

National Health Insurance Bill & Implementation



Greyfriars

www.health.gov.za/nhi/

13 APRIL 2024



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REPUBLIC OF SOUTH AFRICA





- Part 1: Why reform?
- Part 2: What is NHI all about?
- Part 3: What are we doing in NDOH?
- Part 4: How do we transition to NHI?



PART 1:

Why reform?

What are we aiming to 'fix'?



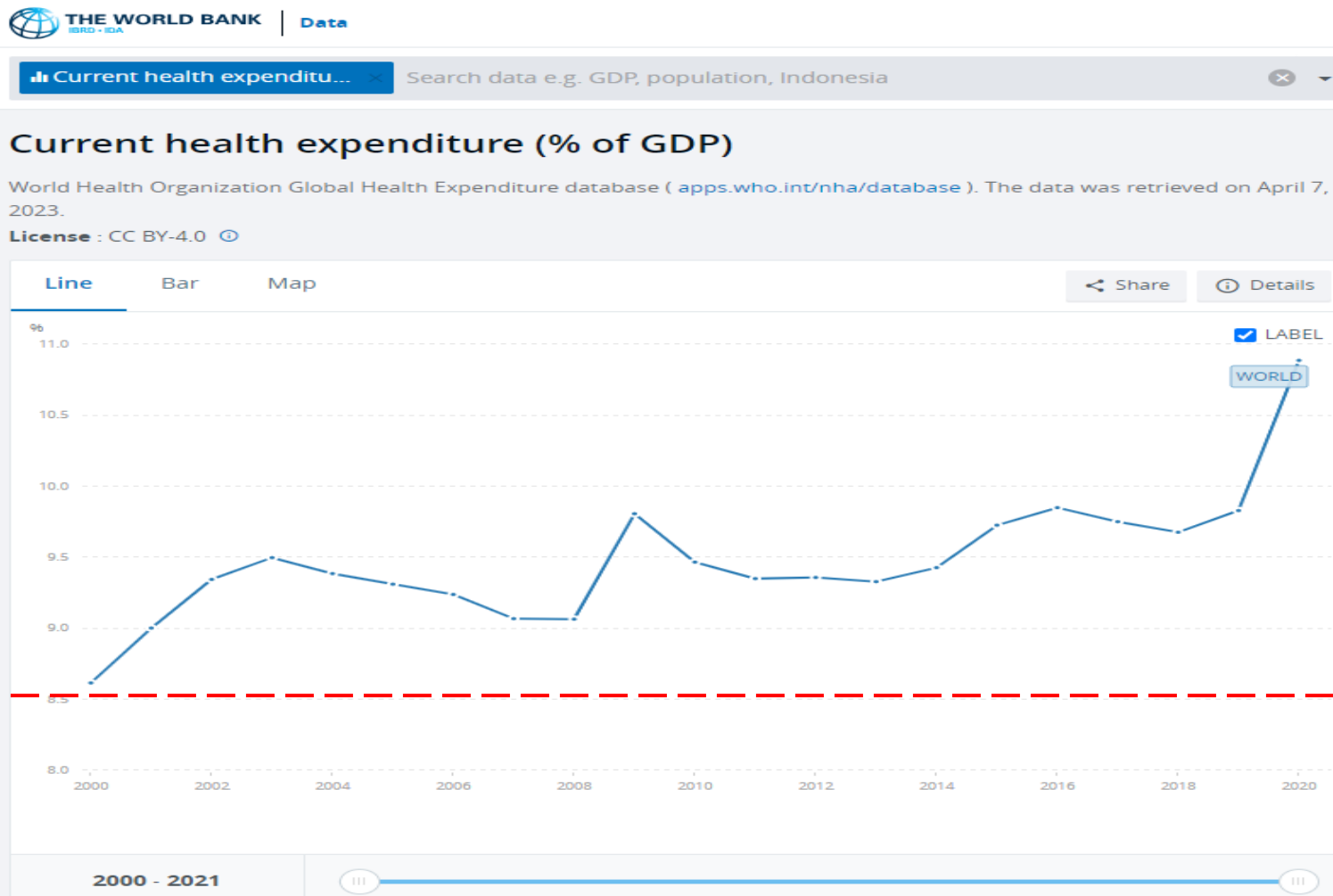
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World Bank Report %GDP on Health



