PARLIAMENT
OF THE REPUBLIC OF SOUTH AFRICA

17 May 2021

National Health Insurance Bill [B11-2019]

A Summary of the Submissions on the National Health Insurance Bill [B11-2019] for the Public Participation Process

This is a brief summary of the submissions by stakeholders on the National Health Insurance Bill [B11-2019].

WEEK 1: 18-20 MAY 2021

Stakeholder	Bill: B11- 2019	Stakeholder comment and suggestion
DAY 1		
1. South African Nursing Council (SANC)	Preface	The South African Nursing Council welcomes the NHI, an initiative to improve access to quality health services in South Africa.
	Definitions	The South African Nursing Council (SANC) recommends that the following definitions be included in the bill: - Emergency Medical Treatment should be defined so that there is a common understanding - Emergency Medical Services should be re-defined as Emergency Health Services in order to include emergency health services provided by all health professionals, doctors, allied health practitioners, including nurses. - Healthcare Professional should be defined to mean any persons registered with the health statutory councils in South Africa - Primary Health Care Nurse should be as defined by SANC; a professional nurse capable of providing direct patient care for all types of illnesses and ailments, offering first level of nursing care and is competent to independently render appropriate and skilled primary care service.

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		- Primary care nursing professional is a category not recognized by SANC and must be removed.
	Chapter 2	*Asylum Seekers* - Emergency Medical Services should read Emergency medical treatment in terms of the National Health Act
	Chapter 6	*Constitution and Composition of the Board* - Clause 5: the composition should be clear to include expertise in health care services provision, and health care service financing. As the NHI fund is a health fund it should include persons with expertise in health services provision.
	Chapter 7	*Advisory Committees* - Clause 25.2: Membership of the benefit advisory board should include technical expertise in nursing and pharmacy as these professions are at the frontline of NHI programme implementation in the context of Primary Health Care Engineering, and are not represented by medicine.
	Repeal and amendment of the legislation affected by the Act	The Nursing Act, 2005 (Act No. 33 of 2005) should be listed in this section for amendment. - The promulgation of Regulations for private nurse practice is underway and professional nurse practitioners will offer services through contracting for management of health conditions within their competencies and scope of practice.
	Memorandum on the Objects of the National Health Bill- Strengthening of Primary Health Care Services	Clause 4.4.1. The PHC outreach team led by a nurse will be deployed in each municipal ward. - The term “supported by the nurse” should be deleted and replaced by “led by the nurse” as nurses are the primary health professionals in the first level of the health system and should be empowered to lead the PHC outreach team for quality and patient safety. -

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2. South African Pharmacy Council (SAPC)	Preamble	• The SAPC wishes to express its support towards achieving the envisaged realisation of the right of access to quality personal health care services, and the achievement of universal health coverage. • Furthermore, the SAPC wishes to extend to the Minister any assistance, expertise and skills that the SAPC may have, in ensuring that all pharmaceutical services, pharmacy health care services and pharmacy health care providers are of the highest possible standards as required in order to fulfil the purpose of the NHI Bill.
	Specific comments and recommendations on the certain sections of the NHI Bill:	SAPC's submission is centered around the following sections and chapters: *Section 1 – Definitions* • The SAPC move for the recommendation that the definition of health related products be removed from the Bill, and the correct term should be health goods or health products, with the preference for health products as this is the internationally accepted term as used and defined by the World Health Organization (WHO). In addition, health products should include medicines, vaccines, diagnostics and medical equipment; as such, definition would therefore be aligned to the vision of universal health coverage and the "bigger picture". *Section 5(7)* • Clarification of a potential typing error where Section 5(7) states that "Unaccredited health establishments must maintain a register of all users". Should Section 5(7) not start with the word "An accredited"? *Section 11*

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		• In terms of Section 11(i)(vi), the SAPC recommends the inclusion of the following: "fraud prevention, waste and abuse within the Fund and within the national health system" *Chapter 7 – Advisory Committee established by the Minister* • Section 27 provides for a Stakeholder Advisory Committee, which includes representatives from the statutory health professions councils. The SAPC looks forward to contributing to such Advisory Committee. The SAPC would like to seek clarity as to the funding of such committee, and states for the record that should such committee be established for purposes of assisting the Fund, then the Fund should fund such committee in order to deliver on its mandate. • The SAPC welcomes and supports the inclusion of persons on such committees, as detailed in Chapter 7, based on expertise in medicine. The SAPC trusts that such expertise does in fact include experts in pharmacy. In this regard, the SAPC assumes that "medicine" as it is included herein pertains to the definition of medicine as provided in the Bill. *Chapter 8 - general provisions applicable to the operation of the fund – Section 38* • Section 38, under the title "Office of Health Products Procurement" opens with the statement that the Board must establish an Office of Health Products Procurement which sets the parameters for the public procurement of health related products, and in Section 38(2) it goes on to qualify, stating the procurement of health related products, including but not limited to medicines, medical devices and equipment. • The SAPC states that the statement above is contradiction to the definition of health related products, which expressly excludes "orthodox medicine".

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		• The definition of health goods expressly includes medical equipment, medical devices and supplies. The use of terminology is further confusing as a different undefined term of health products is then used within Section 38. • **Section 38(3)(a)** relates to the selection of health related products, **Section 38(3)(b)** requires the development of a national health products (undefined, and one has to question whether it means *health goods*), and **Section 38(3)(c)** mentions the supply chain management of health related products mentioned in (b), despite the fact that **Section 38(3)(b)** uses the term health products. *Chapter 8 - general provisions applicable to the operation of the fund – Section 39* • Section 39, under the title "Accreditation of services providers", and in particular Section 39(2)(b) states that service providers must comply with the prescribed specific performance criteria, which includes *inter alia* the minimum required range of personal health care services and allocation of the appropriate number and mix of health care professionals. • Although no mention is specifically made of primary health care, but rather a broad mention of a minimum required range of personal health care service, the SAPC wishes to express concern that the absence of pharmacy under the definition of primary health care could limit, if not exclude pharmaceutical services being provided by pharmacies. • This is further highlighted by Section 37 under the title "Contracting Unit for Primary Health Care", which by definition would exclude pharmacy from the contracting for primary health care services. • Another example of potential exclusion for pharmacy is contained in Section 41, under the title "Payment of health care service providers", and in particular Section 41(3)(a), following on from Section 37, where it states that only

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		accredited primary health care service providers must be contracted and remunerated by a Contracting Unit for Primary Health Care. • The SAPC wishes to recommend caution the Minister in terms of duplicating functions by the proposed National Health Insurance Fund, the Health Management Offices and the Contracting Unit for Primary Health Care, in the accreditation of service providers and the potential investigation of complaints. *Chapter 9 – complaints and appeals* • Under Chapter 9 of the NHI Bill, the SAPC mainly comment on the provisions of section 44(1)(a); section 46; and section 47(3). • Section 44(1)(a) which reads, "One member appointed on account of his or her knowledge of the law, who must also be the chairperson of the [Board]" **should have the word "Board" replaced with "Appeal Tribunal".** • On Section 46 of the Bill, the SAPC recommends that the NHI Bill should have the word "**Board" replaced with "Fund" and the second mention of the word "Board" replaced with "Appeal Tribunal**" • Section 47(3) provides that the Appeal Tribunal must determine the outcome of the appeal within 180 days. SAPC is of the opinion that 180 days is **somewhat excessive**, and proposes that an appeal should be concluded **within 90 days**. • In supporting the proposal of 90 days for the appeal to be concluded, SAPC states that given the nature of the business of the Fund, in terms of the fact that the appeal may be by a user who requires health services under the Bill in an emergency. Furthermore, the delay in paying a health care provider or refusing accreditation to a health care provider that may delay the provision of health care services.

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	General comments	• The SAPC notes that throughout the Bill time frames are referred to as timeous or within a reasonable time. The SAPC recommends that for efficiency and accountability specific time frames should be provided where possible. • The SAPC notes that because of the provisions of the Bill may require the amendment of other legislation. The SAPC notes such amendments and shall keep a noting brief on such amendments in order to determine whether such amendments impact on the functioning of the SAPC and its legislation. • In addition to the specific comments relating to the various sections of the NHI Bill, the SAPC wishes to inform the Minister of pending legislation relating to the Specialist Pharmacist: Public Health Management. The SAPC wishes to highlight the substantial role such a qualified and registered specialist pharmacist could add to the functions of the District Health Management Office (Section 36), the Contracting Unit for Primary Health Care (Section 37) and the Office of Health Products Procurement (Section 38).
	Conclusion	The SAPC is in support of the NHI initiative by the Minister of Health, and wishes to: • Express its continued support of universal health coverage; • Continue to play an integral role in advising the Minister and other persons on NHI matters as they relate to pharmacy; and • Support the inclusion of pharmacy in the national health system.
3. Health Professions Council of South Africa (HPCSA)	General comments	- The Health Professions Council of South Africa (the Council) emphasizes that the NHI should be the only funding mechanism for health in the Republic. - An essential prerequisite of establishing the Fund should be a clear pronouncement that it replaces all other funding mechanisms for health. - It must be clear that NHI takes over from CMS and that all assets that sit under CMS must be transferred to NHI. - The Council is of the view that NHI should be about funding and contracting matters. - The following matters should be left under the jurisdiction of the relevant statutory

