THE PRESIDENCY
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF PLANNING, MONITORING AND EVALUATION

SOCIO-ECONOMIC IMPACT ASSESSMENT SYSTEM (SEIAS) for National Health Insurance (NHI)

INITIAL IMPACT ASSESSMENT (PHASE 1)

1 The Problem/Theory of change

1. What is the social or economic problem that you are trying to solve?

The current health system in South Africa has two-tiers - Public and Private. This fragmented system is the legacy of a the pre-1994 Apartheid period in South Africa in which the private sector was highly resourced and benefitted the white minority, while the public sector was systematically under-resourced and served the black majority.

Attempts made to transform the health sector in the 1990's and early 2000's were unsuccessful and so the two-tiered system has become further entrenched with access to quality health services now based on socio-economic status, and inequities perpetuated. South Africa currently spends 8.9% of its GDP on health and of this, 49% is spent on 16% of the population in the private sector whilst the remaining 49% is spent on 84% of the population that is dependent on the public health sector.

Although there are multiple dimensions to access, the root cause relates to financial access. This is due to the disproportionately high level of expenditure spent on the private sector which continues to serve a minority wealthy and urban population and benefits from pre-existing infrastructure; while the majority poor, including key vulnerable populations, continue to be served with a limited financial resources that are both disproportionate to the size of the population served and the burden of disease, and insufficient to address the historical imbalance in infrastructure. This is despite clear evidence that lower socio-economic groups have lower health service utilisation rates and derive fewer benefits from using health care, either public or private. In fact, the burden of ill-health has been shown to be far greater amongst poor.

Financial access is further limited due to the structure of the health financing system in which there is no mechanism for prepayment in the public sector, thereby increasing the level of out-of-pocket expenditure at the time of service delivery; and no mechanism for pooling of resources thereby preventing cross-subsidisation that would provide risk protection to those that would otherwise suffer catastrophic expenditure or forgo access altogether. However, within the private sector too, members of medical schemes often have to make substantial out-of-pocket payments too, such as where the scheme only covers part of the cost of services, where a service is not covered at all by

the medical scheme (e.g. outside the scheme's benefit package) or where scheme benefits have run out. In addition multiple medical schemes prevent risk-pooling and cross-subsidisation across the populations covered by these schemes.

This continued existence of this system has resulted in the failure to achieve Constitutional imperatives contained in Section 27 of the Bill of Rights, and runs contrary to the values of equity and solidarity underlying the United Nations 2012 Declaration on Universal Health Coverage (UHC) to which South Africa is a signatory. In addition, the evidence shows that compared to other countries of similar economic development, the level of expenditure channelled through this system is not translating into the expected health outcomes.

2. Identify the major social and economic groups affected by the problem, and how they are affected. Who benefits and who loses from the current situation?

The general public is affected by the structure and outcomes of the current health system at an individual, community and national level.

Publicly-funded health services are primarily accessed by the poor majority and private health care is accessible for the privileged few. The richest 40% of the population receives about 60% of the health care benefits, meaning that those with the financial means compared to those without, having easier access to health care through the private sector and to highly specialised public hospitals. Furthermore, the richest 20% of the population receives 36% of total benefits, despite their need being less than 10%. In contrast, the poorest 20% received only 13% of the benefits despite having a greater need for health care at 25%. Therefore, under the current system it is the poor that suffer at the expense of the non-poor.

The existing dichotomy has a similar impact on race to that observed during the years of segregation enforced by apartheid. For example, the majority of Africans (75.5 per cent) and slightly more than half of Coloureds (56.1 per cent) rely on public health sector services today. In contrast, the overwhelming majority of Whites (83.4 per cent) and a substantial percentage of Indians (65.5 per cent) have access to the well-resourced private health sector. Whites and Indians are also more likely to have medical scheme coverage which provides risk protection and guarantees better access to quality health care compared to Africans and Coloureds. Recent figures in 2014 indicate that 71 per cent of Whites belonged to some medical scheme, followed by Indians at 47 per cent, Coloureds at 22 per cent and Africans at 10 per cent (Statistics South Africa, 2014). Thus, twenty years after democracy was installed, Africans and Coloureds continue to disproportionately suffer from the existing health system structure.