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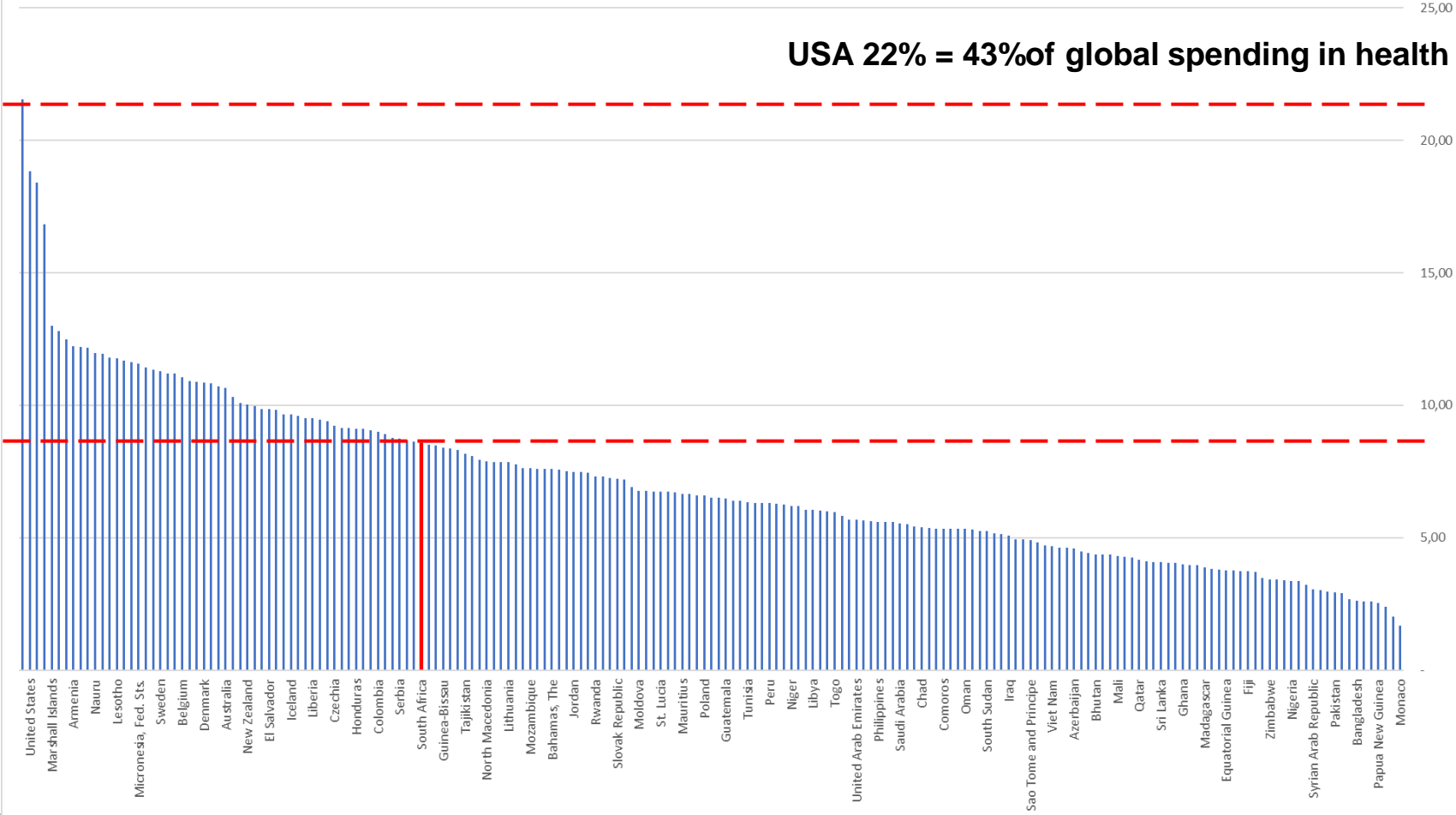


World Bank Report %GDP on Health



%GDP on Health (Most Recent Value)

