kept outside the health system, with no, or very limited, career opportunity. If CHWs are likely to provide essential health services in the medium- to long-term however, then they need to be encouraged to take up available opportunities for training. Lack of career or development opportunity will act as a disincentive and demotivator.

Historically the training of CHWs was done through the medium of non-accredited short courses. With the advent of the current education, training and development framework, four levels of community health workers training have been accredited via the South African Qualifications Authority. A fully qualified CHW could take four years of study. However this process does allow for the development of permeable, portable and laddered career structures, similar (and linked) to the structure of the National Qualifications Framework within bands of health care professions. In addition after completion of Level 3 and 4, CHWs could be recruited for mid-level worker training (particularly pharmacist assistant and nursing assistant) with the advantage of depth of knowledge and experienced gained whilst working as a CHW.

There are plans to introduce a category of community based workers known as Community Care Givers who would be employed by NGOs and whose training would be based on skills set.

d) **Development opportunities for mid-level worker cadres**

Career paths and progression and the integration of MLWs into the staffing structures of the formal health system have not been addressed satisfactorily, a fact that contributes to their continued lack of legitimacy and acceptance within health services. Nor do the current qualifications allow for career pathing into either professional categories.

There is a particular need for government to undertake an extensive training programme for lay HIV/AIDS counsellors - who are currently largely employed by NGOs - although they are usually facility-based. They therefore have the same uncertainties regarding stability of employment and access to career pathing as do CHWs.

e) Development opportunities for emergency services

The training of emergency services personnel is of crucial importance. It is estimated that only about one quarter of those trained are working in the public sector and many have emigrated.

At present the training of the emergency services personnel is divided into two streams, namely the modular and tertiary streams. However, the modular stream which covers the Basic Ambulance Course, the Ambulance Emergency Assistant Course and the Critical Care Assistant Course is set to be stopped. The tertiary model is actually a midlevel worker course i.e. it produces Emergency Care Technician (ECT). The first intake will graduate this year with National Diplomas and the B Tech degrees.

At present there are only 4 colleges in the country that are accredited (though not fully) to provide the ECT training and 4 University of Technology providing national diplomas (NDip) upwards. There will be approximately 20 ECTs graduating in April 2009 but this will still not be adequate in terms of what is required relative to the shortage. A University of Technology can only produce about 15 graduates per year which again is clearly not enough for the country. The modular courses were producing a substantial amount of graduates and now since it has been terminated the challenges have been compounded.

f) Development opportunities for support worker

Other health workers such as cleaners and porters also do not have a clearly defined career-pathing programmes. Career-pathing programmes in areas such as administration and procurement/ordering should be considered.

12.6 In-Service Training And Skills Development

The devolution of authority as envisaged by the NHI will require changes in management culture towards decentralised and empowered management and a renewed focus on the strengthening of management skills at all levels of the system, including skills in financial management and procurement, people and programme management and monitoring and evaluation.

The need to train healthcare professionals for the needs of the country in terms of epidemiology in the population must be recognised.

The development of norms and standards and the alignment of staff and service norms referred to in Chapter 13 will also facilitate the review of training provisions and capacity and the development of training and development plans.

Appropriate in-service training and skills development of employees – particularly management training and maintenance of competencies through Continuing Professional Development (CPD) training – must be expanded and made sustainable. Sources of funding are directly from the National Skills Fund and efficient utilisation of Skills Development levies within each Department.

There needs to be a specific training programme for the support service staff, addressing issues such as procurement, in order to ensure efficiency in National Health Insurance Authority. This is illustrated by the current situation in the public sector in the procurement process whereby the support service staff or procurement officers do not have adequate knowledge of the health sector. This results in procurement of incorrect and inappropriate material, further compromising service delivery.

So, there a number of in-service and skills development programmes that must be undertaken:

a) Maintenance of health delivery competencies

This training should not be limited to health professionals, but must also include support service staff. However, the maintenance of competencies is not prescribed for the associates/mid-level workers by the HPCs and this remains a priority in the health system.

b) Management training

The devolution of authority as envisaged by the NHI will require changes in management culture towards decentralised empowered management multi-disciplinary teams and a renewed focus on the strengthening of management skills at all levels of the system.

Managers in the health care sector seldom have appropriate management qualifications. The predominant profile is that of a healthcare professional that has migrated into management with no formal management qualifications.

Management training must cascade down to supervisory level. It is well established and accepted that careful and regular supervision impacts profoundly on quality of service delivery.

In a series of research articles, Pillay (2007, 2008) surveyed competencies of hospital managers and nurse managers in both the public and private sector. Results of this survey are included as Appendix A and the following two sections on key findings drawn from Pillay's research reports.

12.7 Key findings in research on hospital managers

Both the public sector and private sector hospital managers rated competencies related to 'people management', 'self management' and 'organising skills' highest and in the same order of importance, followed by 'strategic planning' and 'health delivery', respectively. Public sector managers rated the importance of all the competencies significantly higher than the private sector managers, except for 'people related skills' where there was no significant difference in the level of importance.

Demographics of respondents suggest that the transformation and equity objectives of the public sector are being met and that females are not precluded from occupying senior management positions. Although it is understandable in terms of government's transformation policy, it is of concern that the majority of public sector hospital managers are vastly inexperienced having been in management positions for less than five years.

The use of current public sector managers who are highly experienced could be utilised through an in-house mentoring model in a broader career management and succession planning initiative to develop individuals with management potential. This programme would provide for future sustainability and stability of public sector institutions.

Pillay found that generally, formal management development programmes made no significant difference to competency levels. This is corroborated by the lower self-assessed proficiency levels among managers who attended formal programmes, as well as the lower proficiency rating of public sector managers, the majority of whom admitted to some form of formal training.

Informal approaches significantly improved competency levels in all facets of health management. This implies that the current approach to the development of health managers which is focused on a predominantly formal and didactic approach is having minimal impact on management capacity. Instead, managers are more likely to improve their skills and competencies by informal means based on an experiential approach

which may include mentoring and coaching, networking with colleagues and in-house programmes.
This approach has the benefit of tailoring training to practices and issues relevant within an institution, of exploring issues in a non-threatening environment, of increased acceptability and convenience to participants and of facilitating and enhancing senior manager's contribution to management development.

12.8 Key findings in research on nurse managers

Nurse managers who received some form of informal training (mentoring/coaching, in-service training and non-certified programmes) were significantly more likely to perceive themselves as being more competent in planning, organising and legal-ethical competencies than their colleagues who received no informal in health care management. This is especially pertinent given that it correlates with the findings in the survey on health managers.

The fact that there is a significant difference in competency levels of managers between the different sectors with private sector managers rating themselves significantly higher on all of the competencies, except for health services delivery where there was no difference, may partly explain the differences in performance between the sectors. Plausible explanations for this discrepancy may be that the emphasis and scope of professional development within the private sector may be better and broader within the private sector (Mediclinic, 2008; Netcare, 2008; Life healthcare, 2008), the migration of more experienced managers from the public to the private sector (Matsebula and Willie, 2007; Goudge et al 2002), and the difficulty of managing in a public sector milieu characterized by understaffing, poor resource endowment and higher nurse-patient ratios (Harrison et al., 2007; Padarath et al., 2003).

Ninety-five (95) percent of public sector nurse managers reported having some kind of formal training in health management.

An indication of outcomes from management training is attached as Appendix B

Management qualifications

The need for management qualifications is also acknowledged by the Department of Public Service and Administration, which is an absolutely key requirement of a management qualification for all public sector managerial positions from directorship upwards. Deputy Directors are not required to have formal management qualifications but need to prove substantial managerial experience in the absence of such qualifications.

However it does not appear that this requirement has been applied to public sector health care management appointments. The need for health managers to have formal management qualifications is further supported by organisations such as the World Health Organization that has identified the need to develop managerial competency as critical to achieving the Millennium Development Goals.

Training on the PFMA would have to be delivered by accredited specific training institutes with specialist training competencies.

Management training providers

Universities offer a number of out-service and in-service programmes of varying durations. The providers of management training include a large number of higher education institutions that historically provided generic management training and are systematically beginning to offer generic management training linked to health sector specific management training.

It could be argued that few health care managers require masters level management qualifications such as MBA degrees. There is a benefit in promoting management qualifications that are customised to the needs of the health care sector.

Changing the culture of management for the NHI

The devolution of authority as envisaged by the NHI will furthermore require changes in management culture towards decentralised and empowered management and a renewed focus on the building of a multi-skilled and multi-facetted team within districts and institutions.

There is a growing concern that despite numerous training initiatives aimed at changing the attitudes of staff to the patients there is still a long way to go before the results yield changes.

The inclusion of training on self-mastery, ethics and diversity within customised curricula specifically to address situations peculiar to working in a public health system will be included.

12.7. Towards A Human Resource For Health Plan for National Health Insurance

Most initiatives listed below must be implemented in the short term. However some of the outcome would be medium to long term. The time-frame referred to in the table speaks to the expected date of outcome rather than initiation and the timeframe is defined within the context of a five-year period.