Socio-economic status can also be driven by geographical location and gender. Rural populations which exhibit low population density and therefore higher per capita costs to reach are typically under-resources and thus underserved by the public sector as well as the private sector. For example, although 43.6 per cent of the population in South Africa live in rural areas they are only served by the 12 per cent of doctors and 19 per cent of nurses in the public sector. Thus, residents of urban areas are the beneficiaries at the expense of those in rural areas. Similarly, it is reported that females (63.5 per cent) are more likely than males (57.6 per cent) to use the public health sector and therefore suffer relatively more due to this limited access..

The inequitable access to quality health care contributes to poor health outcomes as a result of preventable communicable and non-communicable diseases. This contributes to premature deaths and high mortality and morbidity rates amongst the vulnerable and disadvantaged sections of the population who are affected by a system that perpetuates underfunded and deteriorating health care services. Viewed through a different lense, without complete structural change, the government elected by that public is limited in its capacity to address health inequalities and affect improved health outcomes that are associated with socio-economic issues of poverty, crime, and poorly educated/unskilled labour force.

3. Which of the five top priorities of the state – that is, social cohesion, security, economic growth, economic inclusion (job creation and equality), and a sustainable environment – is negatively affected by the problem?

The implementation of NHI in South Africa is based on the following eight principles:

i. Right to access health (Bill of Rights, Section 27 of the Constitution)
ii. Equity
iii. Social Solidarity
iv. Health as a public good
v. Affordability
vi. Appropriateness
vii. Efficiency
viii. Effectiveness

Social Cohesion and Security

The Director-General of the World Health Organisation said in 2009 that, "A health system is a social institution... Properly managed and financed, a health system that strives for universal health coverage (UHC) contributes to social cohesion and stability." Health is indeed a public good.

National Health Insurance (NHI) is the vehicle through which South Africa will strive towards the attainment of UHC. The associated structural reform including the creation of mechanisms for a

common financial and risk pool ensures that values such as equity and solidarity become a reality. The effects of decreased health inequalities and improved national health outcomes will also have positive spillovers that support improvement in other social sectors, driving a reduction in poverty and crime, and an improvement in education outcomes and the skill level of the labour force.

Implementation of NHI will improve the capacity of the State to progressively deliver good quality and effective health services, giving all South Africans the best chance of enjoying a long and healthy life, and thereby decreasing the risk of service delivery protest and strengthening national security.

Economic growth and Investment

From an economic perspective, the nexus between health-poverty-income suggests that per capita income and health status are strongly associated. A poorly performing health system affects the economy through the labour market through multiple channels. Where the existing work force is without access to health services, they are less productive and generate lower level of output due to decreased efficiency, effectiveness, and devoting less time to productive activities (i.e. more days off work, a shorter work life span). Decreased life expectancy also narrows the knowledge base in the economy as the gains to education decrease as life expectancy decreases. A decreased "work life" also translates into decreased life earnings and thereby savings to support workers during retirement. These effects are further perpetuated as they become intergenerational. Children who cannot access health care are less likely to exhibit strong cognitive skills and become healthy adults within the workforce. Those that have to support aging parents with insufficient savings are also less likely to add to the knowledge economy.

Economic Inclusion (Employment creation and equity)

The economy of any country is constrained by number of economic active years of the labour force. A weak health system that cannot attract or retain health professionals, nor distribute them according to need, further undermines efforts towards job creation and equitable access to health care services.

Sustainable environment

N/A

4. **What are the main causes of the problem? That is, why does the problem arise and why does it persist?**

The South African health system falls short of the goal of universal coverage due to fragmented funding and risk pools, which limit the capacity for cross-subsidisation that would otherwise allow for the subsidisation of the poor by the rich, the sick by the healthy, and the elderly by the young. It also decreases the efficiency with which available resources can be spent. The problem persists due to vested interests that ensure the structure of the health system of the apartheid era is perpetuated.

