

The South African Society of Psychiatrists (SASOP)'s comments on the  
**NATIONAL DEPARTMENT OF HEALTH'S GREEN PAPER**  
**ON NATIONAL HEALTH INSURANCE**

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The South African Society of Psychiatrists (SASOP) is the only organization representing the interested of the discipline of psychiatry as the peer specialist representative organization in South Africa. These interests are championed by the State Employed Special Interest Group (SESIG) representing the concerns of state employed and academic psychiatrists and the Psychiatrists in Private Practice Special Interest Group (P3 SIG) through the commercial company Psychiatry Management Group (PsychMG), which is a founding member of SAPPF. Attention is drawn to the SAPPF comments pertaining to private practice specialists. SASOP currently represents two thirds of all its potential members in South Africa as paid-up members.

## **1. MOTIVATION FOR THE NHI**

The Board of Directors, the executive decision-making body of the Society (SASOP) took note and approve of the intention of the National Department of Health to ensure universal access to appropriate, efficient and quality health care for the whole population of South Africa. SASOP applauds and supports the ideal of providing equitable and sustainable healthcare.

SASOP took note of the assertion that to successfully implement a National Health Insurance healthcare financing mechanism that covers the whole population four key interventions need to happen simultaneously namely:

1. A complete transformation of healthcare service provision and delivery;
2. The total overhaul of the entire healthcare system;
3. The radical change of administration and management; and
4. The provision of a comprehensive package of care underpinned by a re-engineered Primary Health Care.

SASOP further took note of the quadruple burden of disease as described by Coovadia et al [The Lancet 2009]. SASOP is of the opinion that the discipline of psychiatry has an intricate role to play in at least three of the four epidemics (i.e. non-communicable diseases including mental illness, HIV/TB and its complications as well as accidents and interpersonal violence with consequent psychological trauma). Indeed, Stein, Seedat, Herman et al found in the South African Stress and Health Study (SASH)[British Journal of Psychiatry (2008), 192, 112-117] that 30.3 per cent of the sample population suffered from one mental disorder, 11.2 per cent of two and 3.5 per cent of the sample of three or more disorders. Anxiety disorders had the highest lifetime prevalence of 15.8 per cent of the sample, followed by any substance use disorder with a prevalence of 13.3 per cent. 9.8 per cent of the sample had a lifetime history of a mood disorder. Lifetime prevalence of substance use disorders differed significantly across ethnic groups and the mean age of onset for substance use disorders at 21 years were significantly earlier than that of anxiety disorders (age 32 years) or mood disorders at age 37 years.

Martin Prince wrote in the Oxford Textbook of Community Mental Health [Chapter 7] "The World Health Organization's global burden of disease (GBD) estimates provide evidence on the relative impact of health problems worldwide (Murray and Lopez, 1996; World Health Organization, 2006). Patterns of morbidity seem to be globalizing with non-communicable diseases rapidly becoming the dominant causes of ill health in all developing regions except Sub-Saharan Africa. Within this wider health transition, the GBD report showed for the first time the true scale of the contribution of

mental disorders, this revelation attributed to the use of the disability-adjusted life year (DALY), the sum of years lived with disability (YLD), and years of life lost (YLL) as a single integrated measure of disease burden. Neuropsychiatric conditions (comprising, in descending order of DALY contribution: mental disorders, substance and alcohol use disorders, other neuropsychiatric disorders, dementia, mental retardation, migraine, epilepsy, Parkinson's disease, and multiple sclerosis) account for 14 % of all DALYs and 28 % of all DALYs attributed to non-communicable disease (Murray and Lopez, 1996; World Health Organization, 2006). They are the chief contributor to burden among the non-communicable diseases, more than either cardiovascular disease (22 % of non-communicable disease DALYs) or cancer (11 %). Proportionately, mental disorders account for just 9 % of the burden in low-income countries, compared with 18 % in middle-income and 27 % in high-income countries. This is because the burden of communicable, perinatal, and maternal conditions remains high in many low- and low-middle-income countries, swelling the denominator. However, the absolute burden of mental disorder as indicated by per capita DALYs does not vary much between world regions."