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		bodies: i. Accreditation of professionals and their practices; ii. Accreditation of facilities accredited under the Office of Health Standards Compliance; iii. Standards setting for professions; iv. Registration of professionals; v. Conduct of professionals; and vi. Development of treatment protocols.
	Rights of Users (Clause 6(o))	This clause creates duplicative coverage by medical schemes and undermines the single-payer model of NHI. ***SUGGESTION: To pay through out-of-pocket means, health care services that are not covered by the Fund.***
	Cost of Coverage (Clause 8)	This clause creates duplicative coverage by medical schemes and undermines the single-payer model of NHI. ***SUGGESTION: A person or user must pay for health care services of that person or user.***
	Cost of Coverage (Clause 8(b))	This clause will encourage non-adherence to the referral pathway and will create a parallel system by undermining referral pathways. ***SUGGESTION: Clause (2)(b) should be deleted.***
	Powers of the Fund (Clause 11(h))	The Fund must not be seen to be the player and the referee. ***SUGGESTION: Complaints against the Fund, healthcare providers, health establishment and suppliers should be investigated, in collaboration with law enforcement agencies, statutory councils and regulatory authorities.***
	Constitution and Composition of the Board (Clause 13(6))	There needs to be active participation of strategic members of EXCO in Board. ***SUGGESTION: The CEO, CFO and Chief Actuarial Officer are ex-officio members***

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		of the Board but may not vote at the Board meetings.
	Role of Medical Schemes (Clause 33)	The Council is of the view that the NHI may never be fully implemented. ***SUGGESTION: The future of medical schemes will be to offer complementary cover for services not covered by the NHI, as determined by the Benefits Advisory Committee. The Minister will determine through regulations in a gazette when this phase will ensue.***
	National Health Information System (Clause 34(3))	This clause must be strengthened to ensure that in addition to provisions of the NHA, it must also comply with requirements of this Act. ***SUGGESTION: Healthcare workers, healthcare providers and persons in charge of health establishments must comply with provisions of the NHA and provisions of Section 40 of this Act relating to access to health records and the protection of health records.***
	Accreditation of Service Providers (Clause 39(5))	Section 5(a) should remain. ***SUGGESTION: Section 5(b) – (h) must be moved to Section 40(2).***
	Information Platform of the Fund (Clause 40(2))	***SUGGESTION: Section 5(b) – (h) should be added.***
	Appeal Tribunal (Sectional 44(a))	This may be misinterpreted as Chairperson of Board of the NHI Fund. ***SUGGESTION: Remove the word Board at the end of the sentence.***
4. Board of Health Care Funders (BHF)	Summary of submission	**1. BHF Supports UHC:** BHF supports the concept of universal health coverage (UHC) as defined by the World Health Organization (WHO), i.e. 'Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship'.

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		2. NHI is the vehicle to deliver UHC: It is necessary to emphasise, however, that national health insurance (NHI) is not UHC. NHI is just one of the mechanisms for achieving the objectives of UHC. Even if UHC is an ideal that can never be fully attained, pursuing it gives direction to a health system for improving access to health care services for those who need them; so it is a valuable concept. **3. 'Friends of NHI':** BHF also supports the concept of NHI and has done so since 2008. However, in order for it to work effectively there are certain criteria that must be satisfied. BHF contributed to the first Ministerial Advisory Committee on NHI and had constructive comments and engagements on NHI. When the bill was launched, BHF came out as a 'Friend of NHI'. **4. Constitutional rights:** First and foremost, the NHI Bill must be constitutional, not only in its provisions, but also in its approach to health care financing. The financing system that the bill creates must recognise and respect the constitutional rights of individuals to have access to health care services. It must reflect the government's commitment to protect, respect, promote and fulfil this right, along with the other rights in the Bill of Rights. **5. Constitutional issues in the Bill:** BHF has identified several constitutional issues in the Bill that might impede the implementation of NHI. These are: (1) legal certainty and the rule of law – this relates to the language used in the bill (2) restrictions on the right of health professionals to choose and practice their profession (3) restrictions on the right of access to health care services in the bill, including the role of medical schemes to offer parallel benefits cover (4) the role of provinces and municipalities, the second and third spheres of

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		government in our constitutional system, in health service delivery **6. The NHI Bill needs to be strengthened on several fronts. These are**; (1) the language used in the legislation (2) the constitutional issues raised by the Bill (3) corporate governance of the NHI fund (4) flow of funding from the fund to providers (5) The role of provincial and local government in the delivery of health care services (6) Maintenance of the purchaser/provider split throughout the national health system **7. Accountability – NHI Fund:** BHF is of the view that the NHI Fund must be accountable at three different levels in order to ensure its sustainability and viability. Firstly, the Fund must be accountable to Parliament at a macro level, secondly the Fund must be accountable to the Minister of Health in accordance with the Public Finance Management Act and thirdly the Fund must be accountable to the Prudential Authority for financial institutions created by the Financial Institutions Regulation Act that sits within the Reserve Bank. The Prudential Authority should serve as an overseer of the Fund in order to ensure that its financial risks and affairs are conducted properly and in accordance with independently determined standards. The Public Finance Management Act, although it applies to the Fund, only regulates certain aspects of the Fund. There is a gap which we submit must be filled by the Prudential Authority which has the skills and expertise to provide oversight of the fund's financials. **8. Language used in the Bill:** The bill uses policy language that makes legal interpretation difficult. The language is imprecise and open to different interpretations. There are several unnecessary repetitions. The transitional arrangements section belongs in policy documentation, not law. Similarly, there are specifics in the bill such as reimbursement models the fund will use to purchase health services that belong in regulations. There are sections of the bill

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		that belong in the National Health Act (NHA) and not the Bill. The latter should be purely about the financing side of the purchaser/provider split. It should not contain provisions that relate to the organisation, structure and methods of health service delivery. **9. User vs Beneficiary** BHF prefers the term 'beneficiary' to the term 'user' in the Bill. A 'beneficiary' is someone entitled to benefit from the fund. The NHA has already defined the term 'user' as someone who utilises health care services. We suggest that for the sake of clarity and in order to avoid confusion, the term 'beneficiary' be used in the NHI Bill rather than 'user'. All beneficiaries will be 'users' as defined in the NHA, but not all 'users' will be beneficiaries of the Fund. **10. DHMOs and CUPHCs:** The Bill does not adequately explain the reason for district health management organisations (DHMOs) or contracting units for primary care (CUPHCs). It also does not set out their role, how they will be governed and to whom they will be accountable. BHF is of the view that DHMOs and CUPHCs are unnecessary and will add an unjustifiable layer of administrative costs to the system. **11. Strengthening the role of the Provincial departments of Health and Municipalities:** BHF is of the view that existing structures such as provincial departments of health and municipalities should rather be strengthened in their role as providers of health care services. The creation of new entities to play the role of provincial departments of health and municipalities is not only undesirable but constitutionality questionable. The second and third spheres of government are mandated by the Constitution to provide basic services, which must be financed by their equitable share of local revenue. The Bill ignores this.

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		12. The role of the Minister of Health: BHF does not support the extensive role of the Minister of Health as set out in the Bill. The board of the fund must be autonomous and independent of political influence in its decisions. The board must have complete authority over and responsibility for the fund. The board must run the fund – not the Minister. The Bill gives the Minister the power to potentially veto every significant decision that the board can make. This means that the board cannot be held accountable for its decisions. This is contrary to well-established principles of corporate governance. The board must not be able to escape accountability as a result of a decision by the Minister. The Board must be accountable for all of its decisions. **13. Powers of the Board:** The board must be free to hire or terminate the services of the CEO of the fund without the approval of the Minister. The board must be able to determine benefits to be covered by the fund without the prior approval of the Minister. The board should be appointed by Parliament and not the Minister because this guarantees a more open and democratic process. The board must play an active hands-on role in the running of the fund, so it needs to be a powerful executive Board that operates full time. It is accountable to the Minister in terms of the Public Finance Management Act (PFMA) but this does not mean it should have to obtain the Minister's input on every decision it makes. Indeed, it can only be accountable to the Minister under the PFMA if it can make decisions independently of the Minister regarding the fund. **14. The Benefits Advisory Committee:** The Benefits Advisory Committee must not have the power to determine benefits. This power resides ultimately with the board. The Benefits Advisory Committee must advise the board on benefits to be offered by the fund. No committee contemplated in the Bill must have the power to make financial or strategic decisions concerning the fund. This is the responsibility of the board alone. Advisory committees must be just that – advisory.