5. **Whose behaviours give rise to the problem, and why does that behaviour arise? Remember that several groups, including some in government, may contribute to the identified problem. Their behaviour may arise amongst others because the current rules are inappropriate; because they gain economically from the behaviour; or because they are convinced they are doing the right thing. Identifying the behaviours that cause the problem should point to the behaviours that must be changed in order to achieve the desired solution.**

The unsuccessful attempts made to transform the health sector in the 1990's and early 2000's have meant that a health system originally structured and implemented to create inequity over decades, has become further entrenched. To address this, the behaviours of all stakeholder must change; however, the first twenty years of democracy have shown that in the absence of appropriate incentives structures (i.e. conditions that make it in the best individuals interest of each individual to change their behaviour) various push and pull factors make this highly improbably. For example, a health worker is unlikely to choose to work in a remote area or one with a particularly high burden of disease unless they are compensated accordingly. Compensation may take the form of financial remuneration or simply the guarantee of a supportive work environment. Similarly, a patient that must forgo a day's work to seek health care is unlikely to use a primary health care facility as their first point of entry to the health system as they should, if they expect their condition to require a referral and they believe there is no medical transport available. Thus, what is required is complete structural overhaul of the national health system, to alter the development trajectory and to put in place incentives that make it all stakeholders' individual interests – or at least with minimal cost - to address the current inequities.

This structural overhaul can only be led by the government, and while regulation is required, the first and foremost issue must be the identification and creation of stakeholder and context-specific incentives to drive behaviour. This applies to both the public and private sector and includes key actors such as health care providers, individuals seeking health care services, health professionals, private medical aids, suppliers (e.g. pharmaceutical companies) etc.

It requires the development of a funding system that can ensure efficient collection and pooling of funds as well as active purchasing. Active purchasing in particular involves the replacement of what has traditionally been a passive relationship between purchasers (i.e. those who hold a pool of funds and transfer these funds to providers) and service providers including resources that responds to need in terms of the level and distribution of funding (e.g. geographical distribution of health workers that is aligned to the burden of disease), and tailored budgeting and payment mechanisms that incentivise efficiency and high service quality.

2 Options

1. **List at least three options for addressing the problem, including (a) your preferred proposal, and (b) an option that does not involve new or changed regulation.**

   a. **National Health Insurance (NHI) – Preferred option**

   NHI will be a single payer NHI and will be effective in providing quality health services to the entire population irrespective of one's socio-economic status. NHI will also be effective in pooling of collected revenue, distributing risks through one large risk pool; and will offer government a high degree of control over total expenditure on health. A single payer NHI will be administratively more efficient and will be better able to negotiate prices, purchase commodities in bulk to drive down costs of health care.

   b. **Status quo**

   Continuation of a fragmented dual/tiered health system and with inequities in access and quality of delivery of health care

   c. **Privatisation**

   Full provider privatization, including mandatory contributions from employers will not be effective in reducing fragmentation, improving access and reducing the costs of delivering healthcare.

2. **What social groups would gain and which would lose most from each of the three options? Consider specifically the implications for households earning under R7000 a month; micro and small business; black people, youth and women; and rural development.**

Option	Main beneficiaries	Main cost-bearers
1)National Health Insurance	- Women and Children - the Elderly - Disabled - Working class - Rural communities - Other Vulnerable groups - Employed and Unemployed - Employers - Government	- National Revenue Fund - Contributors to tax revenue - Private individuals seeking top-up coverage for benefits falling outside of the NHI Benefit Package
2)Status Quo	- The wealthy - The employed who can afford to pay for private sector care -	- National Revenue Fund - Contributors to tax revenue - Development Partners
3)Privatisation	- Medical Schemes - Private providers - The wealthy and those who can afford private health care	- Contributors to private health insurance - Individuals - Employees