PROPOSAL	TIME FRAME
Address decline in production of doctors	Medium-term
Re-assessment of public sector nurse training - continue opening nursing colleges .	Short-term to Medium-term
Reprioritisation in provincial and hospital budgets so that public sector resumes its role in the production of enrolled nurses and enrolled nurse assistants.	Short-term to Medium-term
Re-assess projected health professional production totals in the light of the HIV, AIDS and TB epidemics	Short-term
Address career progression of community and mid-level cadres particularly the need for HIV/AIDS lay counsellors.	Short-term
Address training of emergency care practitioners with attention to the implications of stopping modular training.	Short-term
Allocation of more resources to public institutions of higher education including strengthening responsive institutions such as Medunsa.	Medium-term
Establishment of additional tertiary institutions and/or satellites in each province and/or at community level such as in Cuba	Short-term to Medium-term
Strengthen teaching, training and research capability of the tertiary institutions awarding scholarships for training of specialists and super-specialists	Medium-term
Extend internship and community service programme to all health professionals	Short-term
Address Continuing Professional Development for mid-level workers	Medium-term
Extend training and development programme in Cuba to other health professionals and support workers	Short-term to Medium-term
Review the efficacy and efficiency of current management development programmes	Short-term
Undertake audit of management qualifications of all National and Provincial Health Care managers	Short-term
Integrated generic management training with specific material related to health care management	Short-term
Introduce specialised courses on the PFMA	Short-term
New and creative training approaches that combines formal instruction with informal practices to be on team-building interventions to create synergy amongst managers in a particular district/institution	Short-term
Base formal instruction on an experiential approach and include case studies drawn specifically from the	Short-term

experience of the participants	
Include mentoring and coaching, networking with colleagues and in-house programmes in management training programmes	Short to Medium-term
Monitor and evaluate performance of managers on courses	Short -term to Medium-term
Formal training courses to be provided by accredited providers – public bodies (universities) or private organisations	Short -term to medium

CHAPTER 15. TRANSITIONAL ARRANGEMENTS

15.1 INTRODUCTION

The introduction of a National Health Insurance (NHI) system within the South African health system provides a watershed opportunity for the significant transformation of the existing institutional and organizational arrangements in the public and private health sectors of the country. This opportunity entails the transformation of the health system into one that is equitable and offers the national population universal coverage to a defined comprehensive package of services. However, it also implies that there are numerous challenges that will have to be strategically addressed to ensure that in the medium-to-long term a sustainable, equitable, effective and efficient NHI system is established that has the capacity and resources to ensure that the promise of universal coverage is realized for all.

It is therefore imperative that the transitional arrangements are adequately developed and put into place to ensure a smooth re-arrangement of the national health system to create a strong platform for moving towards an integrated health system that promotes financial risk protection and offers universal coverage to all. The strategy that is developed will have to ensure that the following key components or aspects are addressed:

- The development of adequate capacity (financial, infrastructural and human) at all the public sector facilities to ensure that they have the sufficient resources to meet the needs of their target populations
- The phased accreditation process of all facilities (both public and private) that will provide the comprehensive package of services within the NHI system
- The comprehensive registration of people for mandatory health insurance and assigning of facilities (by level) to specific registered populations in the given specific geographical areas
- To allow for the considered establishment of a NHIA and its sub-national level structures (offices, people, new systems and processes)
- To ensure the development of an integrated health information system (based on existing and newly created systems)

In moving towards a uniform national health system that meets the health needs of all individuals and households while at the same time providing them with financial risk protection, it is essential that the reforms cut across the paradigms of legislation and regulations, health services provision and delivery, and funding and resource mobilisation arrangements.

15.2 INTERNATIONAL EXPERIENCES IN TRANSITIONING FROM CURRENT HEALTH SYSTEM TO NATIONAL HEALTH INSURANCE

The decision to reform the healthcare financing arrangements of any given national health system is a massive and acceptably complex undertaking. The need for a proper reflection on the current structure of the health system, including the available

financing alternatives and the challenges that exist in the system is an important element of deciding what reforms to undertake and how to do this in a systematic manner. However, the important factor in all this is to steadfastly keep a clear picture in mind of what the health system reforms are intended to achieve. In the South African context, the premise of the NHI discussions is to achieve universal coverage for all through the establishment of mandatory health insurance system that is funded primarily from general taxes and earmarked contributions.

In the process of planning the transition from the current state to the planned NHI environment, some key elements of the national health system (especially the public health system) will have to be adequately addressed. These include (but are not limited to):

- The existing legislative framework and what has to be changed to create an enabling environment for effective NHI implementation
- The need to create an appropriate overarching institutional and structural framework that establishes the platform for the NHI administration
- Mobilisation of additional financial resources to ensure effective implementation of the NHI and its medium-to-long term sustainability
- Significant improvement of the quality of care offered at existing health facilities
- Enhanced human resource capacity (i.e. management, support staff and healthcare professionals for various fields)
- Systematic public and stakeholder information and education exercises to convey key messages about the NHI regarding, for instance, healthcare benefits and accredited providers
-

Prior to looking at the policy dimensions, it is important to look at the technical elements of the transitional arrangements that will be required to effectively transform the South African health system into an NHI environment. International experience and literature indicates that the countries that have moved towards either a social or national health insurance system of healthcare financing had to carefully examine a number of interrelated issues including, for instance:

15.2.1 The labour and financial market structure

If the country has more formal labour establishments (usually in a country with fair or good economic growth, liberal trade, education and employment opportunities), there is the possibility of expanding coverage through mandatory health insurance. The regular collection of contributions from salaries of employees from the formal sector would be easily managed, while contributions from informal sectors, usually of unstable labour markets, would be difficult. There are some instances where group health insurance schemes have been organized for covering bus, truck or taxi drivers and conductors, fishermen and village agricultural cooperatives

An appropriate managerial set-up on how premium from informal sector employees can easily be collected without much burden, such as payment in kind or contributions on quarterly or yearly basis has to be considered. In addition to the need for understanding the importance of mandatory contributions (national

solidarity), there is a need for adequately resourced and staffed nation-wide financial institutions to manage the collection and disbursement of funds.

15.2.2 Existence of other forms of insurance schemes

Some countries have introduced many forms of insurance as part of financial market arrangements or under the social security framework. Almost all countries have private health insurance as "health riders" to life insurance, mutual funds, and other insurance packages offered by financial institutions. The existence of a strong private health insurance market, as is the case in South Africa, is also an important matter that has to be carefully considered in that the proposed restructuring process could lead to significant resistance and unnecessary delays in moving towards the implementation. A good strategy that can be used to counteract such forces is to involve them in the process of the debates and get their buy-in during the pre-implementation phases.

As the experiences of Germany, the Netherlands and Sweden clearly indicate, as countries move towards universal coverage, the role of private health insurance can change. When public funding is low, private insurance can serve as a transitional mechanism, while public funding is directed at building capacity and providing financial protection for certain segments of the population, such as vulnerable and indigent groups. The institutional capacity, information systems, and skills involved in regulating private health insurance may later be useful in managing a publicly funded Fund/Authority.

15.2.3 Regular contribution from the pay-roll

The plan in most countries that have implemented NHI is that mandatory (earmarked) health insurance contributions come from regular deductions from the pay-roll and are accumulated as a "Health Fund". Although the total contribution is calculated as a percentage of the monthly income, the amount is normally split between the employee and employer, and sometimes even through an additional subsidy by the state, depending upon the national policy and social consensus. One actuarial and explicit policy issue that has to be decided upon is what proportion of salary should be compulsorily deducted (along with other deductions like pension and provident fund, income tax, etc.).

15.2.4 Availability of health infrastructure

The establishment of an NHI Fund/Authority to act as the single purchaser can help to ensure that those covered receive appropriate health care. It goes without saying that the Fund/Authority has to work in an environment where health care facilities are functioning in an adequate manner so that access to health care by the insured people is not denied for any reason. It does not mean that the Fund/Authority should establish its own health care facilities. The only important matter here is that the health facilities are sufficiently resourced to provide the required (contracted) services and that they meet all the minimum specified accreditation criteria. For instance, social security schemes in India and Myanmar

established their own health care facilities in order to fill the gaps left by public health care providers. Similarly, in other countries big state or private enterprises like mines, railways, electricity, petro-chemical industries and other heavy industry complexes have established their own health care facilities. Those population groups who are not insured (due to differences in their employment status, especially people in the informal sectors and mainly from agricultural, fishery and animal husbandry sectors) are often not able to get appropriate health care due to their inability to pay contributions regularly or, in most cases, because of lack of social health insurance coverage. Therefore, the main aim of the Fund/Authority is to add on the health financing resources for universal coverage and to create an institutional and organisational system that ensures that all people have access to needed care.

15.2.5 The management infrastructure

The Fund/Authority needs a large social capital in all aspects: appropriate human resources with skill and knowledge in social science, commerce and economics, disease burden, clinical management, public health management, banking and financial management (i.e. health economists, insurance mathematicians, actuarial scientists, social economists, accountants, demographers, epidemiologists, medical record keepers and statisticians, information specialists, public health legislators). Many countries do not have much national capacity to fulfil the requirement of national social capital. Regional solidarity may be required to improve and strengthen the capacity of social capital. In addition to the need for setting up appropriate collection of funds, there must be a nationally approved mechanism for managing this fund. It is critical to ensure the independence of the "Health Fund" from the general management of public finance.