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		Specific comments on the Bill Clauses is attached BHF Clause by Clause.pdf
DAY 2		
5. Public Health Medicine Specialists and Registrars	Preamble	• **Public Health Medicine Specialists (hereafter referred to as PHM Specialists) are medical doctors specialised in improving the health of populations**. They are a cadre of doctors who after completing their medical undergraduate training, internship and community service, have undergone a further four years of structured theoretical and practical postgraduate training in a range of fields, that include: • Health systems management, organisation, strategy and design • Health informatics, data management and analysis, biostatistics and epidemiology • Health economics and financing • Health research methodology • Medical and industrial sociology • The quadruple burden of disease • Occupational health • Environmental health
	Chapter 7	**Advised structures and roles to build Public Health capacity and strengthen the implementation of NHI:** • **Provincial PHM Intelligence Units,** linked by Service Level Agreements to tertiary academic Schools of Public Health, must be established in each province, which are able to provide outreach and support to health districts requiring analysis of local burden of disease, health information management, monitoring and evaluation of healthcare service delivery, co-ordination of healthcare quality improvement and

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		healthcare outcome measurement. At this level, PHM Specialists are also able to provide technical advice and support to National, Provincial and Health Programmes Managers and Directors. • **Central and Regional Hospital** PHM Specialists should be appointed to monitor and evaluate service delivery and bridge the translational gap between the clinical and corporate functions of the hospital, strengthening decentralised governance structures. Currently, with the hospital-centric nature of healthcare services, in South Africa, many regional, tertiary and central hospitals have micro-complexities (along specialist services). There is therefore a need for PHM specialists and registrars to facilitate common objectives between corporate (i.e. business of health care) and health care service delivery through their day-to-day tasks within such institutions. They are equally capable of demonstrating dual reporting functions to clinical HOD's of general and specialized departments, and to clinical executives. This competence aligns the coordinated efforts of service and support staff to achieve unit-specific and departmental objectives within an iterative implementation, monitoring and evaluation framework. • **District PHM Specialists** should be appointed to the District Clinical Specialist Team, where they will play a critical support role; by bi-directional, continuous translation of pharmacy, finance, and supply chain procurement information to the clinical work of the DCST, and provision of mapped burden of disease, health services and healthcare outcome data to the District Health Management Office and it's Contracting Units for Primary Health Care, by providing evidence based Public Health intelligence to inform healthcare purchasing and priority decision-making.
	Clause 13(5)	PHM Specialists have expertise in health care service financing, health economics, public health planning, monitoring and evaluation and would be suited as either candidates for appointment to the board or as ad hoc advisory members tasked with appointing suitable board members. SUGGESTION: Efforts should be made to include PHM Specialists in the NHI processes.

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	Clause 25 (2)	PHM Specialists have technical expertise in all the fields highlighted in Clause 25(2). Furthermore, they have trained within the healthcare service and are familiar with service delivery requirements at all levels of the health system. They are thus able to merge technical expertise with real world scenarios in the development of health care service benefits for the population. SUGGESTED EDIT: "**[…] consist of persons with technical expertise or specialisation in public health medicine, medicine, health economics, epidemiology, and the rights of patients […]"**
	Clause 26(2)	PHM Specialists have expertise in epidemiology, health management, health economics, health financing, and rights of patients and are thus able to contribute technical expertise to this committee. SUGGESTION: Efforts be made to include PHM Specialists in the processes highlighted above SUGGESTED EDIT: "**[…] expertise in actuarial science, medicines, epidemiology, health management, health economics, health financing, labour and rights of patients, and public health medicine, and one member must represent the Minister."**
	Clause 27	PHM Specialists are well placed to provide a coordinating role between the various stakeholders highlighted in this section. SUGGESTED EDIT: **"[…] associations of health professionals, providers, patient advocacy groups and public health medicine in such a manner […]"**
	Clause 36	Given the cross-cutting competencies held by PHM Specialists (as highlighted above), PHM Specialists would be a valuable addition to the DHMO. SUGGESTION: District Health Management Offices should be headed up by, or include a PHM Specialist which can support the DHMO and the DCST.
	Clause 37	Epidemiological profile analysis of health districts is a core function of PHM Specialists. A District PHM Specialist should be mandated to perform this function in each health district, and thereafter assess referral system functionality, and inform the design of

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		health service benefits for the district. Suggested inclusion 37(2) "**The Contracting Unit is comprised of a district hospital, clinics and, or community health centres and ward-based outreach teams, private primary service providers organized in horizontal networks within a specified geographical sub - district area and with the support of the District Public Health Medicine Specialist, must assist the Fund to-…"**
	Clause 39	Accreditation of service providers requires knowledge and skills related to a wide range of subjects, including quality of care, risk management, health information systems, health system processes (e.g. referral and gatekeeping mechanisms), and monitoring and evaluation, all of which are within the scope of practice of a PHM specialist. SUGGESTION: Efforts should be made to include PHM Specialists in the NHI processes.
	Clause 57(2)	The next phases of NHI implementation will require health system strengthening as well as the establishment of core processes and institutions. PHM specialists, by nature of their work, are able to play a role in multiple settings simultaneously to achieve these goals. There are currently 81 registered specialists in South Africa with registrars completing training on an ongoing basis and these resources could be harnessed for the health system strengthening aspects of the next phases. SUGGESTION: Efforts should be made to include PHM Specialists in the processes highlighted above as well as to allow for PHM registrars to undertake work within the NHI in order to contribute to the process whilst gaining experiential knowledge that would be beneficial to the NHI once they have completed their specialisation.
	Clause 57(3)	PHM Specialists have extensive experiential knowledge within the South African health system and can provide value in the interim committees prioritised in Phase 1. SUGGESTION: Efforts should be made to include PHM Specialists in the processes.
6. Public Health	Preamble	• The aim of the Act is to establish the NHI Fund in order to fund the provisions of UHC,

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Association of South Africa (PHASA)		though the Bill also introduces organisational and structural changes to support functioning of a single purchaser and single payer funding system. Given the uncertainty regarding feasibility of certain proposed structural changes, which we think should thus be given more consideration before being legislated in the Bill, we believe that the Act establishing the Fund should be written in a way that does not hinder future legislative processes, especially for issues that are not inherently related to financing. • Thus, we suggest that **sections of the current Bill that touch on arrangements not directly related to the establishment and maintenance of the Fund should either be removed, or that the level of detail around these other arrangements be reduced; to allow more time to consider the most effective proposals and to allow for learning from experience to decide on best potential future models.** • The NHI Bill as currently formulated is essentially a standalone, independent piece of legislation, largely unrelated to much else in the National Health System. The Bill would be much improved if the financing mechanism underpinning the provision of the NHI were better located and explicitly linked to the National Health System, specifically in reference to the National Health Act, which is only mentioned briefly in the annexures together with other legislation that requires amendment. The National Health Act [61 of 2003] and the White Paper for Transforming Health in South Africa 1997, were foundational documents in formulating the rationale for the NHI Bill and they should work together to give effect to UHC, which the NHI Bill cannot do on its own. • There has been **an inadequate recognition** of the role of **population/community/public health medicine in the Bill**. This could be disastrous and costly to the health system. **Public health professionals, including the discipline of Public Health Medicine (PHM), are a vital resource to assist in the delivery of UHC and** need to be recognised as such. While these skills sets are acknowledged in the last Human Resources for Health policy in South Africa, which specified that the role of PHM Specialists and other Public Health graduates in management and strategy should be more explicit, and that the Department should

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		work with universities and the College of Medicine of South Africa to develop related competency and jobs frameworks. However, this has not yet translated into career paths for Public Health professionals and PHM specialists. The latter is a field that was created specifically to meet the population health demands of the health system, with graduates having a prior medical training and being certified as competent with regard to preventative medicine, health management, strategic planning, monitoring and evaluation, health financing, policymaking, research, and leadership skills. This experience and expertise, in one cadre of human resource, has immense potential to impact the health system and population health if situated appropriately within the health system, which should be a significant consideration during planning for the NHI fund and UHC. • **Occupational health is another arena which provides an example of where non personal services are import.** Occupational health deals with all aspects of health and safety in the workplace and has a strong focus on primary prevention of hazards. The health of the workers has several determinants, including risk factors at the workplace leading to cancers, accidents, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress related disorders and communicable diseases and others. Employment and working conditions in the formal or informal economy embrace other important determinants, including, working hours, salary, workplace policies concerning maternity leave, health promotion and protection provisions, etc. • The Bill should provide finance for the scaling up efforts to provide healthier and safer workplaces and access to occupational health services, and to ensure health coverage for all workers, noting that large numbers of people who develop illnesses and die every year from preventable occupational diseases and injuries.
	Chapter 1	• It is recognised that the NHI Bill is aligned with provisions set out in the Constitution, the National Health Act, the Refugees Act, and the Immigration Act, as relates to refugees' rights to access health care services in South Africa. However, there remains much concern and debate around the lack of full population coverage and the restricted access to healthcare services for asylum seekers and illegal foreigners.

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		There are human rights considerations as well as the potential impact of communicable diseases that are not notifiable, including HIV, on overall population health. The increase in number of foreigners who are living illegally in South Africa emerged over many years and was due to the interaction of many complex factors. The number of **illegal foreigners in the country has been estimated to be as high as approximately 10% to 15% of the current population**. Notwithstanding the Department of Home Affair's efforts to fix and strengthen the immigration system; we believe that, given the current context, **it would be important at a population health level, for asylum seekers and illegal foreigners currently in the country, to be afforded the same rights as refugees, to access health care services**. • Section 5 on registration of users will restrict access to health care for those who might not have been able to register e.g. due to a lack of documentation identified in section 5(5), which could result in hindering access to health care for the most marginalized sectors of the population, and further entrench health inequity in the country. Access to health care services might similarly be prevented in emergency situations. **Thus, we recommend that explicit provisions be made in the NHI Bill, for how users without documentation** will be registered in the system and retain their right to access health care services despite not having documentation. • Section 6 (o) outlines the right of users to purchase health care services not covered by the Fund, through alternate funding mechanisms. This has implications for the package of health care services that will, or should be, offered by accredited health care providers, and for health care service providers whose scope might fall outside the NHI funded benefits package. Additionally, there might be the case where unaccredited providers may decide to offer services not provided for in the Formulary, which could in turn impact performance of the accreditation system, the organisation of health services in a region, and the quality of care provided. • Ultimately, the lack of clarity surrounding organisation of the service delivery platform and the benefits package needs to be addressed, albeit be via alternate prescripts and legislation, before many decisions related to the rights of users can be appropriately determined.