3. **For each option, describe the possible implementation costs, compliance costs, and the desired outcomes, listing who would bear the costs or, in the case of outcomes, enjoy the benefits. In addition, note the risks that could threaten implementation of each option.**

Option	Implementation costs	Compliance costs	Desired outcomes	Risks
1)NHI	Implementation costs include the costs of setting up the NHI Fund and its infrastructure as well as administration of the NHI Fund. These costs will be in line with international best-practice that is at 3% of total direct health care costs. These costs will commence at 0.8% in the first year of implementation and will gradually increase until full implementation where they should remain at a constant of 3% or less.	Cost of meeting OHSC requirements is what the health system must invest in to ensure that it meets the norms and standards as stipulated by the OHSC for the health establishment to be certified. This is estimated at 10% of the total health expenditure. Regulations such as the Certificate of need will regulate geographic distributions of provision of services by health professionals to areas of greatest need	- Equity in access and provision to all South Africans irrespective of socio-economic status - Reduced costs of providing health care - Social and financial risk protection - Increased geographic access especially for rural and vulnerable communities - Improved quality of health services - Improved performance of the health system - Social Solidarity and social cohesion - Increased life expectancy and quality of life	- **Underfunding** by a hostile government. - **Mismanagement** and the risk of inept or corrupt management - **Recession: Funding for NHI will** rely on a combination of taxes - **Poor participation:** Lack of uptake to participate by providers such as doctors
2)Status Quo	- Significant investment to upgrade health infrastructure - Ability to recruit and retain health professionals	- Cost of meeting OHSC requirements is what the health system must invest in to ensure that it meets the norms and standards as stipulated by the OHSC for the health establishment to be certified. This is estimated at 10% of the total health expenditure.	- Increased geographic access especially for rural and vulnerable communities - Improved quality of health services - Equity in access and provision - Improved performance of the health system - Increased life expectancy and quality of life	• Rising prices in the private sector • Affordability; • Access to health care at the time of need not guaranteed and further subjected to waiting times and queues. • Continuation of poor quality of health services as a result of maldistribution of financial and human resources
3)Privatisation	Currently the private medical schemes industry's level of administration of the schemes is	- Cost of meeting OHSC norms - Regulations such as the Certificate of need will regulate geographic	- Improved access to services for those who can afford to pay - Profit maximisation by both private funders and providers of private health care	-Rising prices -Affordability -Exacerbation of income-based segregation or tiering in terms of access to

Option	Implementation costs	Compliance costs	Desired outcomes	Risks
	estimated at 20% to 25% of overall health expenditure in the private sector	distributions of provision of services by health professionals to areas of greatest need	- Minimal regulation in the funding and provision of healthcare - Free market principles	health care -Improved health outcomes and life expectancy may be restricted to certain sub-populations

4. Based on the table on costs and benefits, describe how the different options would contribute to or detract from national priorities. Remember this is a think-tool, so explore the issues freely.

Priority	Option 1) NHI	Option 2) Status Quo	Option3) Privatisation
Social cohesion	-Creation of mechanisms for a common financial and risk pool ensures that values such as equity and solidarity become a reality. -Decreased health inequalities and improved national health outcomes will also have positive spillovers that support improvement in other social sectors, driving a reduction in poverty and crime, and an improvement in education outcomes and consequently the skill level of the labour force. 2.1.1	-Health outcomes and life expectancy will not be improved without addressing fragmentation in risk pools and equity of access. Social cohesion will not be achieved.	-Multi-payment and provision systems will not contribute to financial and risk pooling, thereby undermining the ability to achieve equity and social cohesion.
Security	-A strong health system will contribute to reduced threat from global health security issues.	-Recent experience of countries that have been affected by outbreaks of highly contagious disease (e.g. Ebola in West Africa and MERS in North Africa) have shown that weak and fragmented health systems can have massive implications for all facets of a country's economy.	- A strong private provider system will contribute to reduced threat from global health security issues.
Economic growth and investment	- Improved patient outcomes and increased life expectancy will increase the number of economic active years - It will Increase productivity and output -It will increase the knowledge base in the economy	-Any economy is constrained by the labour force, specifically the number of economic active years -If health outcomes and life expectancy fail to improve, it will directly impact on the economy.	- A private model will contribute to improved health outcomes and number of economic active years; but will be limited to a subset of the non-poor population who are most likely to benefit - A private for-profit model will in itself contribute to economic growth.
Economic inclusion (employment creation and equity)	-Increased capacity to attract, retain and distribute health professionals according to need	- Continued challenges to recruit and retain human resources undermine the capacity to improve health outcomes and life expectancy;	-Rising prices -Affordability -May increase the cost of labour which could result in job losses.
Environmental sustainability	N/A	N/A	N/A