As early as 2001 Bing, Burnam, Longshore et al reported a strong correlation between HIV infection and psychiatric disorders [*Arch Gen Psychiatry*. 2001; 58:721-728]. Factors independently associated with screening positive for a psychiatric disorder in their study included number of HIV-related symptoms, illicit drug use, drug dependence, heavy alcohol use, and being unemployed or disabled. Factors independently associated with screening positive for drug dependence included having many HIV-related symptoms, being younger, being heterosexual, having frequent heavy alcohol use, and screening positive for a psychiatric disorder. Goodkin confirmed that anxiety, depressive spectrum, neurocognitive, and psychotic disorders present with symptom profiles and in settings that are specific to HIV infection and require the need for individually tailored psychiatric care [Focus 7:303-310 Summer 2009]. Cluver and Gardner [Annals of General Psychiatry 2006, 5:8] investigated mental health outcomes for urban children parentally bereaved by AIDS in South Africa. According to their study the number of children so bereaved is expected to rise from 1.1 million in 2003, to 3.1 million by 2010, peaking at 5.7 million in 2015. They further commented that children orphaned by AIDS are exposed to multiple stressors which may compound and complicate the grieving process. They may have cared for and witnessed the death of parent/s with a debilitating illness, loss of bodily functions, and sometimes AIDS-related mental illness. Their study in essence found that orphans were more likely to view themselves as having no good friends, to have marked concentration difficulties and to report frequent somatic symptoms. Orphans were more likely to have constant nightmares and 73% of their sample scored above the cut-off symptom cluster for the diagnosis of Post-Traumatic Stress Disorder.

Given these findings, SASOP is of the opinion that psychiatric care at all levels of service delivery (municipal ward, district care, regional hospital based, central hospital and specialist hospital based care) is essential in rendering both preventative and curative care. SASOP would argue that psychiatric services should form part of all benefit packages. This will be in keeping with the Mental Health Care Act (Act No. 17 of 2002) which in its preamble recognizes that "health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services" (own emphasis added). Indeed the objects of the Act are to make the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the available resources; to co-ordinate access to mental health care, treatment and rehabilitation services and to integrate the provision of mental health care services into the general health services environment [Section 3]. According to the Act it is incumbent on every organ of State responsible for health services to ensure the provision of mental health care, treatment and rehabilitation services at primary, secondary and tertiary level and to promote community-based care, treatment and rehabilitation services [Section 4]. Section 8 of the Act demands that every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop full potential and to facilitate his or her integration into community life

SASOP noticed that the NHI will be guided by the principles of the right to access; social solidarity; effectiveness; appropriateness; equity; affordability; and efficiency. This is in keeping with the Mental Health Care Act, which, in Section 6 demands that health establishments must provide mental health care, treatment and rehabilitation services at the appropriate level and within the professional scope of practice.

SASOP took note of the objectives of NHI namely:

- 1. To improve access to quality health care services**
- 2. To pool risks and funds to achieve equity and solidarity through the creation of a single fund To provide services on behalf of the entire population**
- 3. To strengthen the under-resourced and strained public sector so as to improve system performance.**

## **2. THE RE-ENGINEERED PRIMARY HEALTHCARE SYSTEM**

Primary Health Care (PHC) services will be re-engineered to focus mainly on community outreach services and to ensure a comprehensive primary care package of services, extending beyond services traditionally provided in health facilities such as clinics, community health centres and district hospitals. SASOP strongly argues for the strengthening of psychiatric services at community level and for its inclusion into the primary care package of services.

The re-engineered PHC will focus on health promotion and preventative care, whilst also ensuring quality curative and rehabilitative services. SASOP supports the principle that all members of the population will be entitled to a defined comprehensive package of health services at all levels of care in keeping with the spirit and letter of the Mental Health Care Act.