USA 22% = 43% of global spending in health



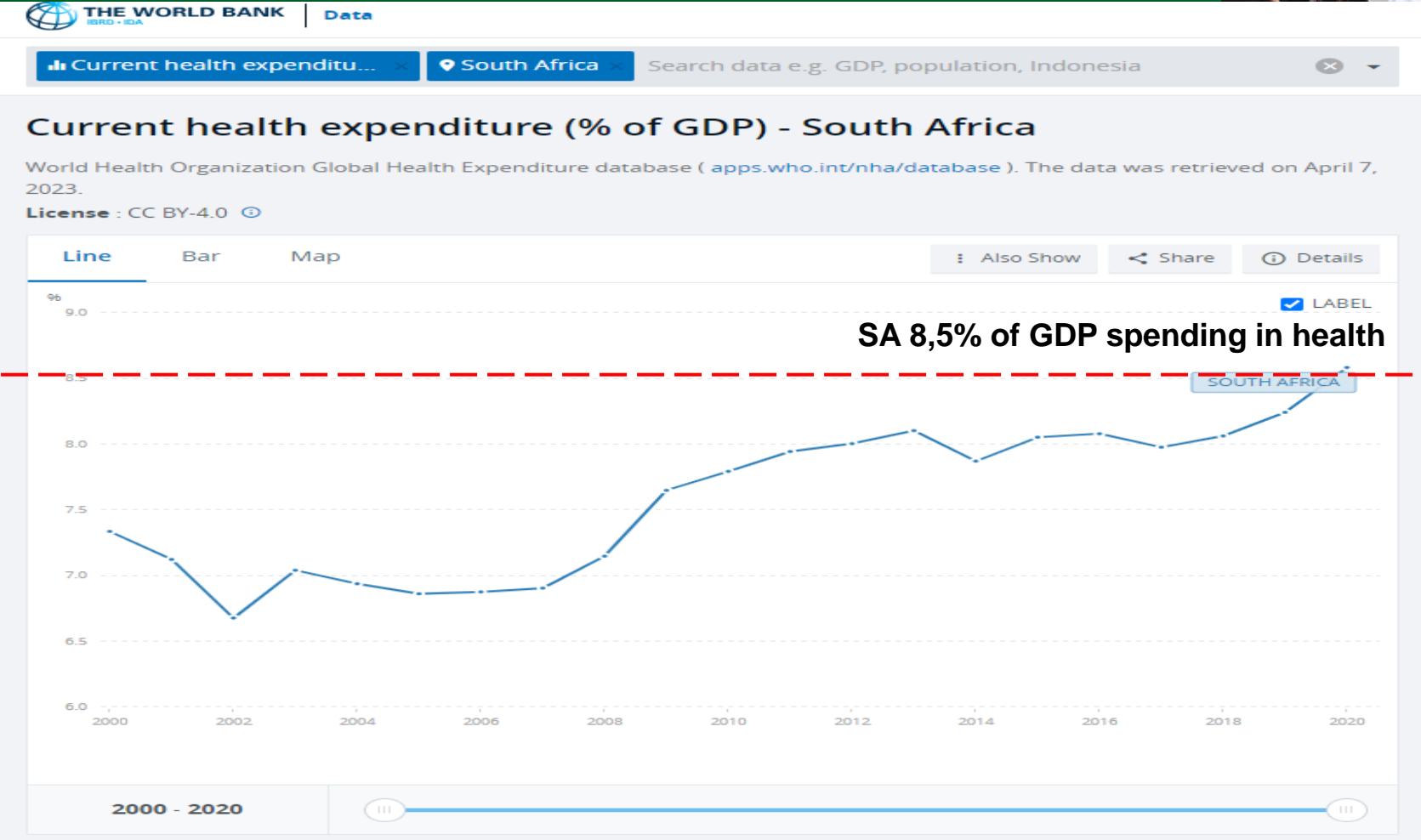
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World Bank Report RSA %GDP on Health