There is also the need to ensure transparency in how the fund is being managed, particularly to strengthen the people's trust in public management of the fund. Some countries are still keeping the social security agency or agency managing social health insurance as an integral part of government public departments. They collect the contribution and put them into the general revenue. The Fund/Authority has to compete with other public agencies for their annual budget, thus limiting the scope and work of the agency. In many middle-income countries, the Fund/Authority is usually managed by an independent single agency or multiple agencies, as parastatal bodies or private enterprises (with their own budget, legal status and management). However, the evidence clearly indicates that one of the key success aspects of this is that the Fund/Authority should be governed by a sound, clearly defined and reasonably tight legislative framework.

What is clear from the above 5 points is that without a clear strategy of how the transition to NHI will be undertaken in any given context, the plans for universal coverage are likely to fall flat. The key pre-requisites require firstly a clear legal framework on which all the structures, functions and activities of the NHI Authority will be based. Secondly, sufficient and appropriately trained and qualified human capital is required to feed into a process towards establishing and maintaining efficient and effective managerial or administrative capability to organise nation-wide structures, promoting adequate collection, timely and proper provider reimbursement, efficient management of revenues and assets,

and the creation of strong monitoring and evaluation systems of the regularly collected health and financial information. Thirdly, a clear understanding of the NHI conceptual framework by all key stakeholders to achieve nation-wide consensus on the principles and objectives is important for implementation.

Taking the preceding matters into consideration, the next section of this document provides an analysis of the key spheres that the transitional strategy of the move towards NHI in South Africa will have to effect to ensure effective realisation of the principle of universal coverage.

15.3 THE TRANSITIONAL STRATEGY FOR SOUTH AFRICA

There are a number of institutional and organisational aspects of the national health system that have to be changed to help towards moving to an NHI environment in the South African health system. A majority of these aspects relate to what can best be described as elements of the "PRE-NHI IMPLEMENTATION PHASE" and the "POST-NHI IMPLEMENTATION PHASE". It is important to note here that most of the elements in the first phase ("PRE-NHI IMPLEMENTATION PHASE") are likely to continue into the second phase ("POST-NHI IMPLEMENTATION PHASE") to ensure a continuous, streamlined process of strengthening of systems, structures and institutions to effectively realise universal coverage for the national population.

The transitional strategy will be undertaken over a period of 5 years, with the majority of the activities being initiated in the first phase and then continuing through to the phased five year framework. The strategy will address the following key aspects:

15.3.1 THE NATIONAL HEALTH INSURANCE BILL/ACT

The NHI Bill will have to be drafted and presented to Parliament in earnest to ensure that the relevant legislative and regulatory environment is in place prior to the establishment of the structures and institutions required to move towards NHI. The Bill will have to clearly stipulate the various committees and support structures required for the NHI Authority (NHIA) and should also adequately identify in broad terms the scope of services that will be offered as part of the comprehensive package of benefits under NHI. A key component of the Bill is that it must stipulate that participation in the NHI is mandatory for all and that those earning an income above a defined threshold would have to make mandatory contributions which will be earmarked for the NHI.

15.3.2 HEALTH FACILITIES & INFRASTRUCTURE

The National Office of Standards Compliance will have to be created. This will be done through the amendment of the National Health Act which provides for the creation of the Office of Standards Compliance. This will have to be undertaken at the same time that the NHI Act is being drafted to ensure that the process of facilities accreditation can be undertaken through this office with inputs and collaboration from the relevant private sector organisations.

A key element of this aspect of the transitional strategy is the pace at which both public and private health establishments at all levels (Community/Primary Health Care, District, Regional and Quaternary Hospitals) are accredited to meet the standards and norms as specified by the NHIA. Because the plan is to ensure that all facilities are accredited in the shortest possible time, the recommendation here is that 25 percent of all existing facilities (at all levels of care) in the country are accredited annually. This means that the entire national stock of health establishments linked to the NHIA will have to be accredited in 4 years. This process will also be accompanied by a strong programme developed to ensure that all those facilities that are lacking in some way are adequately refurbished and enhanced to meet the minimum standards for accreditation and participation in the NHI.

15.3.3 REVENUE MOBILISATION, POOLING & PROVIDER PAYMENT MECHANISMS

The existing revenue mobilisation systems for the health system, particularly in the public system, will be adjusted. Funding for the NHI will come from both the general tax revenue and mandatory contributions. Mechanisms must be developed to introduce a component of performance-related budgeting to ensure improved value for money from public facilities contracted to the NHI. The existing concurrent functions between the National, Provincial and Local spheres of government with respect to funding of health programmes, outcomes and accountability will be addressed in manner that ensures that the best health outcomes are achieved for the country. This means that the NHIA must be provided with a strong legislative mandate that will enable it to ensure that all national health priorities and programmes are properly funded by lower spheres of government. Additionally, the existing fee-for-service provider reimbursement system that is prevalent in the private health sector will be changed to a risk adjusted capitation-based model. A key element that will be used to achieve this is that the NHIA will be based on a single-purchaser model so that it can reap the full benefits (i.e. economies of scale) of purchasing resources and services. The key short-term objective should be to achieve a single funding pool that will allow for income and risk cross-subsidies and to control the health care cost spiral and explicitly and actively promote improved public sector health services and gradually reduce public-private provision differentials overtime.

15.3.4 HUMAN RESOURCES FOR HEALTH

Within the "PRE-NHI IMPLEMENTATION PHASE" there will have to be a significant allocation of financial resources towards the recruitment and retention of Human Resources for Health (HRH) and support staff (i.e. clerks, administrators, cleaners, etc) in public facilities in order to develop the capacity of the public facilities in delivering the covered services. A further matter that has to be addressed in the transitional phase is the need for training managers within the health system to ensure that they have strong managerial, planning, budgeting and decision making skills to assist in effective service delivery.

15.3.5 ESTABLISHMENT OF THE STRUCTURES & INSTITUTIONS OF THE NATIONAL, PROVINCIAL & DISTRICT HEALTH INSURANCE AUTHORITY

A shadow process must be adopted to ensure that appropriately qualified professionals are employed to staff the NHIA once the NHI Bill/Act is promulgated by Parliament. The strategy for this will be that a core team consisting of international and local experts will be created to drive this process forward. The use of international expertise will be drawn upon to give inputs on transitional arrangements for systems development and mobilisation of resources that other countries have undertaken in moving towards NHI and also to add credibility to the whole process of creating the institutions and structures to support the envisaged system.

15.3.6 REGISTRATION OF THE POPULATION

A multi-pronged strategy will have to be devised with regards to registering people for the NHI. All individuals carrying a South African identity document will be required to register as a member of the NHI. All those who are South African citizens and permanent residents but have not yet been issued with an identity document will be registered as beneficiaries under their parents or nominated guardians. Those who are formally employed will be registered through the submission of their tax returns with the support of the South African Revenue Service (SARS). For all those who are recipients of the social support grants provided by the South African Social Security Agency (SASSA) they will be registered at the point of collection of their grant (if already receiving the grant) and new recipients will be captured at the same time that their grant application is authorised. Additionally, regional offices of the NHIA will be created across the country to allow people the opportunity for "walk-in" registrations among other things.

15.3.7 ESTABLISHMENT & STRENGTHENING OF PROVINCIAL HEALTH DEPARTMENTS & DISTRICT HEALTH COUNCILS

The PHAs and DHAs will be strengthened both financially and in terms of human resources so that they have the adequate capacity to properly budget, plan and deliver services for their registered catchment population. Strong links will be developed here with the mobilisation of HRH and support staff so that these respective authorities are not lacking in their capacity to deliver good quality and acceptable care to those that they are intended serve.

15.3.8 CONTRACTING & PROCUREMENT PROCESSES

The existing procurement processes will have to be reviewed to ensure that they are congruent with the intentions of the single-purchaser model for the NHIA. Contracting arrangements for the supply of defined health services and complementary resources (i.e. pharmaceuticals, medical devices, consumables, etc) will be explored to ensure that the ultimate model that is adopted reaps the economies of scale associated with a single-purchaser NHIA.

Additionally, public private partnership (PPP) arrangements will have to be provided for within the realm of contracting and procurement processes. The

PPP arrangements will have to be based on the National Treasury PPP framework which is based on the principles of value for money, affordability and appropriate risk transfer. The contractual arrangements entered into will not just be for clinical services, but will also include managerial expertise, training of different health cadres, and other non-clinical services.

In the instances where a private provider approaches the National Department of Health and the NHIA with a proposal to establish a facility in a previously unserved area alternatives will be considered. The private provider will still have to meet the requirements of the yet to be promulgated Section 36 of the National Health Act. Additionally, consideration will be given to entering into concessional agreements with the provider so that the operation of the facility is shared between public and private providers. A key matter here is to ensure that once the facility is fully functional, it is appropriately accredited and enters into contractual agreements with the NHIA to provide services to a target population at agreed reimbursement rates.

The NHIA will have to develop contractual arrangements with suppliers of pharmaceutical products and other related consumables. This will be done according to the National Framework Agreement and will be driven primarily from a national level to make use of the purchasing power of the single fund.