**Primary healthcare services shall be delivered according to the following three streams:**

### **a. District Clinical Specialist Support Teams**

**An integrated team of specialists will be based in the districts.** The specialities will include: a principal obstetrician and gynaecologist; a principal paediatrician; a principal family physician; a principal anaesthetist; a principal midwife and a principal primary health care professional nurse. The role of these teams will be to provide clinical support and oversight, particularly in those districts with a high disease burden. The Medical Schools in the country should be able to provide these teams, even if on a rotational basis.

SASOP noted with concern the absence of a principal psychiatrist in the proposed District Clinical Specialist Support Teams. As pointed out above psychiatric services is vitally important in community based, district services and is demanded by the Mental Health Care Act. The discipline of Psychiatry has been acknowledged as a major specialty on par with Internal Medicine, Obstetrics and Gynaecology, Paediatrics and Surgery by the Health Professions Council of South Africa for over a decade. In view of the oversight and planning function of the proposed District Clinical Specialist Support Teams, SASOP will strongly argue for the inclusion of **Psychiatry** as a separate speciality with expertise in its professional scope of practice to advise on and plan for the provision of appropriate mental health care, treatment and rehabilitation services within each of the **52 districts**. SASOP believes that inclusion of these principal psychiatrists will fulfil the objectives of promoting innovative models of providing specialist healthcare closer to the patients' home; promoting integrated working practices between GPs and hospital based specialists; improving the quality of services rendered at the first level of care by ensuring adherence to treatment guidelines and protocols and provide peer support for specialists working in primary care.

SASOP took note of the proposed School Health Services and believes it has a role to play in the provision of programmes which will focus on child and sex abuse, substance abuse, and sexual and

reproductive health rights including family planning services, and HIV and AIDS related programmes. The programme will ensure the general state of physical, mental and well-being of school-going children from pre-Grade R to Grade 12.

SASOP took note of the proposed system of Municipal Ward-based Primary Health Care Agents.

### 3. HEALTHCARE BENEFITS UNDER NATIONAL HEALTH INSURANCE

The term “**benefit package**” describes how different types of services are organised into different levels of care in the public sector (J. Doherty, 2010). It also defines the types of services that are considered as achievable for the country commensurate with its resources. (p 26.GP)

The Department of Health (DOH) has developed benefit packages for primary health care, district hospital services, regional hospital services and tertiary services. Providers will have to comply with measurable targets and acceptable standards of care. These will enable managers at facility, district, provincial and national levels to compare performance and challenges between individual and groups of similar facilities.

SASOP would strongly argue for the inclusion of psychiatric services as part of primary, secondary and tertiary benefit packages. Such benefit packages will be in keeping with the requirements of the Mental Health Care Act and the definition of health according to the Alma Ata declaration. As argued before psychiatric services should be part of district health services in SASOP’s view.

#### **Hospital-Based Benefits**

These services will be based on a **defined comprehensive package** that is appropriate to the level of care and referral systems. (Patients will be referred to different levels of care.) The package will include all levels of care namely: primary, secondary, tertiary and quaternary healthcare services.

#### **Designation of Hospitals**

Hospitals in South Africa will be re-designated in **five groups: district hospitals; regional hospitals; tertiary hospitals; central hospitals; and specialised hospitals.**

Each level of hospital designation will be **managed at a newly defined level with appropriate qualifications and skills as defined by the National Health Council.**

#### **District Hospitals:**

These hospitals will supply **general medical services.** In terms of specialist care, they are limited to four **basic areas namely: obstetrics and gynaecology; paediatrics and child health; general surgery; and family medicine.** District hospitals will also provide services like **trauma and emergency care, in-patient care, out-patient visits, rehabilitation services, geriatric care, laboratory and diagnostic services, paediatric and obstetric care.**

SASOP would strongly argue that psychiatric services should be included in the benefit package of district hospitals. District hospitals are often the entry point for mental health care users in need of emergency involuntary care, treatment and rehabilitation services. It is often also the health establishments in which the 72 hours observation is conducted before a mental health care user is referred to secondary or tertiary care. Provision of psychiatric services at district level hospitals will not only be in keeping with the provisions of the Mental Health Care Act and its regulations but will also prevent fragmentation of service delivery and enhance seamless referral and continuity of care.