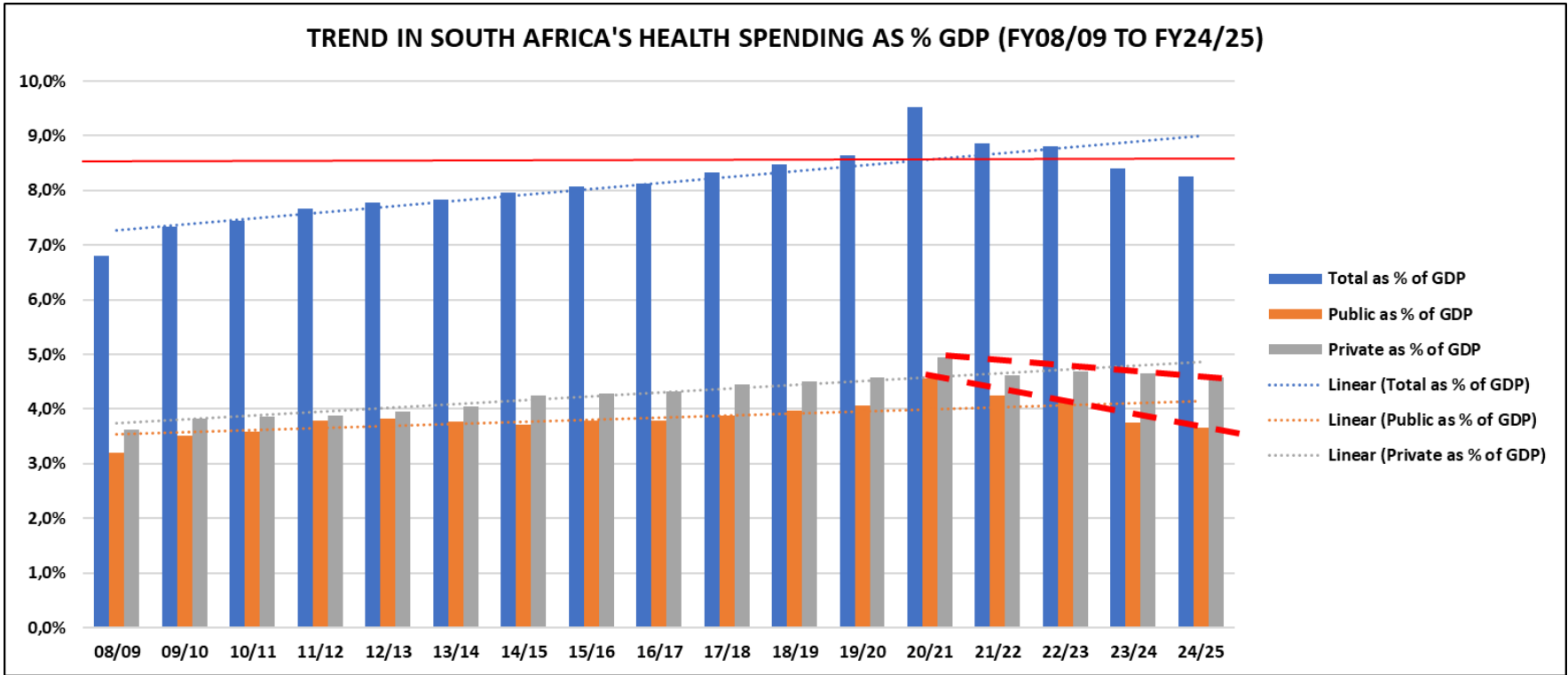


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Health sector funding trends as % GDP over the past 15 years



High level

- National spend currently is around 8,5%GDP (up from below 7% in 2008/09)
- Both Public and Private spending increased as %'s of GDP until 2020/21 but both are decreasing, public faster than private – this is too rapid



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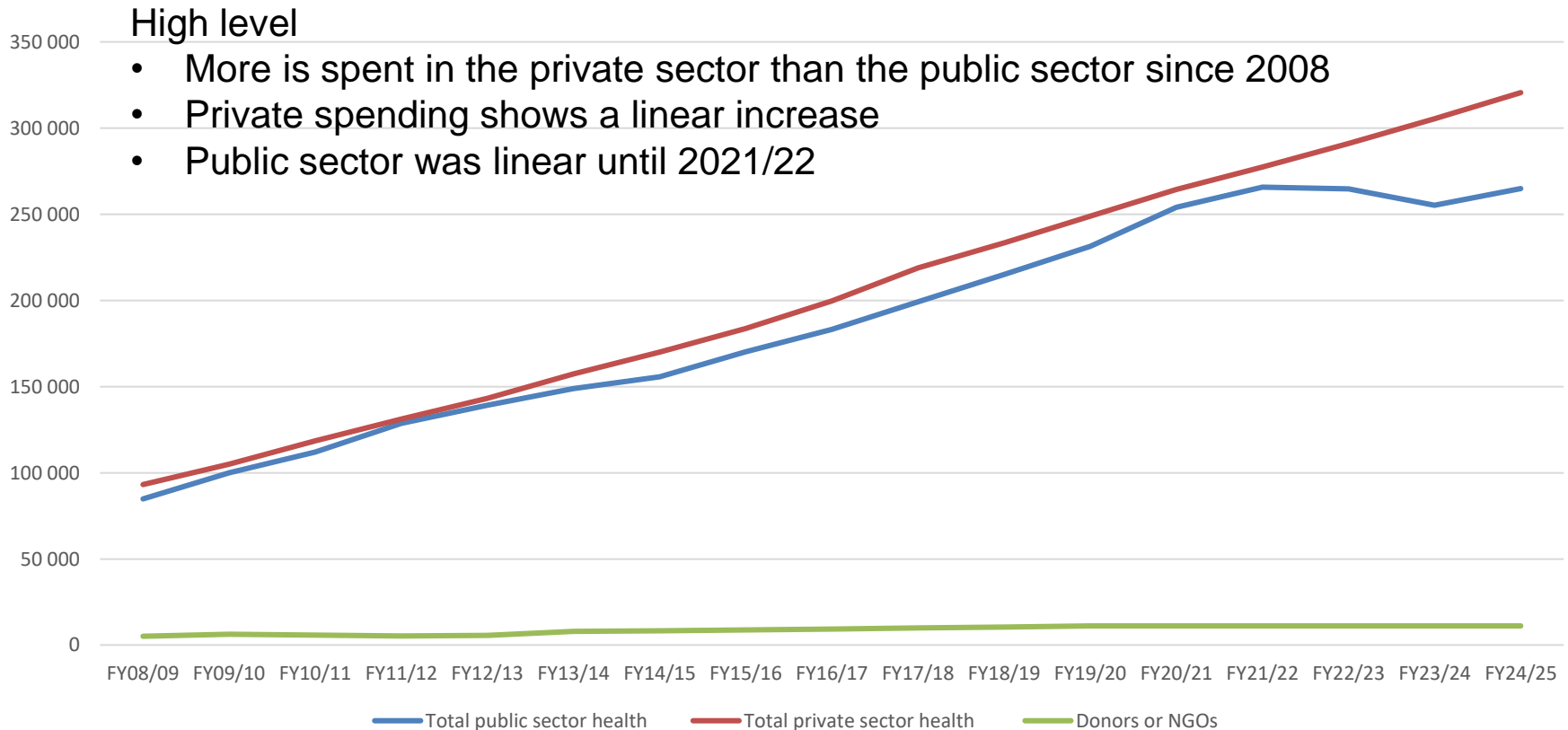
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Inequitable health sector funding trends over the past 15 years



TOTAL HEALTH SPENDING SOUTH AFRICA (RAND) (FY08/09 TO FY24/25)