15.3.9 COSTING OF THE COMPREHENSIVE PACKAGE OF HEALTH SERVICE BENEFITS

Prior to the promulgation of the NHI Bill, a complete costing of the comprehensive package of health benefits that individuals will be entitled to under the NHI will be undertaken. This costing will be used to determine the amount of resources required to adequately fund the provision and delivery of the covered services within the NHI at all levels of care.

The critical issues which need to be considered under the transitional arrangements for the comprehensive package of services include: (i) continuous, effective access to essential primary and secondary health care services, as the system is restructured; (ii) the strategies that will be adopted in targeting populations with special needs, especially women, children and the indigent who are the primary users of PHC services (and linking this to the targets set for the Millennium Development Goals (MDGs)). The revitalization of services for management diarrheal diseases, antenatal and postnatal care will be a critical priority; (iii) the need for detailed needs assessment and geo-mapping to assess health facility feasibility in terms of population movement and functional existing facilities; (iv) coordination and strengthening of emergency medical services, to enhance the responsiveness of the health system to patients' needs; (v) health sector capacity, to mobilize health managers and health staff from local and international sources to enhance the capacity of the public system; and (vi) how health promotion and disease prevention strategies will be incorporated as part of the package of services. The planned costing for the health services package must clearly make provisions for a surge in utilisation rates of specific services which may require specialized care.

15.3.10 NATIONAL HEALTH INFORMATION SYSTEM FOR THE NATIONAL HEALTH INSURANCE

A key element to quality planning and decision making is the existence of good quality, reliable and easily accessible data and information. An innovative programme that is aimed at creating a synergised health information system will be developed. This system will be developed in manner that allows for a streamlined collation of information related to patient profiles at clinics and hospitals, the financial records of all NHIA contracted facilities and key monitoring and evaluation indicators. Additionally, an effective Disease Surveillance System must be put in place in the early phases of moving towards NHI so that proper population epidemiological profiles can be used to feed into policies and programmes designed to address the nation's disease burden across all regions. The systems for data collection should be structured in manner that systematically and cohesively collects information (in collaboration with existing institutions like Statistics South Africa) on a whole range of issues including:

- Good primary data collection and secondary data analysis;
- Greater care to eliminate bias, misinterpretation and to do systematic literature reviews on medical interventions, drugs, medical technology and health preparations;
- Households views on health insurance, quality of care, and necessary services
- Evaluating how providers respond to mixes of payment mechanisms and the impact of these on the sustainability, affordability and efficiency of the NHI system.

More attention will be paid to measuring and monitoring specific health outcomes through a strengthened health information system platform. Effort will also be directed at collecting health data backed by formal systems in place for monitoring standards of the collected data.

15.3.11 NATIONAL, PROVINCIAL & DISTRICT STAKEHOLDER & PUBLIC ENGAGEMENT

A key principle upon which the proposed NHI system is based is the idea of social solidarity – the willingness of the better-off and healthy sections of society to support the well-being and health of the worse-off and sick members of society. Therefore, beginning to sensitise South Africans to the necessity for an NHI with clear, simple articulated reasons based on the inequities and cost containment problems that plague the health system at present will help to generate public support for a health system based on the principle of social solidarity and universal coverage. A systematic strategy will be adopted to sensitize the general public on what NHI is and what benefits it provides to society as a whole. This will help drum up support for smoother implementation process and one that has buy-in from a wide range of stakeholders.

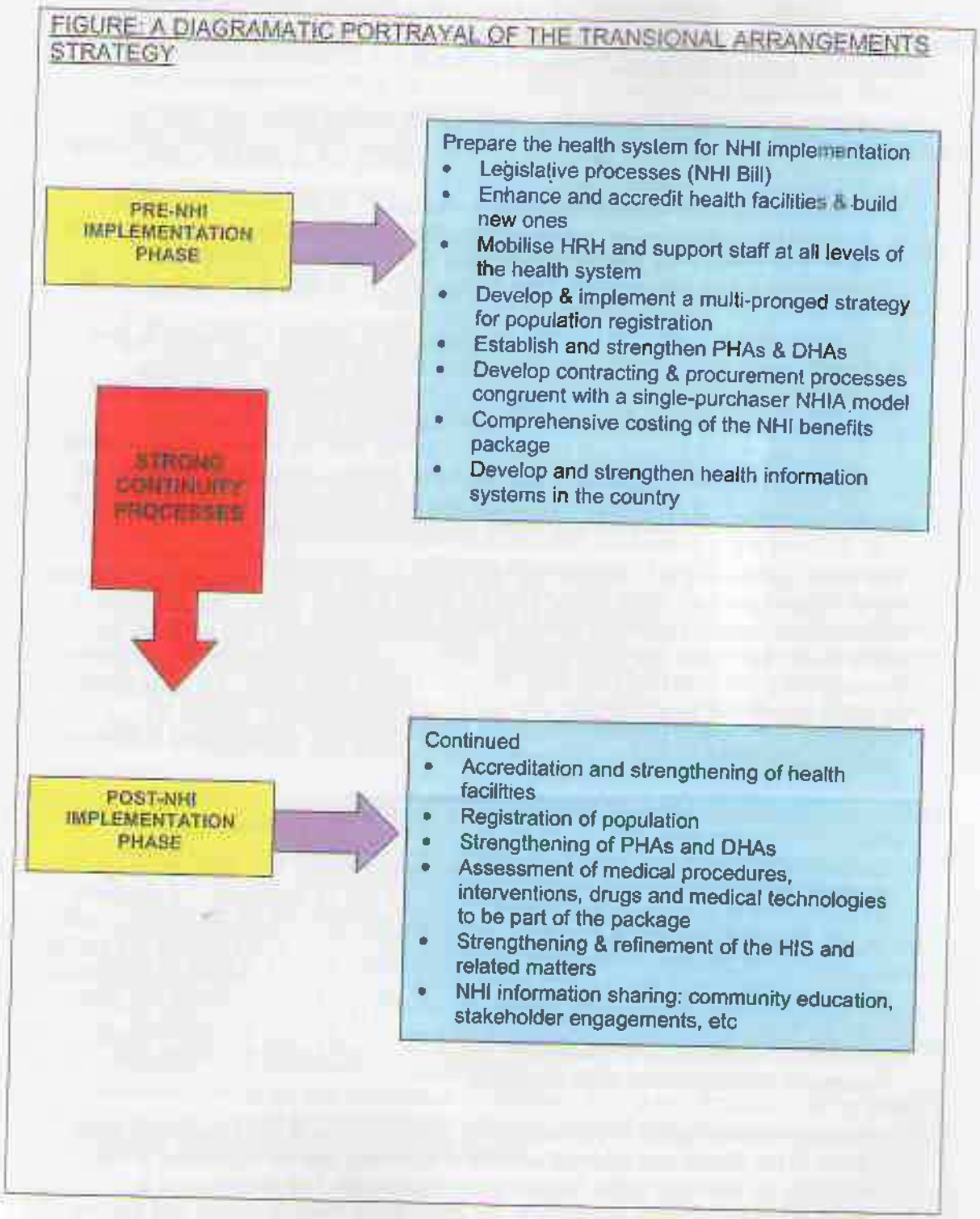
The table below summarises the key aspects of the transitional phase, the timeframes attached to each aspect and the approach that will be used to bring to fruition the plans for the NHI and who will be responsible

Summary of the key issues, timeframes and approaches for the transitional plan to NHI

Key transitional issue	Time frame (years)	Approach
THE NATIONAL HEALTH INSURANCE BILL/ACT	0 – 1	• Review existing legislation and ensure it is aligned with the NHI policy proposal and draft the Bill • Consultation on the Bill in Parliament through public hearings • Bill debated in Parliament • When passed it goes to the President for signing and promulgation
HEALTH FACILITIES & INFRASTRUCTURE	0 – 4 +	• Audit current infrastructure, building and equipment • Determine cost of refurbishment • Develop a plan for refurbishment • Continuation of expansion of current clinic building programme to cover all areas currently without adequate PHC facilities. Investment priorities to be determined
REVENUE MOBILISATION, POOLING & PROVIDER PAYMENT MECHANISMS	1 – 4 +	• Revenue Collection • Sources of Funding • Mandatory contribution • Government Contribution and Tax Revenue • Out of Pocket contribution • Revenue Collecting Mechanisms • Pooling Functions • Single-Risk Pooling • Allocation of National Health Insurance
HUMAN RESOURCES FOR HEALTH	1 – 4 +	

REGISTRATION OF THE POPULATION	0 – 4 +	
ESTABLISHMENT OF THE STRUCTURES & INSTITUTIONS OF THE NATIONAL, PROVINCIAL & DISTRICT HEALTH INSURANCE AUTHORITY		
ESTABLISHMENT & STRENGTHENING OF PROVINCIAL HEALTH DEPARTMENTS & DISTRICT HEALTH COUNCILS	0 – 4 +	
CONTRACTING & PROCUREMENT PROCESSES	0 – 4 +	
COSTING OF THE COMPREHENSIVE PACKAGE OF HEALTH SERVICE BENEFITS	0	
NATIONAL, PROVINCIAL & DISTRICT STAKEHOLDER & PUBLIC ENGAGEMENT	ONGOING	
NATIONAL HEALTH INFORMATION FOR THE NATIONAL HEALTH INSURANCE	1 – 5 +	

FIGURE: A DIAGRAMATIC PORTRAYAL OF THE TRANSIONAL ARRANGEMENTS STRATEGY



15.4 PRINCIPLES CONSIDERED FOR THE IMPLIMENTATION OF TRANSITIONAL ARRANGEMENTS

The key principles for the transitional strategy in each of the 9 components of the health sector listed above will be:

- *Equity*: Expansion of service provision to underserved areas, the poor and vulnerable population sub-groups. This will ensure that those with need benefit the most.
- *Effectiveness*: Increasing the access to and quality of key services such as surgical basic care, laboratory and other diagnostic services and in-patient care relevant to conditions that contribute most to the burden of disease (e.g. HIV/AIDS & TB). This will help the country reverse its dismal performance with regards to the health-related MDG targets.
- *Appropriateness*: Adoption of new service delivery models to respond to new health needs and new ways of doing things. This will include developing appropriately detailed accreditation norms and standards so that the covered population has access to acceptable, good quality health care services
- *Efficiency*: Greater overall efficiency with savings used to finance some of these measures. The key here will be to ensure that minimal resources are spent on the administrative structures of the NHI and that value-for-money is achieved in the translation of resources into actual services for the people.