### **Regional Hospitals**

These hospitals will **offer a range of general specialist services, receive referrals from district hospitals and provide specialist services to a number of district hospitals** (preferably 6 or less).

The 8 general specialist services that will be provided is **general surgery, orthopaedics, general medicine, paediatrics, obstetrics & gynaecology, psychiatry, radiology and anaesthetics.**

### **Tertiary Hospitals**

Tertiary hospitals will render super **specialist and sub-specialist care**. They will also serve as a main platform for **training of health workers and research**. Most care provided in these hospitals, requires the expertise of teams led by experienced specialists. This includes **cardiology, cardiothoracic surgery, craniofacial surgery, diagnostic radiology, ear, nose and throat (ENT), endocrinology, geriatrics, haematology, human genetics, infectious diseases, general surgery, orthopaedics, general medicine, paediatrics, obstetrics & gynaecology, radiology and anaesthetics**. These services may be included in more developed tertiary services like cardiothoracic surgery, renal transplant, neurosurgery, oncology, nuclear medicine, and a range of paediatric sub-specialties.

### **Central Hospitals**

These national referral hospitals will be **attached to a medical school and provide a training platform for the training of health professionals and research**. They will render highly specialised tertiary and quaternary service on a national basis. They will also be highly specialised referral units for the other hospitals, use high technology and employ highly trained staff.

### **Specialised Hospitals**

The specialised hospitals are **usually one discipline focused**. There are a wide range of possible specialties that could be focused in a hospital, the two most common being **TB and psychiatry**, but they may also **include spinal injuries, maternity, heart, orthopaedics, urology and infectious diseases**. These units may also provide either acute, sub-acute or chronic care or all of four levels of care.

## **4. ACCREDITATION OF PROVIDERS OF HEALTHCARE SERVICES**

### **The Office of Health Standards Compliance (OHSC)**

The OHSC will be established through an Act of Parliament. It will consist of three units, namely:

- a. Inspection;**
- b. Norms and standards; and**
- c. The office of the ombudsperson.**

Norms and standards will be set up to undertake the inspection of all health facilities. This will be done in close collaboration with the implementation of quality improvement plans to ensure facilities are ready for accreditation and contracting with the NHI. Interim assessments will be conducted to ensure that set standards are maintained. Recommendations will be made on the introduction of continuous quality improvement in public healthcare facilities, with associated training.

**The OHSC will facilitate the development of multi-disciplinary organisational standards for healthcare facilities to evaluate compliance and to monitor progress.**

Certification will enable management at all levels of the health system to use the information generated to make informed decisions about quality improvement.

**Public and private establishments that wish to be considered for rendering health services to the population will have to meet set standards of quality.**

Other criteria for accreditation will include service elements, management systems, performance standards and coverage.

**The accreditation standards will specify the minimum range of services to be provided at different levels of care.** These will include competent health and medical staff with appropriate skills, adhering to the referral procedures as defined by the NHI. The referral system will be clearly defined for services within and outside the health sub-district, district and province to assure continuity of care and effective cost containment.

## 5. PAYMENT OF PROVIDERS UNDER NATIONAL HEALTH INSURANCE

Existing provider payment mechanisms and associated accountability processes will be changed into a more sustainable and effective one.

- 5.1 **At primary care level**, accredited providers will be reimbursed using a **risk-adjusted capitation system linked to a performance-based mechanism**. The annual capitation amount will be linked to the size of the registered population, epidemiological profile, target utilization and cost levels.
- 5.2 **At hospital level accredited and contracted facilities** and global budgets will be used in the initial phases with a **gradual migration towards diagnosis related groups (DRGs)** with a strong emphasis **on performance management**.
- 5.3 **Public emergency medical services** will be reimbursed through the **public hospital global budget initially** and a case-based mechanism as the system matures. Contracted private emergency services will be reimbursed using a **case-based approach**.
- 5.4 **Capitation** will be one of the basic forms of provider reimbursement. However, **adjustments** should be made in its application, with the following principles:
  - a. The capitation amount will be a uniform amount for the defined levels of providers;
  - b. The capitation amount should be linked to an appropriate index;
  - c. The public and private health providers contracted by the NHI, will be assisted in controlling the expenditure through a recommended formula, and adherence to treatment protocols for all conditions covered under the defined package of care; and
  - d. The budgets will be calculated on the basis of a **risk-adjusted capitation formula taking into account population size, age and gender and disease/epidemiological profile**.