5. For each option, indicate what can be done to mitigate the identified risks.

Option	Identified risks	Mitigation measures	Comments
a) NHI	1. Underfunding of NHI by a hostile government: a government that favours privatization might take measures to undermine a strong public health system and NHI.	1. In South Africa, this is unlikely given the increased attention to accelerating service delivery including health and as the NDP Vision 2030 clearly envisions NHI. It is generally acknowledged that funding for health care has to increase significantly as part of revitalising that sector.	
	2. Recession and economic downturn: the funding of NHI and a transformed health system will rely on the ability to raise taxes, which may be constrained during recessions and periods of economic downturn.	**2.** South Africa currently spends 8.9% of GDP on health most of which disproportionately benefits the wealthy and employed. Single payer NHI will ensure that this expenditure benefits equitable those with the greatest need The current economic downturn will affect the tax revenues collected and constrain the fiscal space. However, innovative budgeting as it relates to how the current allocations are restructured through the reforms to the IGFR Framework for health will go a long way in improving equity and efficiency in the health sector. The budgets allocated for national priority sectors such as Health, will be ring-fenced through the NHI Fund and will have immediate and long time benefits on productivity and quality of life of our people.	
		3. The proposed governance structure for NHI provides for direct accountability of the Fund to the Minister of Health	
	3. Mismanagement: the risk of inept or corrupt management could misallocate funds in a single payer system, taking away money from vital services and decreasing quality.	4. Changes to the contracting plans (contracting in or out) and reimbursement strategies as well as a review of the policy of Remunerated Work Outside of Public Service (RWOPS) has to be undertaken	
	4. Poor participation: Lack of uptake to participate by providers such as doctors		

Option	Identified risks	Mitigation measures	Comments
b) Status quo	- Continuation of tiering and fragmentation within and between both public and private health sectors - Access to quality health care at the time of need is not guaranteed and further subjected to waiting times and queues especially for the most vulnerable sections of our society - Fiscal federalism in the public health sector undermining equity considerations - Lack of financial risk protection in both public and private sectors - Affordability: Rising prices in the private health sector	-Private sector price and benefits regulation -Regulation restricting geographic provision of private services by health professionals -increase investment in public sector infrastructure and production of health professionals in the public sector - improve remuneration and incentives to retain health professionals in the public sector -Improvement in quality through compliance with OHSC norms and standards.	A gap will nonetheless remain in financial risk protection. Failure to implement a mechanism for prepayment of health care will still leave the majority of people exposed to health care costs associated with catastrophic illness. This is underpinned by no mechanism of risk pooling and cross-subsidisation. Active purchasing by the payor is also necessary to improve performance of providers
c) Privatisation	- Affordability: Rising prices in the health sector. - Perverse incentives in a sector that is not optimally regulated especially in a fee for service environment. Compliance challenges with existing legislation and associated regulations. - Exacerbation of income-based segregation or tiering in terms of access to health care. This will result in variable packages of services with better sections of the population accessing more services than the poor - Medical cost escalation that is difficult to control (e.g. due to different payment mechanisms and practices, and different control of utilization by members) - High administrative and transaction costs associated with data intensive and expensive risk equalisation	-Price and benefits regulation -Regulation restricting geographic provision of services by health professionals such as through a certificate of need -Improve and regulate remuneration / reimbursements and incentives to retain health professionals whilst also ensuring affordability in delivering health care -More stringent regulations to the privatised funding environment Improvement in quality through compliance with OHSC.	As in the status quo, the issues around financial risk protection, prepayment, and pooling apply.