The most urgent need is to ensure that the public sector is well-capacitated to deliver the envisaged services at all levels. This will make it easier for the NHI Authority to translate into access the clearly defined comprehensive health care package and public health programs (services and activities) that reduce vulnerabilities, promote financial risk protection and save lives. Primary Health Care (PHC) services should be easily accessible where people live while the existing referral system to secondary, tertiary and quaternary care services should be strengthened to ensure effective continuity of care.

15.5 CONCLUSION ON TRANSITIONAL ARRANGEMENTS

It is apparent that if a number of factors are appropriately and adequately addressed then universal coverage through NHI will be achieved in a relatively short time in South Africa. The general level of government allocations to health will play a critical role in the ability of the State to revamp and enhance the quality of services provided in the public health sector. Significant financial resources will be required to mobilize human resources for health (i.e. to capacitate the public sector facilities to accepted norms), to train managers and administrators, to undertake the facilities accreditation processes, and to build additional and revitalise existing health establishments.

Another relevant factor in the transitional arrangements is the speed with which those in the formal and informal sectors of economy can be registered to start enjoying the services in the comprehensive package. The existence of a relatively large informal economy in the agricultural, manufacturing and service sectors of the country dictates that an effective, multi-pronged registration strategy must be developed to ensure that all people that must be registered are registered. Sufficient capacity must be provided for to deal with administrative difficulties and complexities associated with assessing incomes and collecting contributions because so many people do not receive a formal salary. This may

impede provision of health protection for the informal segment of the population, especially when the NHI would be funded from both earmarked contributions and general tax. Related to this matter is the size of the administrative costs which may be influenced further by the distribution of the national population. The population in urban areas, where there is likely to be at least a minimum quality and quantity of infrastructure, services and communications, and high population density, is likely to be easier to serve with the NHI system than a widely dispersed rural population.

A further factor is the country's ability to administer. The establishment of an NHI Authority requires a sufficiently skilled labour force with technical capacities and expertise in various professional fields. Secondary and tertiary education should ideally respond to such training needs. Related markets, such as in financial services, other insurance businesses and even well-established international organisations must be drawn upon to provide appropriately trained personnel. Their staff can also be called upon to be involved in the training and general capacity building of NHI Authority's staff.

While it may seem nebulous to some, the level of solidarity within a society and the ability of the implementers to draw on this can go a long way in influencing the pattern of implementation and the ensuing successes of the process. A society with a higher level of solidarity is interpreted here as being one where individuals are more willing to support other individuals. A system of full financial protection requires a significant amount of cross-subsidization, both from rich to poor and from low risks to high risks. Obviously the appropriate level of solidarity to enable such cross-subsidization is context driven. Therefore, at times policymakers can impose solidarity through legislative mandates, but it must be kept in mind that a sufficient degree of innate solidarity in society is needed in order to implement and sustain the cross-subsidization inherent within NHI.

Finally, it will still take government's stewardship to launch and guide a process that leads to compulsory health insurance for all. The stewardship of the health system is the responsibility of the State. The State is responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry. One important element of governmental stewardship is therefore to allow the various stakeholders and the population at large to have a voice in policymaking. Open and transparent political debate and availability of information help the population to gain trust in government and other agencies involved in NHI implementation. It is therefore warranted that the stakeholders to NHI, the providers and the population (for example through community and professional associations) are engaged with in the process of decision making so that consensus is reached. Key to this process is for a *'policy champion'* to push for the implementation of the NHI and garner public support to ensure buy-in from the national population.

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ANNEXURE A: KEY COMPETENCIES FOR HEALTH MANAGERS

Data for this study come from a cross-sectional survey of hospital managers in the public and private sectors in South Africa, using a self-administered questionnaire. The survey was conducted among all managers of public hospitals in six of the provinces in South Africa (3 provinces did not respond to the call to participate) and all managers of private hospitals registered with the Hospital Association of South Africa, who represent 94% of private hospitals in the country. The sample comprised 215 public sector managers and 189 private sector managers.

The respondent had to rate a list of 39 management competency items in a self-assessment survey. The competencies were derived from the literature and several other stakeholders with an interest in hospital management.

Key competencies for health managers (adapted from Pillay[19])

SELF MANAGEMENT
Time management
Balancing work and life issues
Self awareness
Self development
CONTROLLING / TASK RELATED SKILLS
Medical informatics
Structuring of health services organization
Financial performance evaluation
Budgeting and resource allocation
Measuring performance of health care organizations
Evaluation of health service technology
Quality control and improvement in health service organization
HEALTH DELIVERY
Clinical competance and expertise
Ability to conduct clinical audit
Health promotion skills

[19] The skills gap in hospital management: a comparative analysis of hospital managers in the public and private sectors in South Africa - Original Research Article, Dr Rubin Pillay, UWC

Epidemiologic analysis
Managed health care principles
Evidence based medicine
Bioethics
ORGANISING
Computing skills
Management of information systems
Marketing of health care organization
Human resource management
Learning from experience
Managing delivery
Health economics
PLANNING
Understanding the district health system
Strategic thinking
Planning for future needs
Analysis of internal and external environment of organization
Analysis of the wider health system
Analysis of government programs
Budgeting and resource allocation
Health economics
PEOPLE RELATED SKILLS
Motivating staff
Managing people and teams
Communication skills
Managing conflict
Management of change
Labour relations
ETHICAL LEGAL
Integrity and ethical conduct
Analysis of legal issues

Key competencies for nurse managers (adapted from Pillay[20])

Data for this study come from a cross-sectional survey of senior nursing managers in the public and private sectors in South Africa, using a self-administered questionnaire. 215 senior nursing managers in public hospitals in six of the nine provinces in South Africa (3 provinces did not respond to the call to participate), and 205 senior nursing managers in private hospitals registered with the Hospital Association of South Africa, who represent 94% of private hospitals in the country, were surveyed.

[20] [20] The skills gap in hospital management: a comparative analysis of nurse managers in the public and private sectors in South Africa - A Research paper, Dr Rubin Pillay, UWC

Module 9: Strategic Marketing and Customer Relations

	Exit level outcome
1	Explain the impact of marketing research on service delivery
2	Use information to develop an appropriate marketing mix for an organisation
3	Conduct an environmental analysis to determine specific market variables
4	Develop an effective marketing plan for an organisation
5	Differentiate between marketing of goods and that of services
6	Demonstrate a customer focus in service delivery
7	Render market-driven, customer-focused services to a specific target group

Exit level outcome	Learning outcomes
1,7	Understand marketing in the context of customer needs, wants and demands
1,5	Apply the principles pertaining to the marketing concept
	Differentiate between marketing of goods and that of services
1,2, 3,4, 5	Develop an effective marketing plan for the organisation
2	Select an appropriate segmentation strategy for the organisation
6	Determine an effective communication strategy for the marketing intervention
6	Explain the role of customer satisfaction in relation to service delivery
1	Use the concept of provider gaps

Module10: Financial Management

	Exit level outcome
1	Understand the basic financial concepts, procedures, calculations and activities of an enterprise
2	Demonstrate analytical skills through finding, organizing, assessing and, analyzing financial data appropriate to a given situation
3	Use ratio analysis to understand the performance of an organization
4	Demonstrate information technology skills as they apply to today's business environment to solve business problems
5	Communicate effectively using written mathematical skills by drawing up a budget and use it to control costs

Exit level outcome	Unit outcomes
1, 4,5	Draw up a balance sheet
1,4	Draw up a profit and loss account
1	Recognise the key accounting conventions
2,5	Demonstrate recognition of the source, flow and distribution of money
2	Explain the difference between profit and cash
3	Use selected ratios to analyse the liquidity of organisations
3	Calculate profitability ratios and comment on organizational performance
3	Determine gearing and growth (investment) ratios and use them to interpret the effects of a organisation's capital structure on its current profits, future profits and capital raising potential
3	Evaluate organisations' use of assets using relevant ratios
3	Calculate employee ratios
2	Appreciate the key factors in budgetary planning and control
2, 3, 4,5	Prepare a master budget (profit and loss account and balance sheet)