## 6. HEALTHCARE CODING SYSTEMS AND REIMBURSEMENT

The NHI will adopt a **coding system that allows providers to uniformly report on the services rendered or goods provided for the purpose of reimbursement**.

A code relating to a particular service will be allocated. The system will also provide the necessary health information on the burden of disease for planning purposes.

The reimbursement system for **inpatient services will be according to disease related groups**. A case mix or grouper system will be adapted for the South African environment.

## 7. UNIT OF CONTRACTING PROVIDERS OF HEALTHCARE SERVICES

The District Health Authority (DHA), as part of the health service provision system, will contract with the NHI in the purchasing decisions for health services. **The DHA as a contracting unit will be supported by the National Health Insurance Fund (NHIF).**

The DHA will ensure **adequate and accessible services** for the population within a defined health district. It will also **monitor the performance** of contracted providers within a district and performance will be linked to a reimbursement mechanism that is aimed at improving health outcomes in the district.

**Functions of purchasing and provision of services will be separated within the NHA.** A clear delineation of the roles and functions of provincial and National Government on the one hand and National Health Insurance will be undertaken in order to ensure an effective purchaser – provider split.

## 8. PRINCIPAL FUNDING MECHANISMS FOR NATIONAL HEALTH INSURANCE

Funds can be obtained from a combination of sources (e.g. the fiscus, employers and individuals). The precise combination of these sources will be further clarified in the next 6 months in parallel to the public consultation process.

As the NHI matures, consideration will be given to the alignment and consolidation of health benefits offered by other relevant statutory entities.

### **The Role of Co-Payments under National Health Insurance**

Co-payments will be necessary for:

- a. Services **not in accordance with the NHI** treatment protocols and guidelines;
- b. Healthcare benefits that are **not covered under the NHI** benefit package (e.g. originator drugs or expensive spectacle frames);
- c. **Non-adherence to the appropriately defined referral system;**
- d. Services by **providers not accredited and contracted** by the NHI; and
- e. Health services utilised by **non-insured persons** (such as tourists).

## 9. HOW MUCH WILL NATIONAL HEALTH INSURANCE COST?

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

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

A defined comprehensive package of services is provided for all South Africans, but **this package is not specified as in current medical schemes. The model presents the estimated resource requirements using a Public Sector Framework. Costing is based on Public sector Unit Costs, but at improved resourcing levels.**

The improvement in resourcing is phased in over an initial 7 year' period (the urgent intervention). This will be to accommodate an increase in utilisation of the “currently uninsured”. It will take considerable time for the supply capacity (facilities and healthcare professionals) to grow to accommodate such utilisation increases. For this reason these increases are phased in over 14 years.

“This model indicates that resource requirements under this model increases from R125bn in 2012 to R214bn in 2020 and R255bn in 2025 if implemented gradually over a 14-year period. These figures are expressed in real terms (i.e. these are the values in real 2010 financial terms). These figures should be placed **within the context of current spending levels**. The 2010/11 health MTEF budget is R101bn and increases to R110bn in 2012/13 (2010 prices). This does not include spending by other departments (such as health spending by Defence and Correctional Services). In addition, a similar amount is being spent on medical scheme contributions (totalling R90bn (2010 prices)) in 2009 – the most recent year for which audited figures are available – and estimated to total about R92bn in 2010 based on the rate of increase between 2006 and 2008). This represents a total of over R227bn being spent on health services in South Africa in 2010, which is equivalent to almost 8.5% of GDP.” (*Preliminary Cost estimates explained in table on p 39 – available on request*)

**Increased spending on the NHI will be partially offset by the likely decline in spending on medical schemes. NHI will require an increase in spending on health care from public resources** (general tax revenue and a mandatory NHI contribution) that is faster than projected GDP increases. This NHI contribution should be compared to the current level of medical scheme contributions. Based on data from the 2005/06 Income and Expenditure Survey, the overall average level of contributions for all medical scheme members is over 9% of income. The intention is that NHI benefits will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply draw on their NHI entitlements.