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	Chapter 2	• The Bill stablishes the Fund as a Schedule 3A autonomous public entity, yet the powers of the Minister are heavily concentrated throughout the structure of the Fund, likely undermining its autonomy. The Bill provides for significant centralisation of decision-making power with the Minister, including for very technical issues raising the question of accountability and transparency. The Fund should be ultimately accountable to parliament, and the powers of the Minister should be reduced to minimise the risk of political co-option. International evidence has shown the importance of having long-term vision that is not undermined by the five-year political life cycle of a Minister2, and requires leadership that is vulnerable to political motivation.
	Chapter 3	• Sections 13 (1), (3), (8), and (9), grant extreme power and authority for appointment and removal of Board members, to the Minister of Health. There are no mechanisms in place to ensure that a Minister is not vulnerable to potential political influences that might lead to politically motivated appointments, rather than purely technical experts, who would be in a better position to provide unbiased and independent oversight. • International evidence has clearly demonstrated the importance of the clear separation of political and administrative powers across every level of the public health system. • The Minister's oversight powers should be reduced or counter-balanced by another authority, such as Parliament. Mechanisms should be specified beyond the public interview process, defined in Section 13 (3), in order to ensure that appointments are not politically motivated, and there should be an open process of appointment, such as that used for appointing the SARS commissioner.
	Chapter 4	• Section 19 (1) indicates that a transparent and competitive process will be undertaken to appoint the CEO. However, Section 19 (2) indicates that the Board, which was appointed by the Minister, will conduct interviews and that the Minister will approve the recommendation of the Board. • This presents a potential conflict of interest, with the Ministers having excessive influence, and could undermine the autonomy of the CEO. We suggest that this appointment be confirmed at a higher level, either by Parliament or by the Presidency.
	Chapter 5	• The three advisory committees to be established i.e. the 1) Benefits Advisory

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		Committee, 2) Health Care Benefits Pricing Committee and 3) Stakeholder Advisory Committee, all have vital and inherent implications for the implementation of the Fund and the provision of UHC in the country, and there is a need for transparency around the creation and constitution of them. All these committees are also currently defined as “advisory”, which suggests that they have no actual power to take decisions. That power again lies with the Minister who, according to the Bill, must have a representative on each of the committees. • The Stakeholder Advisory Committee needs to have a strong, impactful voice; else it will simply become a token structure. Additionally, there needs to be clear definitions of powers, roles and capacities of all committees; in relation to the Board and the Minister.
	Chapter 7	• Section 19 (1) indicates that a transparent and competitive process will be undertaken to appoint the CEO. However, Section 19 (2) indicates that the Board, which was appointed by the Minister, will conduct interviews and that the Minister will approve the recommendation of the Board. • This presents a potential conflict of interest, with the Ministers having excessive influence, and could undermine the autonomy of the CEO. We suggest that this appointment be confirmed at a higher level, either by Parliament or by the Presidency. The three advisory committees to be established i.e. the 1) Benefits Advisory Committee, 2) Health Care Benefits Pricing Committee and 3) Stakeholder Advisory Committee, all have vital and inherent implications for the implementation of the Fund and the provision of UHC in the country, and there is a need for transparency around the creation and constitution of them. All these committees are also currently defined as “advisory”, which suggests that they have no actual power to take decisions. That power again lies with the Minister who, according to the Bill, must have a representative on each of the committees. • The Stakeholder Advisory Committee needs to have a strong, impactful voice; else it will simply become a token structure. Additionally, there needs to be clear definitions of powers, roles and capacities of all committees; in relation to the Board and the Minister. Section 31 (1) outlines the role of the Minister as being responsible for

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		governance and stewardship of the national health system, as well as governance and stewardship of the Fund. We believe that the latter presents the similar conflict of interest raised previously, in relation to the excessive power and responsibilities placed on the Minister. • We suggest that the duty of governance and stewardship of the Fund, be assigned to the CEO of the Fund. Section 33 states that once the NHI has been fully implemented, medical schemes may only offer complementary cover for services that are not reimbursable by the Fund. We believe that ultimately, when the health system is in a position to deliver UHC, there will be a diminished role for medical schemes and this clause may become more appropriate. However, during the transition period from the current, through to the transitional system, and finally to the point of optimal coverage of health care services under an NHI-funded system; patients might encounter aspects of suboptimal quality care, e.g. unduly long waiting times, which might impact health outcomes and there might be related litigation risks. Consequently, it would be safer to allow patients and their medical schemes the option of paying for health care that might be needed. • Thus, we suggest that there not be a restriction on the services that medical schemes are allowed to fund. Related to the above point, attention needs to be paid to the quality of care of services from providers that have not been accredited by the OHSC or by the NHI fund. • Some considerations would include the need for certification and/or monitoring of all establishments and practitioners, to be able to provide healthcare services irrespective of whether they contract with the NHI fund or not, and related support for the achievement of this end, as well as incentives for contracting with the NHI fund. Section 37 of the Bill makes provision for the establishment of contracting units for primary health care (CUPS), comprised of a district hospital, clinics or community health centres, ward-based outreach teams, and private providers. Inter alia, the role of these units includes identifying accredited public and private health care service providers, and managing contracts entered into with accredited health care service providers. These new structures seem to be the equivalent of the current sub district

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		units, with prescribed levels of care and enhanced health financing competencies. While the CUPs sounds theoretically comprehensive, it is concerning that a new operational model is being introduced into the health system nationally, as part of the Act, without prior proof of concept or contextual feasibility. Of most concern is the varied availability of all prescribed levels of care within different sub-districts in the country, with decreased availability in rural areas. The private health care sector also currently functions without consideration to interdependence, and it is vital that the mechanisms and manners in which private providers will form part of the service delivery platform, within and NHI-funded healthcare system, be articulated before integration can be planned. • Additionally, we caution against the assumption that contracting mechanisms, however effective, are an appropriate substitute for strong leadership and governance. A key issue in the current system is the prevailing 'compliance culture' that prevents the public health system from being responsive to contextual challenges and local communities, and from creatively responding to routine challenges. Replacing compliance-driven regulatory mechanisms with contractual mechanisms is unlikely to resolve, and may exacerbate, this issue, further constricting the capacity of the system to be responsive to shifting population needs. • We suggest that the introduction of CUPS into the District Health System be reconsidered at this point in time. If, however, this revised organisation of the system is felt or found to be the best model to adopt, we suggest that the structures, capabilities, and capacities of the existing District Health System be considered in relation to the envisaged model. We further suggest that required changes then be planned for with appropriate consideration given to structural investment, capacity development, incremental and realistic timelines for introduction of sequential changes, inclusion of provisions for a responsive, learning health system, and ultimate consideration to the potential of the proposed system to provide for optimal coverage and equity in healthcare provision. We also suggest that provisions be put in place to ensure that relevant contracting units are responsible not only for contracting health care providers, but also have the mandate and resources necessary to engage actors

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		outside the formal health system including community groups, civil society organisations and NGOS, and other government sectors whose actions affect population health. In addition, for effective functioning, the funding of health promotion and prevention should match the support for service provision. This should include working with communities to ensure active community participation and collaborating across sectors to address the social determinants of health. The proposed role of the Provincial departments of Health is not apparent in the Bill. The current National Health Act places the responsibilities for implementation of national health policy, norms and standards at the provincial level, though the NHI Bill might suggest that these functions will be moved to the District and Sub-district level. Section 20 including (2(ii)) of the NHI Bill indicates that liaising with the District Health Management Office is a responsibility of the CEO of the NHI Fund. If this is the case, significant structural and functional changes to the current health system are being proposed, which disregards the already established Provincial Health Management systems that are in place. • We suggest that the structures, capabilities, and capacities of the existing Provincial Health System be considered and that any proposed changes be planned for with appropriate consideration given to structural investment and capacity development required at lower levels, incremental and realistic timelines for introduction of sequential changes, and inclusion of provisions for a responsive, learning health system. Overall, the lack of clarity surrounding the envisaged service delivery platform needs to be addressed, albeit be via alternate though simultaneous planning and legislative processes, ahead of being able to decide how these services will be funded. Currently, attention is given to the organisation of services within the public health system. Though, for optimal purchasing within the NHI funded system, the entire health system needs to be considered, including public health care facilities, patient transport systems, referral pathways, private health care facilities, and Non-Governmental Organisations (NGOs). The latter two are especially relevant, given the marked potential for incorporation and coordination with these sectors to address many shortages and gaps within the current Public Health system, and for the

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		inclusive service delivery platform to be able to support the goal of UHC and health equity. The current status of the South African healthcare system does not offer the quality and equality of healthcare service provision, as envisioned in an NHI-funded health care system. It is concerning that approximately one percent of the 696 public health establishments assessed by the Office of Health Standards Compliance (OHSC) were judged to meet the standards for accreditation in the latest report issued4. There is consequent concern that the accreditation process will render the majority of public sector facilities ineligible to be contracted by the NHI fund, therefore resulting in a heavily private sector dependent delivery model. Accreditation by the OHSC introduces the risk of creating an open market for the private sector, as there is a very real concern that if relatively few public facilities achieve accreditation, the NHI would result in de facto privatisation of the public health system. • The implications of this need to be considered and related regulatory mechanisms should be developed to avoid cost escalation in circumstances where private providers are competing against other private providers for contracts. Relatedly, the Bill provide should clarity on what would happen to public facilities that do not achieve accreditation and measures to strengthen the public sector capacity to meet accreditation standards.
	Chapter 8	• This Chapter outlines the revenue sources for the Fund, auditing by the Auditor General and processes for submitting annual reports to Parliament. There are concerns related to the sustainability of sources of funding and the critical need to maximise efficiency of the system through proper governance and risk management at all levels, and in both public and private sectors. Strict controls for prevention of corruption and elimination of wasteful expenditure need to be considered throughout the system. Given the current context, there is also an urgent requirement to safeguard the funding pool against litigation. South Africa's health litigation bill is spiralling out of control5. South Africa's nine provincial health departments faced a R24 billion patient litigation bill6 between 2010 - 2014, of which only R500 million has been paid. Medical litigation history in South Africa illustrated that there was little defence if a healthcare worker did not follow protocols. In many instances records are