	Self-development.
CONTROLLING	**CONTROLLING**
Medical informatics	Nursing standard and guideline setting
Structuring of health services organization	Assessing the impact of health services delivery on health of population
Financial performance evaluation	Assessing the quality of care
Budgeting and resource allocation	Assessing patient satisfaction
Measuring performance of health care organizations	Evaluating health service delivery programmes
Evaluation of health service technology	Evaluating financial performance
Quality control and improvement in health service organization	Measuring of organisational performance
	Providing feedback to patients and staff
HEALTH DELIVERY	**HEALTH DELIVERY**
Clinical competence and expertise	Use of tools to standardise patient management
Ability to conduct clinical audit	Evaluating medical necessity and effectiveness of products or interventions
Health promotion skills	Planning and implementation of health promotion programmes
Epidemiologic analysis	Use of epidemiological data
Managed health care principles	Delivery of primary preventive services
Evidence based medicine	Integration of nursing services with district health system
Bioethics	Delivery of curative services
	Implementing doctors' orders
ORGANISING	**ORGANISING**
Computing skills	Budgeting
Management of information systems	Controlling and allocating financial resources
Marketing of health care organisation	Using management information system
Learning from experience	Using health service technology
Managing delivery	Managing of nursing quality
Health economics	Managing of environmental safety and sanitation
	Setting organisational culture
	Communicating organisational goals
	Implementing health quality improvement systems
PLANNING	**PLANNING**
Understanding the district health system	Planning programmes
Strategic thinking	Creating a vision for the hospital

Planning for future needs	Planning further needs and developments
Analysis of internal and external environment of organization	Developing organisational goals
Analysis of the wider health system	Preparing of a strategic plan
Analysis of government programs	Planning of resources
Budgeting and resource allocation	Structure Health Service organisation
Health economics	
PEOPLE RELATED SKILLS	**PEOPLE RELATED SKILLS**
Motivating staff	Using HRM principles appropriately
Managing people and teams	HR planning
Communication skills	Managing personnel
Managing conflict	Planning nursing training
Management of change	Labour relations
Labour relations	Managing teams
Human resource management	Motivating employees
	Managing conflicts
	Managing workforce diversity
ETHICAL LEGAL	**ETHICAL / LEGAL**
Integrity and ethical conduct	Identification and analysis of an ethical issue in a health care setting
Analysis of legal issues	Identification and analysis of an liability issue in a health care setting
	Labour-related legislation
	Health-related legislation

ANNEXURE B: EXAMPLE OF MANAGEMENT DEVELOPMENT CURRICULUM

1. PURPOSE OF THE COURSE

The programme has been designed to develop the participant's strategic management capabilities by broadening their view of their role in the health sector and developing key managerial competencies required to successfully manage in such an environment.

1. LEARNING OUTCOMES

After engaging in the learning challenge and assessment opportunities inherent in this course the participant will be able to meet the following outcomes:

Critical cross field outcomes

- Identify and solve problems through critical thinking;
- Work effectively as members of a team;
- Collect, analyze, organize and evaluate information;
- Use science and technology responsibly; and
- Communicate effectively using electronic means.

Exit level outcomes

- Apply fundamental management principles in a work-based context;
- Apply quantitative methodologies in making work-based decisions;
- Utilise technology to communicate effectively;
- Conduct basic research;
- Solve marketing problems;
- Interpret financial statements;
- Manage information in a business context; and
- Demonstrate knowledge of basic economic principles.

3 MODULES

Module 1: Managing Yourself

No	Exit level outcome
1	Demonstrate self-management skills such as decision making and goal setting
2	Exert control over their lives through the application of time and stress management strategies
3	Plan and set short-and long-term personal development goals
4	Prioritise changing and often conflicting demands
5	Reflect on the effectiveness of their planning and modify their plans as required

6	Demonstrate enhanced self awareness
7	Demonstrate varieties of strategies for personal development planning
8	Demonstrate positive behaviours

Exit level outcome	Learning outcomes
6	Identify the component elements of the concept of personality as described in the dominant models
6	Evaluate the benefits and problems of personality testing as an aid to management decision-making
1,5	Identify the attitudes that have a negative influence at work and determine the best strategies and tools to adopt when attempting to change attitudes
6	Explain the significance of perception in determining behaviour
6	Identify the problem that differing perceptions can create within an organisation
6,7, 8	Examine the values which affect your behaviour
1,2, 3,7	Analyse how you spend your time and identify what strategies to use to deal with "time robbers"
1,2, 3,7	Understand what causes stress and identify the strategies for coping with stress
1	Identify the interpersonal skills required to allow relationships to develop
5,8	Model positive assertive behaviour and skills
1,3, 5,7	Apply proper planning principles in your personal goal setting

Module 2: Human Resource Management and Development

	Exit level outcome
1	Demonstrate an understanding of employment relations in an organisation
2	Apply a number of motivational theories in practice
3	Solve problems by applying human resource management procedures and techniques applicable to the immediate working environment
4	Understand critical labour legislation as it applies to the immediate working environment
5	Understand the principles of negotiation
6	Demonstrate an understanding of what a legal contract and agreement is

Exit level outcome	Learning outcomes
1	Differentiate between the personnel management and human resource management
1	Apply the HRM principles that form an integral part of your role as manager
2	Identify a number of motivational theories and use them to develop strategies for improving motivation within your organisation
3	Identify the types of behaviour found in groups
3	Define the various roles required to ensure that a team functions effectively
3	Manage group conflict
5	Understand the overall objectives of the Labour Relations Act 66 of 1995
5	Give an overview of the objectives of the Basic Conditions of Employment Act 75 of 1997
3,5	Understand the principles of negotiation involved
5	Give an overview of the aim of the Employment Equity Act 55 of 1998
3,6	Demonstrate an understanding of what a legal contract and agreement is
3	Apply the skills required in a disciplinary and grievance situation

Module 3: Resource Mobilisation and Donor Relations

	Exit level outcome
1	Identify and solve problems related to lack of resources by using critical and creative thinking
2	Undertake the different processes of the resource development cycle
3	Apply entrepreneurial thinking to fundraising strategies
4	Communicate effectively by writing a successful case statement and proposal
5	Demonstrating an understanding of the world as a set of related systems by recognising the challenges and common mistakes in raising funds
6	Working effectively with others as a member of a team, group, organisation and community

Exit level outcome	Learning outcomes
1	Understand the difference between fundraising vs. fund development within the challenges of the South African context
2	Know the different types of fundraising practices
3	Appraise possible sources for your own organisation.
1,4, 5	Write an feasible funding proposal, that takes into account the common pitfalls and demonstrates elements of what makes a proposal get funded
2	Conduct an comprehensive internal and external assessment of your organization
2	Articulate and evaluate your cause and program(s) to ensure sustained financing to meet your development objectives
4	Develop an effective case statement
6	Identify potential partners that can help advance your organisation's cause
6	Demonstrate an understanding of the key components of maintaining relations with donors

Module 4: Understanding the South African Healthcare Environment

	Exit level outcome
1	Demonstrate an understanding of health systems as a set of related systems while recognising the political, social and economic contexts involved
2	Identify, analyse, organise and critically evaluate the main policy debates on funding and provision of care
3	Understand the trends and driving forces that shape health policy reform
4	Demonstrate attitudes appropriate to promote values of solidarity and commitment with the patient community
5	Show respect for the diverse opinions, values, belief systems, and contributions of others
6	Communicate his/her understanding of the framework of the South African health system in all the written assignments in this course

Exit level outcome	Learning outcomes
1	Demonstrate an understanding of health systems as a set of related systems while recognising the political, social and economic contexts involved
1,2	Identify, analyse, organise and critically evaluate the main policy debates on funding and provision of care
2,2	Understand the trends that shape decision making in health
2	Demonstrate a general understanding of the South African health system's structure and funding
3	Analyse the contribution of the epidemiological and demographic factors to the health challenges in South Africa.
4	Demonstrates attitudes appropriate to promote values of solidarity and commitment with the community
5	Show respect for the diverse opinions, values, belief systems, and contributions of others.
2,4	Understand the key statutes of parliament relating to health and health care practitioners on the delivery of health care
3	Recognise the opportunities and threats that are posed by globalization of health care

Module 5: Project Management

	Exit level outcome
1	Develop a project plan based on the phases of the project cycle
2	Collect, organize, analyze and critically evaluate the roles and interests of stakeholders so that appropriate techniques are selected for approaching and obtaining their positive response
3	Demonstrate an understanding of the world as a set of interrelated systems by recognizing that factors influencing the project activities of the healthcare manager do not exist in isolation and that wider political and community issues can affect operations
4	Communicate effectively using visual, written and oral communication modes to manage plans for a project
5	Work effectively with others as a member of a team, group, organization or community for the planning of the project
6	Appreciate that it is people who make a project a success, not just the use of project management tools
7	Value the need for flexibility, creativity, and not adherence to rigid prescriptions

Exit level outcome	Unit outcomes
1	Develop a project plan based on the phases of the project cycle
2	Collect, organize, analyze and critically evaluate the roles and interests of stakeholders so that appropriate techniques are selected for approaching and obtaining their positive response
3	Demonstrate an understanding of the world as a set of interrelated systems by recognizing that factors influencing the project activities of the healthcare manager do not exist in isolation and that wider political and community issues can affect operations
4	Communicate effectively using visual, written and oral communication modes to manage plans for a project
5	Work effectively with others as a member of a team, group, organization or community for the planning of the project;
6	Appreciate that it is people who make a project a success, not just the use of project management tools;
7	Value the need for flexibility, creativity, and not adherence to rigid prescriptions.