The preliminary costing estimates indicate that NHI is affordable for South Africa. The present system of fragmentation, associated with the high cost, curative and hospi-centric approach and excessive and unjustifiable charges, especially within the private sector is not sustainable.

The high cost, curative and hospi-centric system cannot be sustainable not only for the implementation of NHI, but also for any form of healthcare financing mechanism, including the present medical scheme environment.

### **Funding Flows**

**All revenue collection would be undertaken by SARS, including the mandatory contribution. All funding for personal health care services will flow through the NHIF. Treasury will allocate general tax revenue for personal health care services and the payroll-linked mandatory contribution to NHI** in consultation with the Minister of Health and the National Health Insurance.

## **10. THE ESTABLISHMENT OF THE NATIONAL HEALTH INSURANCE FUND (NHIF)**

The NHIF will be a **government-owned entity that is publicly administered**. It will be a **single payer entity with sub-national offices to manage nationally negotiated contracts with all appropriately accredited and contracted health care providers**. The covered services will be defined as a comprehensive package of services that includes personal care, health prevention and promotion services. NHIF will **purchase health services on behalf of the entire population from contracted public and private health care providers**. The NHIF will report to the Minister of Health and Parliament.

The Department of Health will continue to play its overall stewardship and will remain a major provider of services through its national, provincial and district level structures and facilities. The DoH will also continue to provide non-personal services including overall responsibility for infrastructure development and direction of health worker training and planning. The NHIF will purchase personal services in accordance with the approved plans by the National and Provincial Departments of Health.



On **national level**, the NHIF will be managed by a **Chief Executive Officer (CEO)** who will **report directly to the Minister of Health**. The CEO will be supported by an Executive Management Team and specific technical committees including a technical advisory, audit, pricing, remuneration, benefits advisory committee and others.

At a **sub-national level**, the NHIF will establish sub-national structures that will be responsible for managing the nationally negotiated contracts with the District Health Authorities that are located within particular health districts.

## 11. THE ROLE OF MEDICAL SCHEMES

Membership to the NHI will be mandatory for all South Africans. However, **the general public may choose to continue their membership of voluntary private medical schemes**. These schemes will continue to **exist alongside the NHI**, but there will be **no tax subsidies** for those who choose to continue with medical scheme cover.

The exact form of services that medical schemes will offer may evolve to include top-up insurance. Existing expertise in the private healthcare sector, like administration and management of insurance funds, will be drawn upon from within the NHI if necessary, to ensure that adequate in-house capacity is developed.

## 12. REGISTRATION OF THE POPULATION

The NHIF will only deal with **registered citizens** as provided by the Department of Home Affairs. **A NHI card will be issued for the registered population** and it will allow ease of access to patient information and the portability of health services. The card will be the same for the entire population, regardless of their contributory or other status, in order to avoid the stigma that may be associated with subsidised households and individuals.

## 13. INFORMATION SYSTEMS FOR NATIONAL HEALTH INSURANCE

The NHI will contribute to an integrated and enhanced National Health Information System. This will contribute towards the **determination of the population's health needs and outcomes**. It will also be essential for portability of services for the population. The information system will be **based on an electronic platform**, with linkages between the NHI membership data base (with updated contribution status) and accredited and contracted health care providers

## 14. MIGRATION FROM THE CURRENT HEALTH SYSTEM INTO THE NHI ENVIRONMENT

The implementation of NHI will be done in a **phased and systematic manner at both the national and sub-national levels**. The migration period will occur in **three phases over 14 years**.