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		only retained for five years and cases coming to court after this period are indefensible, because the records have been destroyed. To compound this, there is very little incentive for the professionals concerned, for in general terms, the liabilities rest with the State rather than the professionals concerned. It has be anticipated there is a very serious threat to depletion of funds available within the NHI fund, in a manner that cannot be budgeted for or anticipated. The reality is that the NHI fund, in pooling all available funds, is potentially also lining the country up for exponentially escalating legal claims. The litigation industry has shown itself to be very adept at exploiting this weakness, as been demonstrated with the road accident fund, and the system that allows prosecuting lawyers to take a significant cut of any pay out – doubling their hourly rate to take up to a maximum of 25% of the pay out, when they win their case. • Thus, the NHI Bill must include a "no fault" compensation provision in the Bill, which will ensure for the fair recompense to those injured during the care process, and thereby limit the liability of the fund to legal claims in a similar way as Road Accident Fund Amendment Act 19 of 2005 provided for the no-fault payment of compensation for loss or damage wrongfully caused by the driving of motor vehicles. This is far better than leaving the process up to the results of litigation based on the principle of "tort", roughly the notion of the finding of individual fault in a court of law. Several "no fault" compensation systems with different characteristics operate internationally in Denmark, Sweden, Finland, and New Zealand, which seem to offer far more progressive ways of dealing with the compensation of individuals who have been injured (whether negligently or not) without the need to involve expensive litigation. An optimal compensation system should compensate injuries when they occur, but also reduce errors and harm. The tort system used in most countries is increasingly anachronistic and an obstacle to progress on patient safety. A "no fault" system of compensation such as that used in New Zealand may result in better quality of care.
	Chapter 10	• The Bill is silent on the implementation of the Fund. The NHI Implementation Unit has been established, and mechanisms for feedback and learning should be legislated. Importantly, this can't all happen at national level and must allow for bottom-up learning that supports further implementation. The phasing in of NHI does not consider

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		how to develop system capability through implementation, monitoring, and responsiveness over time. It takes a top down approach, which does not allow for potential gaps to be detected and proactively addressed. • It would be optimal to clarify some of these basic principles for implementation in the Bill e.g. goals to work towards, support for experimentation, the need for monitoring and learning, and resources for capability development, ahead of implementation steps. • Additionally, there should be dedicated funding to support learning for implementation/capability development, that would involve commissioning and tendering outside the usual government procurement processes and that would require shared priority setting between government and research actors. A bottom up process should be proposed, where the phasing in of changes actually support and enable system capability. For example, phase 1 could include plans for how to implement the next steps and develop system capability, and how to support this, including setting up evaluation/learning processes. Phase 2 could include waves of implementation at district level, based on district performance against specified outcomes/goals and linked to greater delegation of authority -only when performance is adequate against outcomes/goals would further delegation be made. A specific body (or several at sub-national level) and process could be identified to support districts to develop capacity to manage delegations, which should also be linked to learning/evaluation work.
	Chapter 11	• Avoiding over-medicalisation: balancing personal & non-personal care services • The approach to health care in the NHI is based almost exclusively on the provision of personal health services. It is focussed on provision of services in clinics, GP practices and hospitals. While clinical service provision is undoubtedly an important aspect of health improvement, as will be argued in the following sections, **non-personal services, which cannot be costed in the same way as the personal health services, are crucial to improve health outcomes.** The risk of this approach is the spiralling costs of clinical health care provision and missing out on the considerable cost savings of taking a more preventative approach. • The **Bill is essentially silent on the financing of health promotion**. The language in

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		the Bill is currently quiet about the need for effective health information provision. It is widely acknowledged that taking measures to promote active and healthy lifestyle, including physical activity in the entire population and for all ages is one of the most cost-beneficial areas for health intervention. The same can be said for food security and health eating. As well as ensuring a world free from malnutrition in all its forms, nutrition is crucial to deal effectively with nutrition to stem the escalating the burden of chronic disease such as obesity, diabetes, heart disease, cancer etc. • The Bill should prioritize **health promotion and disease prevention for example stressing mechanisms to support all people having access to adequate food and enjoying diversified, balanced and healthy diets throughout their lives, with special emphasis on breastfeeding and protection of children in their first 1,000 days.** • **Social determinants of health** include the recognition that a huge array of social, economic and environmental factors impact on the health of people and magnify or diminish the costs of illness. As it stands at the moment, the Bill does not recognise this at all. • The Bill should recognize that a large number of factors beyond personal health services affect the health outcomes of a nation. **For example, adequate and sufficient nutritious food as well as sustainable, resilient and diverse nutrition-sensitive agriculture and food distribution systems are vital for healthier populations**. Furthermore, the Bill needs to recognize the impact of many other important and urgent challenges to the health system. Critical examples included climate change and **the impact of environmental degradation** on the clean air and safe drinking water. Numerous other issues impact profoundly on health, such as **decent work, sanitation, secure shelter, education, safe transport, social safety nets**, and so on, all of which are needed to promote and protect people's health. • The Bill needs to unequivocally **acknowledge the importance of such social determinants in its preamble**, expressing concern for the people living in fragile settings where protracted humanitarian crises, and health and other emergencies, including armed conflicts, challenge national systems capacities and the provision of

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		essential health services, and stress the urgent need for a more coherent and inclusive approach to strengthen health systems and health security. It implies that health services must work **in an intersectoral manner**. • A fundamental tenet of the **PHC approach** is addressing the social determinants of health through **inter-sectoral action,** and facilitating individual and collective community participation in healthcare planning and implementation. While the 2017 NHI policy document states that "NHI aims to transform delivery of healthcare services by focussing on health promotion, disease prevention and empowered communities", the **current Bill reflects a bio-medical model of health care, and does not consider** the **inter-sectoral actions necessary** to support health promotion and address the social determinants of health. • The Bill should provide **for strategic leadership on UHC** at the highest political level **and promote greater policy coherence and coordinated actions through whole-of-government and health-in-all-policies approaches**, and forge coordinated and integrated whole-of-society and multi-sectoral response, while ensuring to align support from all stakeholders to national health policies. • **Community participation** – the recognition that people's engagement and the inclusion of all stakeholders as a core component of PHC and effective health system governance is essential to fully empower the people of a nation to improve and protect their own health. Community participation is therefore an essential building block contributing to the achievement of UHC • The Bill should emphasise the need to engage with all relevant stakeholders, including the civil society, private sector, philanthropic foundations, academic institutions as well as the community through the establishment of participatory governance platforms and multi-stakeholder partnerships, in the development and implementation of health- and social-related policies and progress monitoring to the achievement of national objectives for UHC, while giving due regard to managing conflicts of interest. • The Bill should further provide for financial support to strengthen the capacity of national government authorities to exercise strategic leadership and strengthen the capacity of local authorities to engage with their respective communities. It should

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		create mechanisms to build effective, accountable and inclusive institutions at all levels to ensure social justice, rule of law, and health for all. As a means of providing the regulatory and legislative framework for the achievement of UHC, the Bill should ensure access to health services, products and vaccines as well as to provide funding to assure the quality and safety of services, products and practice of health workers.
7. Committee of Dental Deans in South Africa (CoDD)	Preamble	**The key principles on working arrangements** that the profession is advocating for in the NHI Bill: 1) We promote a strong multidisciplinary approach (we need dentist led teams with dental therapist, oral hygienist, dental technician and dental assistants working side by side each practicing to their scope) 2) We promote group practices models and discourage solo practices models 3) There should be various contracting models for primary, secondary care in general dental practice and tertiary/quaternary services through hospitals care 4) Acceptable and cost-effective clinical protocols and guidelines to be used to guide clinicians are developed by the profession 5) A proper referral system to guide the profession to be followed by patients 6) Local contracting mechanisms of dental services within district health authority and move away from central government 7) Dental service package for all population group serving children, adults, elderly, special needs and prison settings are developed 8) Education and prevention should be part of the primary prevention benefit package. 9) Immunization/vaccination programs such as fissure sealants must be a strong feature in the school health program 10) The word medical deans in the NHI should also include dental deans to ensure consistency and ensure dental is not left out 11) On numerous occasions, the bill mentions minister must appoint person with expertise in the field of medicine, we propose that the word medicine should include dentistry /dental 12) Dental deans should be part of the National Governing Body on Training and

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		Development 13) Dental deans should be part of the National Tertiary Health Services Committee 14) Dental deans should be part of the Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance 15) Dental deans should be part of the Ministerial Advisory Committee on Health Care Benefits for National Health Insurance
	Chapter 7 clause 25	**On the key Ministerial Committees*, chapter 7* we propose that;** At least one or 2 members of the dental profession to be included in each of the key committees such as 1) Benefits advisory committee, ***(chapter 7section 25 sentence 2 of the Bill)*** 2) Health benefits pricing 3) Stakeholder advisory committees 4) Technical committee including remuneration committees
	Clause 25	**Benefits advisory committee, we propose that:** 1) There should be a recognition that Oral health is not just Primary Health care alone, NHI fund to ensure that Oral health benefits must be defined across all levels of health care from primary, secondary, tertiary and quaternary services 2) The design of package of services will be designed by the oral health profession 3) Norms, standards and prescribed minimum benefits for oral health 4) Clinical protocols and guidelines for oral health to be developed in these committees
	Clause 34	**National Health Information System, we propose that:** 1) A universal standardized electronic clinical record system for oral health to be developed 2) The system can interface with others such as the medical fraternity, home affairs, etc. 3) Minimum data indicators for oral health at various levels of care are developed