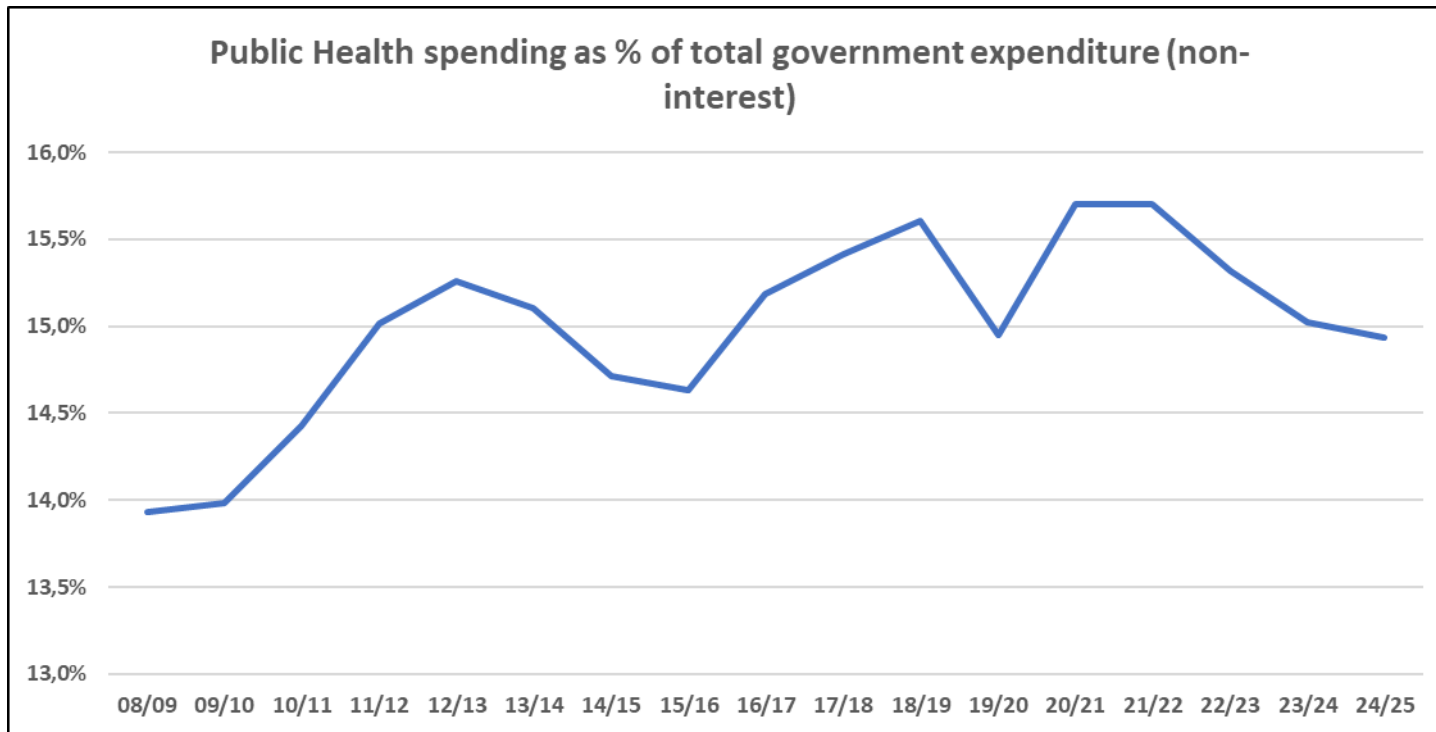


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Government spend on health



High level

- Spending by government on health has increased as a % of allocations from the fiscus (from 14% to 15,5% and **now at around 15%**)