Option	Identified risks	Mitigation measures	Comments
	mechanisms to achieve some form of appropriate cross-subsidisation - Improved health outcomes and life expectancy may be restricted to certain sub-populations		

3 Summary

1. Based on your analysis, as reflected in the discussion of the three options above, summarise which option seems more desirable and explain why.

The alternatives to the preferred option of National Health insurance (NHI) are a continuation of the Status quo, and Privatisation.

The Status quo has the advantage of requiring no structural reform. And while it is likely that prices would continue to rise, and availability of resources continue to be inequitably distributed, there would still be opportunity for discrete regulatory intervention. In addition, resources can be channelled into the training of health professions and the development of incentives to retain them. Similarly, investment in infrastructure and improvement in quality of services may be possible through compliance with the Office for Health Standards Compliance (OHSC). However, a gap will remain in financial risk protection. Failure to implement a mechanism for prepayment of health care will still leave the majority of people exposed to health care costs associated with catastrophic illness. The would be further undermined by the absence of any mechanism for risk pooling which would present an obstacle to the realisation of efficiency gains, which are so critical in the current economic climate. The current economic climate also limits the level of resources available for proposed investments in infrastructure and training. Ultimately, were national health outcomes and life expectancy to increase, the benefits would likely accrue to certain sub-populations from higher socio-economic background. Therefore, the Status quo will not address the issue of equitable access and therefore progress towards universal health coverage (UHC); and it is likely to have negative consequences for the national priorities, in particular social cohesion, security, economic growth and investment, and economic inclusion.

A Privatisation model would bring about similar results to the Status quo option and increase the number of economic active years in the labour force thereby positively affecting economic growth. However, it is also likely to lead to an increase in the cost of labour and ultimately job losses and eexacerbation of income-based segregation or tiering in terms of access to health care and undermine social cohesion. It would also require significant regulation.

National Health Insurance (NHI) is aimed at moving South Africa towards universal health coverage (UHC). NHI is aimed at ensuring that all South Africans irrespective of their socio-economic status

have access to quality health services, free at the point of care when they need to access the health system and are afforded financial risk protection, especially from catastrophic health expenditure.

NHI is based on the following principles:

i. Right to access health care as enshrined in the Bill of Rights, Section 27 of the Constitution
ii. Equity
iii. Social Solidarity
iv. Health as a public good
v. Affordability
vi. Appropriateness
vii. Efficiency
viii. Effectiveness

NHI will be funded through a prepayment mechanism that is largely tax-funded and involves pooling of available public and private resources into a single pool that will strategically purchase personal health services on behalf of the covered population. Individuals will contribute according to their ability to pay and they will be able to access a better standard of health care. NHI is pro-poor and will provide greater access to health services for women, children, the vulnerable, the elderly and the disabled. Appropriately determined poor and indigent individuals will be exempt from contributing towards the NHI but will still benefit from health services according to their health needs.

The benefits of implementing single payor, single purchaser NHI are multiple: improved access to quality health care especially for the poor, working class, people with disabilities, the elderly and women especially in under-priviledged areas and this will be achieved through accreditation of public and private providers and strategic purchasing of personal health services; better health outcomes across all socio-economic groups, improved efficiency and cost containment through streamlined administration and purchaser-provider split; improved accountability on use of funds through appropriate governance mechanisms and transparency in performance reporting; Improved financial protection through increased pre-mandatory payment funding; Improved human capital and productivity; economic growth and social cohesion. A more responsive health system is likely to improve user satisfaction and contribute to the general quality of life of the citizens.