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

These elements include:

- a. Development of a strategy that allows the strengthening of district health structures to support the NHI. This will entail the **re-engineering of the Primary Health Care Approach, establishment of Municipal Ward-based family health teams, District-based specialist teams and the roll-out of the school-based health programmes.**

The strengthening of the District Health Management teams will improve the District Health Authority's capacity to contract with the NHI Fund.

- b. The Office of Health Standards Compliance will **inspect, licence and certify all health care facilities.** The NHI Fund will contract with accredited healthcare providers based on prescribed criteria and standards.
- c. Addressing the **current Human Resources (HR) shortages in the health system.** This will include increasing the capacity of nursing colleges and health science faculties to produce more health professionals. Mobilisation of additional financial and HR resources will be undertaken to support enhanced health systems delivery within the NHI.
- d. Conducting **real-life demonstrations and pilots** in prioritised health districts on the management capacity, appropriateness of the service package, and ability of the accredited and contracted providers to deliver on the defined comprehensive package of health services to be provided at the appropriate level of care. The prioritised districts will be selected based on demographic, socio-economic and epidemiological profiles as well as management functionality at the selected health districts.
- e. The assessment of existing health infrastructure (including facilities, technology and management capacity) in the country and developing a plan to improve its capacity and effectiveness to support health services delivery and provision within the NHI.
- f. **Implementation of hospitals management reforms that include governance reforms, improvements in financial management, decentralisation of authority associated with hospital management autonomy and accountability.**
- g. Development of a plan that informs the processes around implementing innovative purchasing and procurement processes to allow the NHI to yield the best economies of scale.
- h. Development of an integrated plan to support the processes around **population registration.** This will include conducting research on the type of NHI card to be used.
- i. Refinement of the financial resources required to fund the NHI and service delivery platforms at all levels. Refining of **the revenue mobilisation strategy and pooling systems.** Alignment of health benefits and tariff system under the Road Accident Fund, Compensation for Occupational Diseases and Injuries, Compensation Commission for Occupational Diseases and the Occupational Diseases in Mines and Works Act.
- j. Refinement of the **provider payment mechanisms strategies and implementation of interim mechanisms** to move from the current to the proposed performance-based payment system.
- k. Development of a **detailed transition process** from the current fragmented health information system to an integrated health information system that supports efficiency, effectiveness, information portability, confidentiality and enhanced proactive decision making and system

planning.

k. Review of existing legislative and regulatory laws in **preparation of the Bill/Act for the implementation of the NHI and the NHIF.**

l. **A National Health Insurance Conditional Grant will** be allocated to the National Department of Health as part of the resource allocation processes to support activities directed at piloting key aspects of the NHI.

A summary of some of the key elements that will be addressed through the three phases of implementation is found on p.48 – 52 of the Green Paper:

**The first table deals with the phasing in of NHI in the first five years.**

It deals with: NHI White Paper and legislative process; management reforms and designation of hospitals; hospital reimbursement reform; establishment of the Office of Health Standards Compliance; public facility audit; quality improvement and certification; appointment of district clinical specialists; municipal ward-based primary health care agents; school based PHC services; public hospital infrastructure and equipment; human resources for health; information management and systems support; NHI conditional grant; costing model; population registration; establishment of NHI Fund; and accreditation and contracting of private providers by NHI Fund – (2013 – 2014).

**The second and third tables deal with phase two: 2016 – 2020 and phase three: 2021 – 2025.**

## **15. PILOTING OF NATIONAL HEALTH INSURANCE**

Ten districts will be selected for piloting, based on the results of audits as well as the demographic profiles and key health indicators. Health profiles, demographics, health delivery performance, management of health institutions, income levels and social determinants of health and compliance with quality standards will also be considered.

**In time other districts will be determined on an annual basis** for inclusion in the roll out.

In the first 5 years (phase 1) of NHI the focus will be on: management of health facilities and health districts; quality improvement; infrastructure development; medical devices, including equipment; human resources planning; development and management; information management; and systems support and establishment of the NHI Fund.