Module 6: Managing Strategy and Change

	Exit level outcome
1	Identify the nature and process of strategic management
2	Identify and solve problems by using techniques associated with strategic management
3	Work effectively with others as a member of a team, group, organisation, community
4	Communicate effectively to manage resistance to change
5	Demonstrate an understanding of the world as a set of related systems by recognising that resistance to change does not exist in isolation

Exit level outcome	Learning outcomes
1	Describe the concept strategic management
1	Identify the three phases that constitute the strategic management process
1, 2	Conduct an environmental analysis of your organisation using a variety of tools
1	Explain the importance of matching resources to strategy
1	Describe different types of strategies
1	Discuss the drivers and barriers to strategy implementation
1	Discuss reward systems as a driver of strategy implementation
1	Explain the difference of the three types of change provided in the generic model of change
2,5	Explain why resistance to change is a natural and innate response to new situations
2,4, 5	Provide guidelines on how to manage the resistance to change
3	Explain how a manager will attempt to effect change in an individual

Module 7: Leadership

	Exit level outcome
1	Identify and assess different perspectives on, and approaches towards, leadership issues to inform decision-making
2	Differentiate between Manager and Leader behaviours
3	Understand power motives and bases
4	Explain the meaning of Leadership Style as it relates to Situational Leadership theory
5	Develop a Leadership Approach that matches the needs of the organisation, staff and self
6	Use and adapt relevant leadership and management knowledge and skills to practically engage with problems in the workplace
7	Undertake the Six Essential Tasks of Leadership
8	Communicate effectively using written and spoken word and listening skills in order to develop relationships, manage conflicts and work across differences

Exit level outcome	Learning outcomes
1	Discuss the challenge for leadership in South Africa
2	Differentiate between behaviours of managers and leaders
1,2, 3	Explain the various roles of leaders and managers in an organisation and their use of power
1,4	Identify leadership theories as evidenced by the behaviour of others
1,4	Explain the relevance of Situational Leadership to your current position
5	Develop your own leadership approach that matches the needs of your organisation, staff and yourself
6	Explain how and when interpersonal skills will be applied by managers and leaders, in both the work and personal situations
6	Identify the behaviours and roles people demonstrate in teams
6	Manage diversity in teams
6, 8	Design a conflict resolution strategy
7	Distinguish between the qualities of an effective and ineffective leader
7	Describe the Six Essential Tasks of Leadership

Module 8: Managing Information (M&E)

	Exit level outcome
1	Differentiate between surveillance, audits, monitoring and evaluation
2	Apply a structured process to effectively develop a Monitoring and Evaluation plan
3	Select and make use of relevant Monitoring and Evaluation indicators
4	Implement the Logical Framework as an active tool for Monitoring and Evaluation
5	Gather and analyse qualitative and quantitative data, and effectively present such data as interpreted information
6	Understand how to utilise Monitoring and Evaluation data to improve decision-making and implementation performance

Exit level outcome	Unit outcomes
1	Understand the monitoring and evaluation framework in the context of indicators and data sources
2	Select and use appropriate indicators and tools for an M&E plan
2	Formulate an understanding of the ethical and legal issues surrounding monitoring and evaluation
2, 3, 4, 5	Demonstrate an understanding of the components of monitoring and evaluation
2, 3, 4, 5	Be able to develop a monitoring and evaluation plan
3, 5	Formulate study design and methods
3, 5, 6	Communicate research findings in graphs and written format

Module 9: Strategic Marketing and Customer Relations

	Exit level outcome
1	Explain the impact of marketing research on service delivery
2	Use information to develop an appropriate marketing mix for an organisation
3	Conduct an environmental analysis to determine specific market variables
4	Develop an effective marketing plan for an organisation
5	Differentiate between marketing of goods and that of services
6	Demonstrate a customer focus in service delivery
7	Render market-driven, customer-focused services to a specific target group

Exit level outcome	Learning outcomes
1,7	Understand marketing in the context of customer needs, wants and demands
1,5	Apply the principles pertaining to the marketing concept
	Differentiate between marketing of goods and that of services
1,2, 3,4, 5	Develop an effective marketing plan for the organisation
2	Select an appropriate segmentation strategy for the organisation
6	Determine an effective communication strategy for the marketing intervention
6	Explain the role of customer satisfaction in relation to service delivery
1	Use the concept of provider gaps

Module10: Financial Management

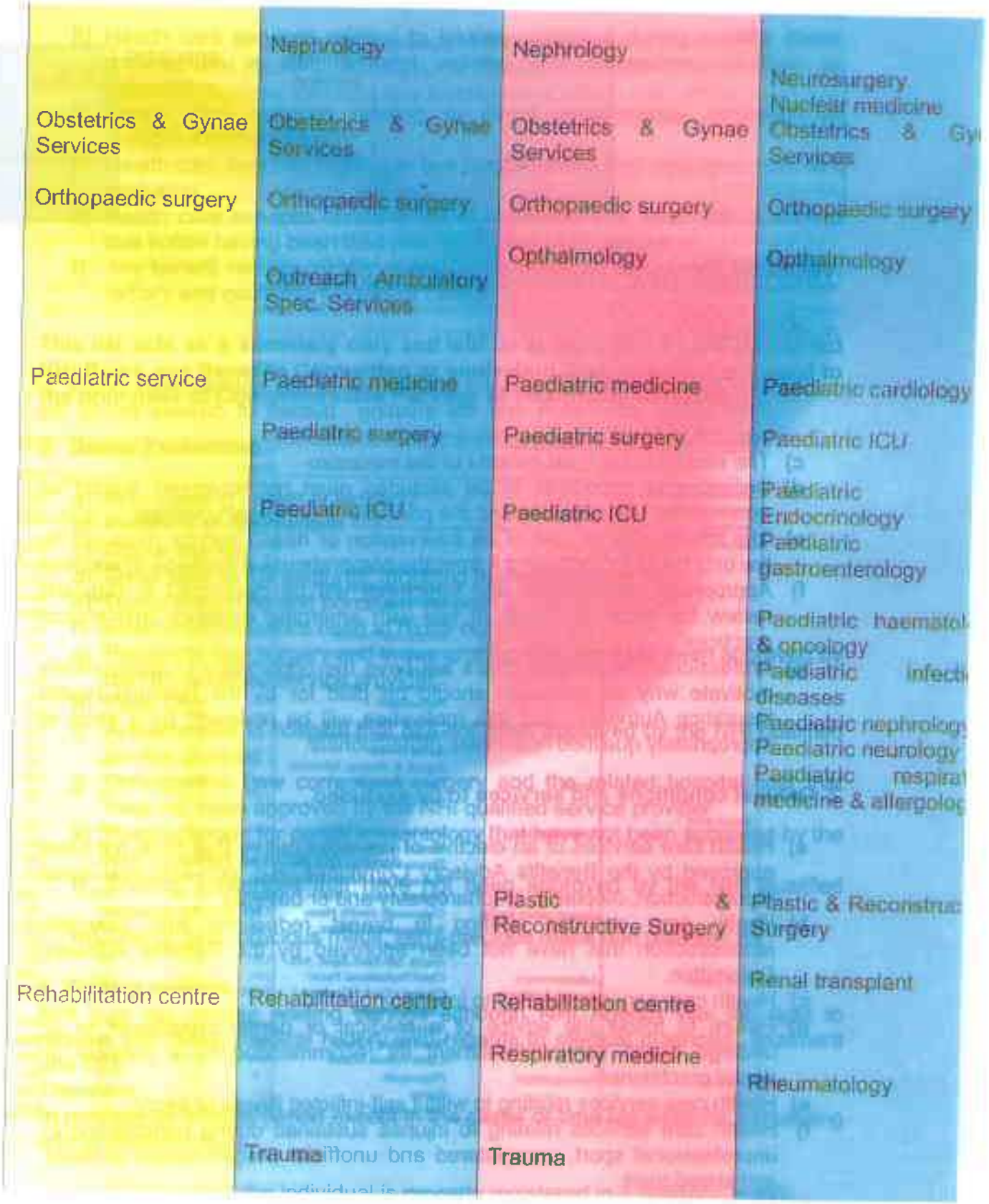
	Exit level outcome
1	Understand the basic financial concepts, procedures, calculations and activities of an enterprise .
2	Demonstrate analytical skills through finding, organizing, assessing and, analyzing financial data appropriate to a given situation
3	Use ratio analysis to understand the performance of an organization
4	Demonstrate information technology skills as they apply to today's business environment to solve business problems
5	Communicate effectively using written mathematical skills by drawing up a budget and use it to control costs