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		4) The system should include radiology, pharmacology, laboratory and clinical record modules 5) The system must be able to interface at all levels of care primary through quaternary care 6) The system must be compatible with other systems and be upgradable to ensure future sustainability
	Missing in the Bill	**Finally, there are some grey areas that needs more attention and clarity from the Bill:** 1) The Bill needs to be clear on oral health services eligible for refugees and foreign nationals as the current model may be unsustainable 2) The bill needs to define exclusions for oral health services that can then be channelled to private medical insurance 3) The office of health standards and compliance OHSC needs to strengthen the inspectorate for oral health to inspect dental practices and dental facilities in the hospitals and ensure tools that are tailor made/more suitable for the dental settings 4) The capitation vs the fee for service models of reimbursement needs to be balanced with a more hybrid system to counter the effects of both under servicing and overserving of patients
5. South African Human Rights Commission (SAHRC)	General comment	The success of the NHI will depend on, among others good governance. The NHI must be adequately protected against corruption, mismanagement and various forms of abuse.
	Definitions	Basic health services must be clearly defined to be in line with the Constitution as well as accepted international standards.
	Population coverage	Less restrictive means should be employed to limit the right of asylum seekers and foreign nationals to access to health services, beyond emergency treatment.
	Powers and functions of Chairperson, Deputy Chairperson and Members of the Board	The Bill should clearly sate the powers and functions of the Chairperson, Deputy Chairperson and well as powers and functions of individual members in order to clarify potential conflict and ensure an efficient Board.

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	Conditions of service of Board members	- A definitive fixed term of appointment of the Board should be specified. The Commission recommends that each member should serve a minimum term of three years to promote the independence of the Board and ensure continuity. - Section 44 seems to limit who the Chairperson of the Board must be. - The remuneration and conditions of service of Board members should be clearly stipulated. It is recommended that the remuneration of the Board be determined by the Independent Commission for the Remuneration of Public Office-Bearers.
	Stakeholder Advisory Committee	The Commission as well as other relevant Chapter 9 institutions should be included on the advisory committee. Other relevant Chapter 9 institutions, for example, the Commissions on Gender Equality should also be considered for addition on the advisory committee.
	Appeal Tribunal	The Appeal Tribunal should be completely independent of the Board, to ensure credibility of the Board.
	Concentration of power in the Minister	The Commission notes that in terms of Section 12, the Board is accountable to the Minister of Health. In terms of Section 13, the Board is appointed by the Minister, who is also empowered to remove any of its member(s) or dissolve the entire Board. The Commission is concerned with both the appointment process of the Board and its reporting lines. The proposed governance structure places concentrated power on the Minister and does not adequately ensure the independence of the Board, which is essential given its extensive powers, including strategic purchasing and buying and selling of property. Furthermore, it locates excessive indirect authority with the Minister. - The Commission recommends that the Bill should include further mechanisms for accountability and oversight which are legislated and the process of appointing and removal of members of the Board should be akin to the process of appointing and removal of members of Chapter 9 institutions whereby the National Assembly is involved in the process. - To avoid a conflict of interest, the ministerial representative envisaged may neither

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		be appointed as the Chairperson nor Deputy Chairperson of the Board. - Committees should be appointed by the Minister in consultation with Parliament. - Section 13(5) should specify that the Board members should not have criminal records and must be persons of high integrity.
	Governance	The NHI in its current form is complex and offers myriad opportunities for corruption and looting, particularly in areas where contracts are entered into. Strong governance structures are required to monitor unlawful activities and to ensure the accountability of purchases and contracted parties both to users and the State and to ensure accountability of the State to users and Parliament.
	Registration of users	The Commission recommends that the State considers other forms to identify individuals positively.
	Relationship between the Minister and CEO	The Commission recommends that there should be a separation between political and operational spheres as this may weaken the role of the Board.
	Operation of the Fund	- The role of the contracting units for primary health care needs to be clarified. - The Commission is concerned about the impact of using a diagnosis-related groups (DRG) funding model as it fails to take into account outpatient expenses.
	Information Platform of Fund	- Section 40(4) of the NHI requires health care providers to keep patient information such as information relating to patient health. The Commission is of the view that the NHI does not adequately address current challenges with patient record keeping and is not clear on how patient records and biometric information will be secured to ensure confidentiality. - The Commission has observed that the current health care system has weak patient record system which, is exacerbated by the fact that most health facilities use a manual data capture system and that health care facilities lack adequate administrative staff. - Before the NHI can be implemented, considerable reform and capacitation is required. - The Department of Health would have to consider upgrading the current IT system as the implementation of the NHI requires the electronic registration of new users. - The Department of Health will also need to reform the administrative infrastructure,

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		train and recruit skilled personnel to meet staffing demands.
	Conclusion	- Currently, the South African healthcare system is not equipped to provide healthcare services for all South Africans. - Much upscaling of resources and capacity will be required prior to the implementation of the NHI. - Governance will have to be improved drastically. - The funding of the NHI must not occur at the expense of other rights and services provided by the State and must not result in retrogressive measures in the provision of rights.
DAY 3		
6. National Health Laboratory Services (NHLS)	Preamble	With UHC, more citizens will be able to access health care services that will result in an increased demand for diagnostic testing, both for clinical diagnosis in disease states and for screening of healthy people. This would require regular data on test utilisation and costs to efficiently manage pathology expenses for the NHI fund. The NHLS is uniquely placed to fulfil both the mandates of access and coverage as well using existing data systems to provide pathology utilisation data. In addition, the NHLS has unique pathology expertise to define evidence based best practices for ordering tests to improve the appropriateness of test utilisation.
	Chapter 1	- The NHLS is fully supportive of the introduction of the NHI Bill. The NHLS welcomes the NHI Bill, and endorses the principles of universal health coverage, efficiency, cost effectiveness, quality, and equity. - The NHLS believes that the NHI offers a strategic advantage in the form of monopsony power by creating a market with only one buyer. - The NHI fund will be in a position to pre-dictate prices and set the standard for health care services. - The single purchaser and single payer principle are a good funding mechanisms to achieve the UHC objectives.
	Clause 57	**NHLS as Designated Service Provider:**

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		- The NHLS recommends that the NHI Fund contracts with the NHLS as a designated service provider for all pathology services. The NHLS has been designated as the service provider for the transition phase. This should be the case beyond the transition period. - One of the advantages would be that the NHI can streamline both service provision as well as, pathology payment. The benefits of the NHLS as a designated provided include: o The burden of monitoring provision and payments of pathology services can be taken away from the Fund as the NHLS can perform this and report to the NHI Fund. - It would serve as the repository of all laboratory data using systems that have already been established such as the corporate data warehouse and laboratory information system (LIS). These systems could be used to provide national patterns of test utilisation. This would take the burden of monitoring the pathology service from the fund. Laboratory data could also be interfaced with NHI patient record system for bidirectional communication. The NHLS could implement electronic order entry to facilitate paperless tests ordering.
	Chapter 4	**Composition of the Board:** - In principle, we agree to the concept of technical representation. - The experience from the NHLS Board shows that having organizational representatives has the advantage that these organisational representatives provide important feedback on the services and the end user experience. - The NHI Board will need to implement mechanisms to obtain feedback from organisations and stakeholders, if the Board only has technical representatives. - Consideration should be given to the costs of setting up and running Boards and Committees, which could be substantial. - The Fund could be run as a government component/agency and therefore reduce the expenditure on setting up a Board.
	Clause 48	**Financing mechanisms:** - The NHI Bill does not contain much detail on the financing mechanism for different providers. - Contracting with the NHLS as the designated service provider has the advantage

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		that the NHI only has to determine the financing mechanism with the NHLS and the same mechanism can then be used by the NHLS to sub-contract with the private laboratories. - This mechanism can also be used to cap utilisation and prevent over-servicing.
	Clause 25 & 26	**Benefits design:** - The Bill should state whether the benefit package will be implicit (i.e. name what will be - in the package) or explicit (what will be excluded). - The Bill should also state how benefits will be paid for if it is not in the benefit package. - The NHI Fund should also allow for duplicative health insurance i.e. everyone should be compelled to contribute to mandatory pre-payment. However, for those who want to buy a similar package through voluntary insurance should be able to do so. This will reduce the burden from the NHI Fund. The disadvantage of this however, is that it could lead to a two tier system. This risk can be mitigated by the Fund prescribing administered prices for the voluntary packages.
7. South African Medical Research Council (SAMRC)	General statement	• The South African Medical Research Council (SAMRC) supports the ideal of effective, equitable, quality care for all South Africans and thus committed to contributing to the successful delivery of Universal Health Coverage (UHC) as outlined in the National Health Insurance (NHI) Bill. • However, the SAMRC raises the following issues regarding the current health care services: o One of the World Health Organization's prerequisites for successful universal health coverage (UHC) is an existing efficient healthcare system. In other words, a well-run healthcare system should be in place prior to implementation of UHC. o Primary healthcare (PHC) efforts have been stepped up with teams of ward-based PHC community health workers conducting home visits, mobile clinics servicing schools, and district clinical specialist teams