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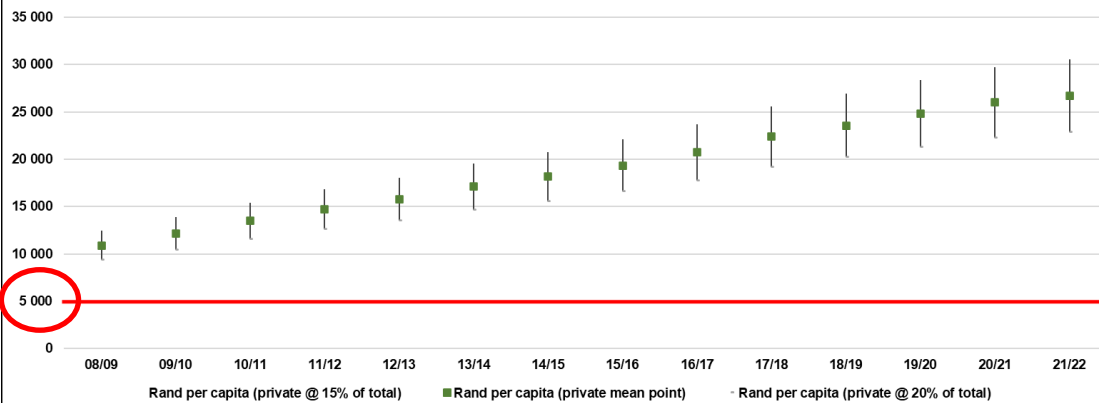
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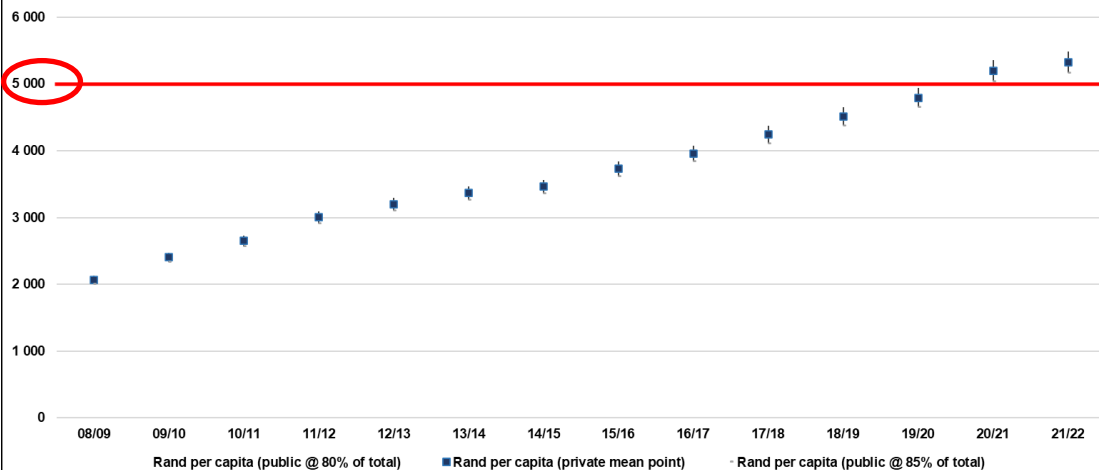
Per capita spending on Health 2008/09 to 2021/22



ESTIMATED PRIVATE PER CAPITA HEALTH SPEND (2008/09 to 2021/22)



ESTIMATED PUBLIC PER CAPITA HEALTH SPEND (2008/09 to 2021/22)



Rand per capita spend on health

- public @ 80% and private at 20% of total
- mean point Rand per capita
- public @ 85% and private at 15% of total

2021/22 FY

- **Private spend per person is 5,0 times that of public**
- Range 4,4 to 5,6 times depending on proportion of the population regularly using private providers

Per capita spending on Health 2021/22

Rand per capita (private @ 15% of total)	R30 515
Rand per capita (private mean point)	R26 700
Rand per capita (private @ 20% of total)	R22 886
Rand per capita (public @ 80% of total)	R5 483
Rand per capita (private mean point)	R5 322
Rand per capita (public @ 85% of total)	R5 161



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Administrative cost of maintaining medical schemes



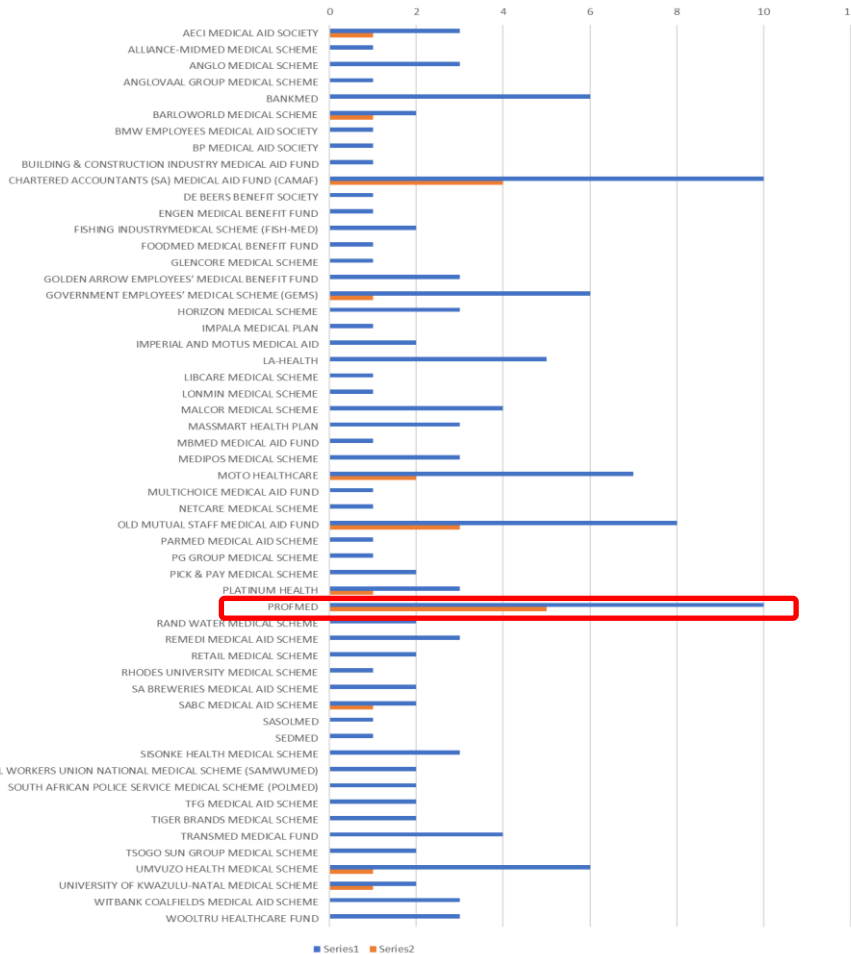
- At the start of 2024 there will be 73 schemes offering 311 'options'
- Schemes had 833 trustees in 2022, at a cost of over R104m
- Principal Officers cost almost **R140m** (several paid over R6m per annum)
- **Gross administration cost of schemes was almost R21bn (9% of R230bn)**