Exit level outcome	Unit outcomes
1, 4,5	Draw up a balance sheet
1,4	Draw up a profit and loss account
1	Recognise the key accounting conventions
2,5	Demonstrate recognition of the source, flow and distribution of money
2	Explain the difference between profit and cash
3	Use selected ratios to analyse the liquidity of organisations
3	Calculate profitability ratios and comment on organizational performance
3	Determine gearing and growth (investment) ratios and use them to interpret the effects of a organisation's capital structure on its current profits, future profits and capital raising potential
3	Evaluate organisations' use of assets using relevant ratios
3	Calculate employee ratios
2	Appreciate the key factors in budgetary planning and control
2, 3, 4,5	Prepare a master budget (profit and loss account and balance sheet)

ANNEXURE D: SUMMARY OF HOSPITAL LEVEL SERVICES BY TYPE OF HOSPITAL

Proposed Package of services to be offered at different hospital types for the NHI

Regional	Developing Tertiary	Fully Developed Tertiary	National Referral
Specialist services available on site	Specialist services available on site	Specialist services available on site	Specialist services available on site
Anaesthetics	Anaesthetics Burns Unit	Anaesthetics Burns Unit Clinical Pharmacology Specialist	Cardiology Cardiothoracic surgery Clinical Immunology
	Critical care & ICU	Critical care & ICU Dermatology specialist services	Craniofacial surgery Critical care & ICU
Diagnostic Radiology	Diagnostic Radiology	Diagnostic Radiology ENT Specialised Surgery	Diagnostic Radiology ENT Specialised Surgery
		Gastroenterology	Endocrinology
General Medicine Service	General Medicine Service	General Medicine Service	
General Surgery Service	General Surgery Service	General Surgery Service	
			Geriatrics Haematology
		Infectious Diseases	Human Genetics Infectious Diseases
Mental Health Services (Psychiatry & Psychology)	Mental Health Services (Psychiatry & Psychology)	Mental Health Services (Psychiatry & Psychology)	Medical & Radio Oncology
Neonatology	Neonatology	Neonatology	


Nephrology
Nephrology
Neurosurgery
Nuclear medicine
Obstetrics & Gynae Services
Obstetrics & Gynae Services
Obstetrics & Gynae Services
Orthopaedic surgery
Orthopaedic surgery
Orthopaedic surgery
Orthopaedic surgery
Opthalmology
Opthalmology
Outreach Ambulatory Spec Services
Paediatric service
Paediatric medicine
Paediatric medicine
Paediatric cardiology
Paediatric surgery
Paediatric surgery
Paediatric ICU
Paediatric ICU
Paediatric ICU
Paediatric Endocrinology
Paediatric gastroenterology
Paediatric haematol & oncology
Paediatric infect diseases
Paediatric nephrology
Paediatric neurology
Paediatric respira medicine & allergolo
Plastic & Reconstructive Surgery
Plastic & Reconstruc Surgery
Renal transplant
Rehabilitation centre
Rehabilitation centre
Rehabilitation centre
Respiratory medicine
Rheumatology
Trauma
Trauma

ANNEXURE E: HEALTH SERVICES EXCLUSIONS LIST

1. Principles:

b) The exclusion list should take cognizance of the epidemiology profile of the national population and the ensuing burden of disease facing the population
c) The exclusion list must be kept to the minimum
d) Decisions of conditions to be excluded must not adversely impact on accessibility to healthcare and the principle of universal coverage
e) The affordability or cost of an intervention or health service must not be the only basis for excluding it from the comprehensive package of services
f) Appropriate mechanisms and structures will be developed to regularly review the exclusions lists in line with emerging evidence and clinical practices
g) Professionals/healthcare givers will have the opportunity to appropriately motivate why an exclusion should be paid for by the National Health Insurance Authority and this motivation will be reviewed by a team of appropriately qualified healthcare professionals.

2. General conditions and services to be excluded

a) Health care services of an elective of cosmetic nature that have not been approved by the Benefits Advisory Committee, e.g. non-essential nasal reconstruction, otoplasty, blepharoplasty and or bat-ears.
b) Health care services relating to breast reductions and cosmetic reconstruction that have not been approved by the Benefits Advisory Committee.
c) Health care services relating to infertility
d) Failure to follow the advice of a medical or dental practitioner or to undergo health services/treatment as recommended by a medical or dental practitioner
e) Health care services relating to willful self-inflicted illness or injury
f) Health care services relating to injuries sustained during participation in unprofessional sport, unregistered and unofficial (illegal) speed contests and speed trials
g) Health care services relating to injuries sustained during participation in a willful and material violation of the law

h) Health care services relating to injuries sustained during a willful illegal participation in war, terrorist activity, civil commotion, rebellion or insurrection.
i) Health care services relating to illegal experimental, unproven or unregistered treatment
j) Health care services relating to any complications that may arise from NHI exclusion
k) Health care services obtained out of the borders of South Africa without due notice having been filed with NHIA prior to departure.
l) Any benefit not specifically stated in the schedule of primary, secondary, tertiary and quaternary levels of care.

This list acts as a summary only and will be superseded by the registered NHI Rules and Benefits Committee or equivalent thereof with due regard to the principles of Comprehensive Package of Healthcare Services.

3. Dental Exclusions

a) Pulp capping (direct or indirect)
b) Polishing of restorations
c) Ozone therapy
d) Metal base to full dentures, including the laboratory cost
e) Dental bleaching and porcelain veneers
f) Fixed prosthodontics used to repair occlusal wear
g) Peridontal flap surgery and tissue grafting that have not been approved by the NHI qualified service provider
h) Perio Chip
i) Apisectomies in hospital that has not been approved by the NHI qualified service provider
j) Orthognathic (jaw correction) surgery and the related hospital cost that have not been approved by the NHI qualified service provider
k) Hospitalisation for dental implantology that have not been approved by the NHI qualified service provider
l) Snoring appliances that have not been approved by the NHI qualified service provider
m) Cost of gold, precious metal, semi-precious metal and platinum foil

4. Waiting periods

NHI may not impose waiting periods although NHI Agency has the right to request and obtain medical history with regards to medical diagnosis, treatment and care
Therefore,
In principle no waiting period except in the cases of time lag while for formalizing administration issues:

a) Ensuring that the individual is properly registered in a resident District

b) Individual is loaded in electronic patient record system
Individual is presenting him/herself to an unaccredited facility thus taking time to sort out whether there exists a contractual and payment arrangement with affected facility/service provider

ANNEXURE F:

The following tables are taken from Broomberg and Shisana (1995). Table 3 (numbering from original report) provides estimates of need based on a detailed, hypothetical cost model that used data from health centres in Alexandra and Soweto. On the basis of this model they estimate human resource requirements for each category of personnel in the PHC system, over a five year period between 1996/97 and 2000/01 (see Table 4).

Table 3: Projected Human Resource Requirements for the PHC system

			Hypoth. District	1996/97	1997/98	1998/99	1999/2000
Catchment population			100000	36,336,531	36,824,646	37,352,889	37,901
Visits per person per annum			1.82	2.00	2.30	2.65	2.04
Treatments			182000	72,673,062	84,708,714	98,826,456	115,33
Clinical							
	Doctors		4.62	1846	2151	2510	2929
	Nurses	Professional Nurse	18.00	7187	8378	9774	11407
		Community health nurse	5.00	1997	2327	2715	3169
		PHC Nurse	26.96	10766	12549	14641	17087
		Staff Nurse	18.10	7229	8426	9830	11473
	Allied Health Workers	Nutritionist/Dietician	1.00	363	368	374	379
		Occupational Therapy Assistant	2.50	908	921	934	948
		Occupational Therapist	1.00	363	368	374	379
		Psychologist	1.00	363	368	374	379
		Physiotherapist	1.00	363	368	374	379
		Physiotherapy Assistant	2.50	908	921	934	948
		Social Worker	2.50	908	921	934	948
		Speech & Hearing Specialist	0.50	182	184	187	190
	Dental	Dental Therapist	2.50	908	921	934	948
		Oral Hygienist	1.00	363	368	374	379
District level							
	Administration	District Medical Officer	1.00	363	368	374	379
		District Health Manager	1.00	363	368	374	379
		Human Resources Manager	1.00	363	368	374	379
		Financial and Admin Officer	1.00	363	368	374	379
		District Admin / Clerk	4.00	1453	1473	1494	1516
	General public health	Community Health Nurse	1.00	363	368	374	379
		Environmental Officer	1.00	363	368	374	379
		Pharmacist	1.00	363	368	374	379
		Health Info Spec./Epid. Ass.	1.00	363	368	374	379
Clinic Level	Administrators	Chief Professional Nurse	5.00	1817	1841	1868	1895
	General Assistants	Cleaner / Cook / Gardener / Domestic worker	15.00	5990	6981	8145	9506
		Security	10.00	3634	3682	3735	3790
		Ward Helper / Porter	5.00	1817	1841	1868	1895
		Clinic Admin / Clerk	15.00	5990	6981	8145	9506
Medicines	Pharmaceutical	Pharmacist	1.50	545	552	560	569
Other		Driver	5.00	1817	1841	1868	1895
		Lab Assistant	5.00	1997	2327	2715	3169