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		reaching out to improve maternal and child health. These activities have been on a pilot basis and evaluations show mixed results. ○ There is, however, much speculation around exactly how the NHI will be implemented in the future in South Africa and in this regard the SAMRC contend that, as the NHI is being initiated, serious thought is given to how the impacts of poverty, poor education, hunger and climate change, among other social determinants of health, are likely to impact on the health status and universal healthcare services in the country, to plan for and mitigate them as soon as possible. ○ Given the poor resources and limited capacity in the public sector, there is real concern that the majority of public sector facilities will not meet the accreditation standards for contracting and the NHI would therefore rely heavily on private facilities for the provision of services. ○ Given that, the country has 3 477 primary health care facilities, and only approximately 1507 were accredited as Ideal Clinics according to the 2019 report. ○ It remains unclear what the total cost of NHI implementation will be and this will largely depend on the benefit package. While the fund will be largely based on income tax, given the large informally employed population in South Africa, particularly rural communities, it is unclear whether taxes will be sufficient to cover the NHI needs and whether sufficient government subsidies will be available to ensure their access. ○ The current health system is very fragmented. Services, HR, budget, information systems, and technology is not standardised – even within provinces and within districts. ○ With limited information available on what conditions are prevalent at the different facilities, it is not clear how the costing will be done, reimbursement calculated for services provided, and health services planned for different facilities. ○ Given that the country has 3 477 primary health care facilities, and only approximately 1507 were accredited as Ideal Clinics according to the 2019

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		report, there is concern that the accreditation process will render the majority of public sector facilities ineligible to be contracted by the NHI fund, therefore resulting in a heavily private sector dependent delivery model. ○ Following the release of the Health Market Inquiry, a number of regulatory mechanisms were suggested to reduce the anti-competitiveness and market control of the private sector. **It is unclear when such regulations will be put into place.**
	Specific concerns on the NHI Bill	• NHI is a proposal to address the response to illness in South Africa, but deals with only one aspect of health inequalities in the country. • Given the absolute low levels of screening and mental health detection at the primary care level, there is a very real concern that mental health services will be relegated to those that can afford complementary cover. The SAMRC states that without explicit inclusion of mental health in the benefit package of the NHI and the complementary services to be provided by the private sector, mental health service inequities in South Africa are likely to prevail. • The NHI Bill does not include a definition for Health Technology Assessment. HTA is an often-used term but may mean different things to different people. For example, some stakeholders may consider it only to include medical technologies like medical devices. • It is proposed in the NHI Bill that a Ministerial Advisory Committee on HTA for NHI will be established to advise the Minister on HTA and 'serve as a precursor to the Health Technology Assessment Agency'. Unfortunately, no further detail is provided to describe the scope, functions or level of autonomy of the HTA Agency, nor the manner in which it will interact with the other NHI committees and units.

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		• The NHI Bill does not specify how the appointments to the Ministerial Advisory Committee (MAC) on HTA for NHI or the HTA Agency Board will be carried out, or the types of stakeholders that will be represented. • Section 38 of the Bill proposes the establishment of an Office of Health Products Procurement. The SANRC is of the view that the functions of this Office overlap heavily with those of SAHPRA, the South African Health Products Regulatory Authority, and the well-established processes for the development and implementation of Standard Treatment Guidelines, which include requirements for related products. • The SAMRC notes that a new, separate, Office of Health Products Procurement as it is outlined may be inappropriate and wasteful, and therefore not required. • Given the importance of the HTA Agency in NHI planning and operations, it is concerning that the NHI Bill does not currently provide a clear mandate for its establishment. The establishment of an independent HTA Agency has been discussed for many years, with stakeholders in both the public and private sector agreeing the need for it and its potential value. There is a significant risk that not mandating the establishment of the HTA Agency in the NHI Bill may result in another few years of discussions and limited action. • Clarity regarding the appointment of the CEO is required as at the moment it is ambiguous - the Bill states that the process will be a transparent and competitive. However, in Section 2 the Bill states that the decision will be made by the Minister who must approve the recommendation of the Board. • Clause 34 identifies the need for the development and maintenance of a Health Information System as well as the need for health workers to comply with the provisions in the National Health Act relating to access and protection of health records. There is a lack of a specificity regarding the extent of development of

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		this health information system and a lack of recognition that the current constraints to the collection of data is a result of staffing shortages, particularly at primary care level(s). • The Bill does not make note of how negative incentives such as reduced quality, increased hospital admissions, early discharge of patients and under-provision of necessary services will be monitored and managed. SAMRC states that there is a need for referral arrangements to ensure that providers will prioritize services for lower-risk patients. • Without appropriate recognition of the burden and service needs for mental health care users, and without technical support to translate policies into District Health Plans that comprehensively address the mental health needs of the District, we are concerned with DHMO capacity to oversee mental health care within primary care settings; especially given the primary care systems central role in referrals. • The Bill makes no note of the reimbursement mechanism that will be adopted for PHC services. Furthermore, there is no reflection on the need to strengthen primary health services in order to be accredited for contracting. • Section 39 refers to accreditation of service providers. While the bill states in section 39(7) that the fund must renew the accreditation of service providers every five years on the basis of compliance with the accreditation criteria, it does not explicitly state whether facilities not accredited at the time of purchasing may be able to reapply for accreditation at a later period. • The clause of the Bill makes no provision on how service delivery in the private sector will be catered for a public health approach to ensure that the lowest categories of staff who can provide quality service within their scope of practice are used.

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		• Section 39(5) refers to information submission requirements for accreditation and reimbursement. This section would more appropriately be located in Section 34 (National Health Information System). The reference to 'recording on the Health Patient Registration System' is too restrictive. A more consistent wording would be 'recording on the national health information system', as referred to in Section 34. • The NHI Bill does not indicate what organization will be responsible for prioritizing and conducting (or commissioning) the research.
	Specific key issues on certain sections and pages of the NHI Bill	• Page 5, line 30: The central hospital is expected to "serve as a centre of excellence for conducting research and training of health workers". Clear evidence is not available to demonstrate that these hospitals would have the appropriate capacity and capability to undertake this. **The SAMRC suggests that outsourcing to suitable service providers be considered.** • Page 6, line 16: Does health care service provider include traditional healers? If so, how are they registered? • Page 6, line 25: 'complementary medicine' should be included in the Definitions. • Page 10, lines 45-46: health technology assessment can take years to complete, especially for innovative technologies. **What happens in a case when the assessment has not been done?** • Page 29, lines 40-46: It is not clear whether the Ministerial Advisory Committee on Health Technology Assessment for NHI has been/ is already established. **It is suggested that this Committee serve as a precursor to the Health Technology Assessment agency.**

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		• Section 6(d) refers to 'unreasonable grounds' for being refused access to health care services. **It is unclear how 'unreasonable grounds' are defined.** • Section 6(o) refers to purchase of services not covered by the NHI Fund. Is there going to be some regulation of costs for health care services being purchased? Health care should not be commercialised. • Section 8.2 refers to access to services not covered by the NHI Fund. It is not clear how this clause will be implemented. What control the National Department of Health have over cost of services provided by private medical schemes for services not covered by the fund. • Will the fund be managed from national with representatives from province and the districts? How is the gap between these levels going to be managed? There needs to be a clear pathway of communication established between these levels are part of the Bill. • Section 13 refers to the composition of the Board of the Fund. How does the Office of Health Standards Compliance fit into the Board of the fund? Specific provision is required for close coordination between the Fund and the OHSC. • An organogram is required to clarify how the committees referred to in Chapters 6 and 7 interact or feed into each other. • Informed decisions on population health needs assessment are needed. This aspect requires external independent review by a body such as SAMRC that has the necessary skills to assess and synthesise the population-level information that will guide this aspect.

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		• Include a clause specifying independent oversight and review by accredited body such as SAMRC. • In addition to the specifications in Section 5, Board Members should have no previous history of working in industries that are associated with imposing a health burden: alcohol, food, tobacco, extractive industries, pharmaceuticals, etc. • Section 15(3)(c) states that the Board must advise on comprehensive health care services to be funded by the Fund through the Benefits Advisory Committee'. Sufficient expertise should be on the Board to ensure that this is possible. This requirement must be stated in Section 13(5)(b). • Section 33 refers to the role of medical schemes, but there is no reference in the Bill to other funders of health care in South Africa. Would it be practicable for the Fund to co-opt funding to cover direct healthcare costs from sources that have been set up to cover the cost of industrial epidemics such as the Road Accident Fund, Workmen's Compensation in terms of COIDA, including exposure to Asbestos, Mining-related injuries, etc. • Section 39, sub-sections (2) to (4), Accreditation of service providers, refers to quality of services in relation to contracting. Further detail is required on how quality assessment/control of services provided by each establishment will be conducted and how participating facilities will be reimbursed for services provided. • The roles of the DHMO and the CUP (Contracting Unit for Primary Health Care) are overlapping. Both are expected to manage the provision of PHC services. The specific role and powers of the CUP (Contracting Unit for Primary Health