SCHEMES WITH HIGHEST COST OF ADMINISTRATION	medical schemes	No of trustees	Trustee remuneration	No. Options 2024	Principal Officer fees	Gross administration expenditure	Ave Trustee Remuneration
Open	18	146	55 278 000	164	56 633 000	10 614 356 000	378 616
Discovery Health Medical Scheme	1	10	10 230 000	22	7 298 000	6 219 239 000	1 023 000
Sizwe Hosmed Medical Fund	1	18	11 849 000	11	4 106 000	413 023 000	658 278
Restricted	57	687	49 109 000	147	83 152 000	5 276 764 000	71 483
Government Employees Medical Scheme (GEMS)	1	12	16 145 000	6	6 166 000	2 436 355 000	1 345 417
Profmed	1	11	3 780 000	10	5 206 000	218 369 000	343 636
South African Police Service Medical Scheme (POLMED)	1	17	6 367 000	2	6 584 000	434 153 000	374 529
Grand Total	75	833	104 387 000	311	139 785 000	15 891 120 000	125 315

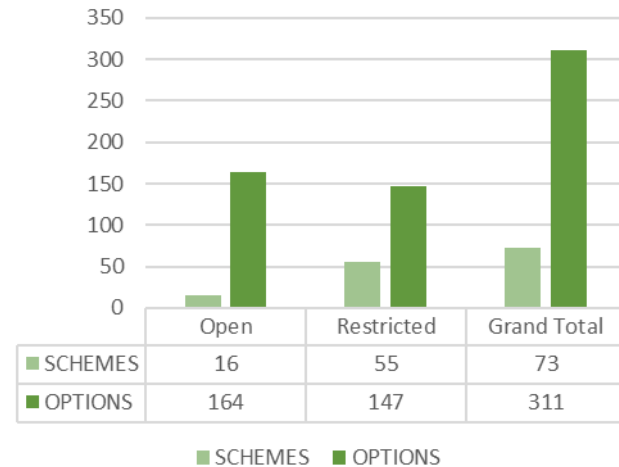


RESTRICTED Medical Scheme Options 2024

Options per RESTRICTED Scheme 2024



2024 Schemes and Options



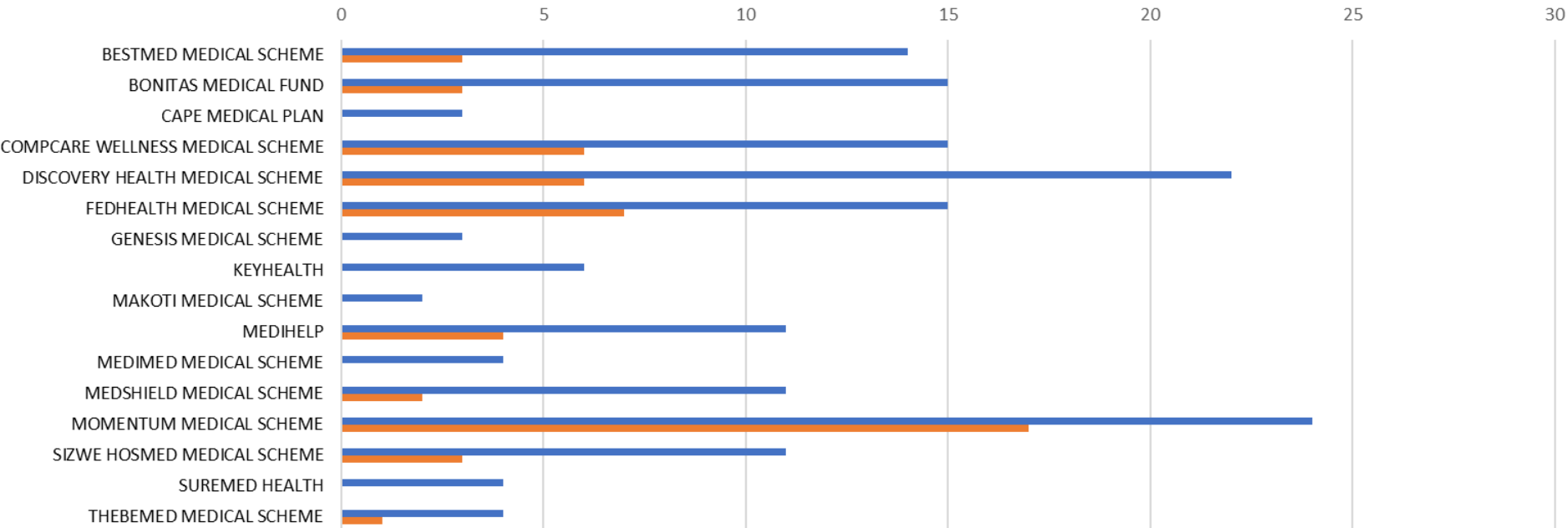
- Even the 55 restricted schemes have 147 'options', some as many as 10 options!
- **Open schemes have up to 24 options!**
- Adds layers of administrative complexity and cost, as well as perverse incentives and fraud