1. What specific measures can you propose to minimise the implementation and compliance costs of your preferred option, to maximise the benefits?

a) Administrative simplification

A publicly administered single payer NHI will save money by reducing administrative costs and by facilitating implementation cost control through centralized administration. Implementation

and administrative costs related to marketing, advertising, or complex billing due to the many private payers will not form part of the administrative processes of NHI. Doctors, hospitals and insurers spend a lot of money hiring administrative staff to deal with billing and handling of claims.

b) **Cost containment:**

In order to be able to control costs in the health care system, it is important to understand the drivers of health care inflation. It is therefore not enough to focus only on reducing administrative costs. A single payer is more likely to be able to manage or control costs because of the centralised nature of its administration. The systems and procedures will be the same across the system. A nationally coordinated process to assess the cost-effectiveness of health technologies that are evidence-based assessments should be made into national policy such as is the case of National Institute of Clinical Excellence (NICE) in the UK. In single payer system, the NHI Fund can use evidence-based assessment of technology to determine what is covered throughout the system, thus minimizing the use of ineffective technologies.

c) **Other cost controls:**

The single payer systems can get better prices for goods and services because of their bulk purchasing power. In South Africa, the current price differentials between public and private sector for procuring medicines goes up to 50%, and with better negotiation by the public sector at the international level better prices are likely to be secured by the public single payer. The single payer should be able to negotiate physician and hospital payment rates. In addition, because billing is done by one entity, the single payer system should facilitate the collection of massive databases that can be used to study and potentially improve practice and utilisation patterns. The databases can also be used to screen for fraudulent billing by providers.

2. **What are the main risks associated with your preferred option, and how can they best be managed?**
   a) **Underfunding by government** especially a government that is hostile to the principles underpinning NHI or favours privatization and market dominance in the health sector might take measures to undermine NHI. **Attention must be given to accelerating the policy and legislative processes of NHI, seeking community / public support and buy-in into the vision of NHI and to accelerate service delivery improvements including infrastructure and**

human resources requirements in health. It is generally acknowledged that funding for health care has to increase significantly as part of revitalising that sector.

b) **Mismanagement** and the risk of inept or corrupt management could misallocate funds in a single payer system, taking away money from vital services and decreasing quality. **The proposed governance structure for NHI provides for direct accountability of the Fund to the Minister of Health**

c) **Economic Recession and the current economic crisis will affect the tax revenues collected.** What is required is innovative budgeting and the review of the IGFR Framework for the health sector pooling of financial resources as we spend 8.9% of GDP on health as the total health expenditure for the country. We need an effective redistributive tool that will ensure that our total health expenditure is spent on those with the greatest need so that we can achieve the desired health outcomes as envisioned in the NDP 2030.

3. **What additional research should you do to improve your understanding of the costs and benefits of the option adopted?**

Further work is going to be undertaken to refine the implementation plan for NHI. The work streams are established as part of the process to provide technical support in developing the implementation strategy for NHI and finalisation of the of the Departmental policy paper on NHI. The Terms of Reference for each of the Work Stream Committees are outlined below.

Work Stream 1: Prepare for establishing the NHI Fund (including intergovernmental functional and fiscal arrangements)

i. Noting the recommendations of the White Paper and noting the legal interpretations, propose the allocation of health service powers and functions between national and provincial levels and resultant amendments for funding flow;
ii. Review current legislation, assessing the legal implications and required amendments to various laws to enable roles at different levels, as well as enabling the establishment of single, national purchaser; (in particular National Health Act). Draft new legislation.
iii. Recommend the decision making roles and accountability of institutions, providers and the health district level; and under which level of government they will fall;

iv. Recommend the sequencing of changes linked to what is feasible in terms of capacity at the different levels and identifying required interventions to build requisite capacity;
v. Determine the appropriate intergovernmental consultation process under the guidance of the Fiscal and Financial Commission;
vi. Propose functions and funding for specific health services to be added to the NHIF on an incremental basis. Recommend options for incremental approaches
vii. Create interim structures and appoint an interim team
viii. Consider the governance and accountability options, based on good practice, available expertise and capacities, aiming for agility and minimized transaction costs;
ix. Consider structure (type of entity, placement and internal design / organogram) and staffing requirements for the NHI Fund