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		Care) (Clause 37) are not clearly defined, nor is the relationship between DHMO (Clause 36) and CUP. Whom is CUP accountable to? It is unclear whether the CUP is a purchaser or a provider with contradictions in the list of functions in the bill alluding to both roles. • **Add 37(2)(j)** advice the District Health Management Office of appropriate interventions to reduce the burden of disease within the demarcated geographical area, in the interests of cost-efficiency of the Fund, including in respect of environmental health and the consequences of climate change.
	Specific recommendations on the Bill	• **Mental Health:** the benefit package must include cost-effective interventions at the primary care level, including the integration of mental health care into routine chronic care management. Care needs to be expanded to include **psychosocial counseling** and **rehabilitation services** at the **primary care level**. A mental health investment case is currently underway on behalf of the DOH, and recommendations emanating from this analysis needs to be considered for the benefit package. • **Section 5** must be expanded to allow for the registration of the user who is on vacation or not within the geographical area in which they have registered (e.g. for work purposes). Add a **clause on how this will be managed**. • **Health Technology Assessment (HTA):** the SAMRC proposes that the NHI Bill should include **a definition for HTA**. For reference, the World Health Organisation (WHO) definition for HTA is as follows: *Health technology assessment is the systematic evaluation of properties, effects and/or impacts of health technologies and interventions. It covers both the direct, intended consequences of technologies and interventions and their indirect, unintended*

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		consequences. The approach is used to inform policy and decision-making in health care, especially on how best to allocate limited funds to health interventions and technologies. • Health Technology Assessment (HTA): the SAMRC recommends the establishment of an HTA Agency should be mandated in the NHI Bill, with the Ministerial Advisory Committee on HTA for NHI steering its inception. It further proposes that a more detailed description of the tasks and stakeholder representation is provided for the Ministerial Advisory Committee on HTA for NHI. In addition, we propose that the NHI Bill provide more clarity on how appointments to the HTA Agency board will be made (as part of the mandate for its establishment). • The SAMRC is of the view that the requirement for 'a global budget or Diagnosis Related Groups' is too specific. It therefore proposes that alternative wording for clause 35(2) is as follows: *"The Fund must transfer funds directly to accredited and contracted central, provincial, regional, specialised and district hospitals based on a global budget or Diagnosis Related Groups agreed funding mechanisms, which could include global budgeting, case mix-based approaches such as diagnosis related groups, and other mechanisms to be determined based on appropriate evidence".* • **Insert Section 10(1)(v):** Establish mechanisms to co-operate and collaborate with non-Health sectors to ensure the prevention of ill health and disease, for example establishing basic, minimum standards for healthy housing and human settlements in an era of climate change and extreme weather, buffer zones between sites of pollution and human settlements, safe drinking water for all,

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		access to electricity for all, improved disaster management responses, institution of health impact assessments for major or potentially polluting developments, prevention of injuries and violence, and so forth. • The SAMRC proposes that the **Fund reports to Parliament** and that the **Minister's powers are reduced**, as the Minister has enormous power as per the current Bill (e.g. sub-sections 13(8) and 13(9)). This may undermine the purpose and effective implementation and independent functioning of the Fund. • **Public participation:** the SAMRC recommends that someone who represent civil society should also be included on the Board (new Section 13(5)(e); the **current Section 13(5)(e) would move to 13(5)(f)**. Furthermore, more details should be included such as shares or stakes in insurance industries, pharmaceutical companies, involvement in tobacco or sugar industries etc. • **Board members:** the Board members should be selected so that they are able to fulfil these functions. Furthermore, it is not clear whether the Board can co-opt or contract advisors to assist with this activity. This should be added to the section.
	General recommendations	In order for South Africa to realise the principle of a universal health coverage, the SAMRC makes the following general recommendations: • If South Africans are to benefit from UHC through the NHI and simultaneously avoid the health risks associated with a changing climate, then one of the fundamental NHI principles, prevention, needs to be centre stage. • A holistic approach that is founded on the essential services of public health is required to help shape climate change considerations and responses. This includes tracking diseases and trends to climate change; investigating disease

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		outbreaks; informing policymakers about health impacts of climate change; creating public health partnerships with industry, faith communities etc. to draft and implement solutions; and ensuring healthcare service provision following disasters. • There also need to be training of healthcare providers on health aspects of climate change; preparation and assessment of preparedness plans; and research, for example, on optimal adaptation strategies. • Health promotion, preparedness and advocating for health protective behaviours, for example, to drink water when conditions are hot, need to be among the top priorities on the NHI agenda. Public awareness campaigns are required for socially isolated and marginalised groups and the effectiveness of these campaigns should also be assessed. • The NHI is planned specifically to reduce the gap in the standard of healthcare between the rich and the poor, thereby reducing the susceptibility of vulnerable groups including against the impacts of climate change. If this is to occur successfully, it will need to be carefully considered with social, spatial and economic lenses. • There is a need for integration of sectors i.e. housing and settlements, labour / occupation, and education to cover social determinants of health (a key aspect of prevention) in the implementation of the NHI, both for its success but also to alleviate the threats of climate change on health, the need for healthcare insurance (especially in the face of natural disasters) and healthcare delivery. The social determinants of health warrant special attention in all NHI health promotion campaigns for disease prevention and healthy communities. • The SAMRC proposes that the research requirements in the planning, development, implementation and maintenance of NHI be described more clearly,

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		as well as the potential sources for these research outputs. • The SAMRC suggest that the DOH strengthen current healthcare services by ensuring good management at all levels of care and employing qualified and competent staff who can be held accountable. There needs to be innovative solutions found for current problems of understaffing, long waiting times, etc. Decentralisation of healthcare services with greater reliance on non-professional healthcare workers, if properly trained and managed holds the potential to alleviate some of the burdens mentioned above. We do not believe that implementing the NHI scheme will necessarily translate to '…all South Africans have access to affordable, quality personal health care services regardless of their socioeconomic status…' (Page 46). • Efforts should be made to strengthen the public sector capacity to meet accreditation standards so to ensure sufficient competition for service delivery. The accreditation process requires: o Provision of the minimum required range of personal health care services, o Allocation of the appropriate number and mix of health care professionals o Adherence to treatment protocols and guidelines; o Adherence to health care referral pathways; o Submission of information to the national health information system; o Adherence to the national pricing regimen for services delivered
	Other general comments	*Process of implementation* • The SAMRC states that the Bill needs to focus on principles and processes for implementation rather than on finalisation. It notes that implementation steps must be **piloted**, **evaluated** and **readjusted** before moving to next stage. Previous piloting in selected districts has yielded very limited or unsatisfactory

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		results. • The SAMRC refers to Thailand, a country that has successfully implemented National Health Insurance mechanisms, has adopted an incremental approach spanning over 40 decades including the development of health system infrastructure including rural health development. As a result, given the lack of clarity, the roles of the DHMO and CUPS, as well as provider payment mechanisms should not be legislated at this stage. • Until the benefit package is defined, it is unclear how the range of health care services and availability of health care professionals can be measured. To estimate the HRH requirements moving forward a needs-based approach should be considered with an incremental path to service coverage. *Role of medical aid schemes* • The SAMRC argues that there are fewer details around the role of the medical aids presented in the Bill (section 33) in comparison to the White Paper. • Furthermore, the bill states that medical schemes will offer complementary services not covered by the NHI. The SAMRC states that it will be critical to ensure that these complementary services do not encompass essential population health needs that would limit the fund's capacity to achieve equity in access and ultimately UHC. *Limited budgets and basket of services* • It remains unclear what the total cost of NHI implementation will be and this will

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		largely depend on the benefit package. • While the fund will be largely based on income tax, given the large informally employed population in South Africa, particularly rural communities, it is unclear whether taxes will be sufficient to cover the NHI needs and whether sufficient government subsidies will be available to ensure access for vulnerable communities. • Links between the country's budget and the Fund's expenditure are virtually absent in the Bill. • At no place it is stated that the Fund will have to remain within the allocated budget, nor is there information on the processes to ensure that this is the case. • The SAMRC proposes that a monitoring and evaluation framework be established to guide implementation. It also proposes that as far as is possible, evidence-based approaches be used to guide and learn from implementation activities. • The SAMRC proposes an additional interim committee that focuses on health systems and services implementation, strengthening, research and evidence generation, synthesis and translation. *The importance of health promotion for the success of NHI* • The NHI Bill, as well as the Memorandum of Objectives and the Department of Health pamphlet explaining NHI, all mention the importance of prevention and promotion. However, this is not translated into concrete proposals of what will be done within the NHI context to achieve this. Moreover, it appears that the conceptualisation of prevention and promotion is extremely narrow and may

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		merely translate into education and information programmes that are not evidence-based and that most health promotion experts regard as a waste of time and resources. It is critical that health promotion within the NHI Fund is: ○ Multi-sectoral ○ Evidence-based and ○ Adequately resourced in order to make a real difference. • The SAMRC states that in order to ensure that interventions are evidence-based and do not merely waste resources, far more research on health promotion is required. It believes that this should be paid for from resources committed by the NHI Fund to the National Health Commission or a Health Promotion Foundation. The SAMRC states that it could play an important role in conducting such independent research.
	International best models	The SAMRC proposes that the country adopt successes from Thailand and Rwanda by exploring the implementation of community based insurance for rural/informal communities. Key features of the model include: • Targeting of poorest for subsidies to identify eligible people, communities were involved in defining criteria and allocating members to different categories. Several categories cover the range of disadvantaged populations (widows, the elderly, and orphans have been found to benefit), and are used to define exclusions, premiums and co-payments. • Support to members to pay their premiums. Members not eligible for subsidy are assisted through annual microcredit grants. They are repaid over a 12-month period with a 4% interest rate. • Mobilisation of additional financial resources. Additional government budget and funding from partners has been allocated to the CBHI scheme. The largest funding source remains household premiums.

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