Work Stream 2: Design and Implementation of NHI Benefit Package

i. Develop an approach to benefits policy that draws on best practice;
ii. Utilize the extensive work that has already been done on packages of services in PHC and priority programmes (e.g. HIV/TB, RMNCH, NCDs, etc) for the design and implementation of the primary health care package (Ideal Clinic and Hospital Packages)
iii. Consider potential for establishment of health technology assessment capability;
iv. Undertake analysis to consider benefits (potentially consider costs, cost-effectiveness thresholds)
v. Register all facilities in the public and private sector in preparation for accreditation
vi. Engage with districts and providers to explore their role and clarify what they must do to prepare for contracts and possible capitation based NHI funding arrangements;

Work Stream 3: Prepare for the Purchaser-Provider Split

i. Propose the optimum service delivery configuration to be incentivized through the NHI Fund (mix of public and private providers; looking at current organization of providers and how they should change);
ii. Review contracts from other countries. Consider ways for institutionalizing results based purchasing/active purchasing, piloting and promotion. Pilot purchasing and contracting with public and private providers;
iii. Contract with independent multidisciplinary group practices;
iv. Propose national information requirements for purchasing, including enrolment/registration that empowers users and provider payment;
v. Introduce reimbursement reform: DRGs and capitation;
vi. Propose changes required to national PFM rules and practices that allow for the introduction of performance based funding of providers under the NHI Fund;
vii. Considering the incentives required for contracting private providers ;
viii. Explore common approaches to address high cost services.

Work-stream 4: Role of Medical Schemes under NHI

i. Create an interim single 'virtual' pooling arrangement;
ii. Establish a unifying information systems for registration and payment;
iii. Consider a standardized benefits package and mandatory participation for 'closed' schemes in the interim;
iv. Consider and propose options for the role of medical schemes;
v. Incremental approaches: How role of medical schemes might change over time
vi. Envisioning roles and changes to medical schemes over the short, medium and long term and review role of medical schemes for Ministers
vii. Consider a review of tax subsidies on 'supplementary' schemes.

Work-stream 5: Finalisation of the NHI Policy Papers

i. Complete alignment of NHI Policy papers with the aim of release by NDOH and Treasury for public comment

Work stream 6: Strengthening of District Health System

i. Determine the necessary capacities i.e. institutional and organisational, that are required for a fully functional and effective District Health Management Office;
ii. Recommend strategic interventions that should be implemented as part of strengthening District Health Management offices in the areas of service planning, decision making, and monitoring and evaluation among others;
iii. In consideration of the outputs of the benefits package work stream, develop/strengthen mechanisms for district health plans to identify service needs taking into account the demographic and epidemiological profile of the district catchment population;
iv. Propose criteria and mechanisms for contracting of service providers at the district level, based on the need in that district.
v. Develop approaches for co-ordinating the provision of health services at a PHC level through accredited clinics, CHC's, and private PHC providers operating within multi-disciplinary practices;
vi. Propose interventions for ensuring that the referral system is functional and that Emergency Medical Services and planned patient transport are able to transport patients between the different levels of care.

4. For the purpose of building a SEIAS body of knowledge please complete the following:

5.1 Was the SEIAS done by the department or by the service provider?

National Department of Health

5.2 If done by the department please provide the following:

Name of the Official: M A Thulare

Designation: Technical Specialist: National Health Insurance

Unit: Technical Policy and Planning in Office of Director-General

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5.3 How long did it take the department to complete this template?

The study was undertaken over a period of 18 months and it took five days to finalise the Report