- **Series 1** are the number of Options
- **Series 2** are the numbers of EDOs (efficiency discounted options)

OPEN Medical Scheme Options 2024



Options per OPEN Scheme 2024



	THEBEMED MEDICAL SCHEME	SUREMED HEALTH	SIZWE HOSMED MEDICAL SCHEME	MOMENTUM MEDICAL SCHEME	MEDSHIELD MEDICAL SCHEME	MEDIMED MEDICAL SCHEME	MEDIHELP	MAKOTI MEDICAL SCHEME	KEYHEALTH	GENESIS MEDICAL SCHEME	FEDHEALTH MEDICAL SCHEME	DISCOVERY HEALTH MEDICAL SCHEME	COMPCARE WELLNESS MEDICAL SCHEME	CAPE MEDICAL PLAN	BONITAS MEDICAL FUND	BESTMED MEDICAL SCHEME
Series1	4	4	11	24	11	4	11	2	6	3	15	22	15	3	15	14
Series2	1		3	17	2		4				7	6	6		3	3

■ Series1 ■ Series2



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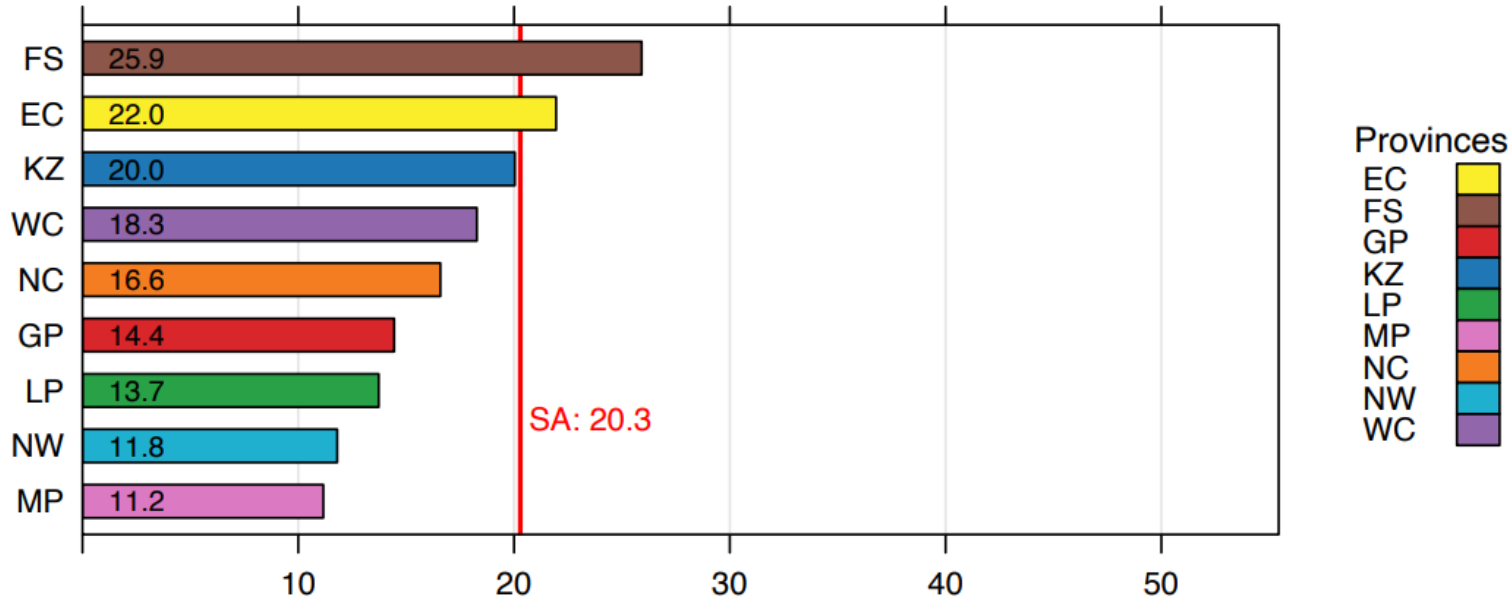
- Series 1 are the number of Options
- Series 2 are the numbers of EDOs (efficiency discounted options)





SECTION A: SERVICE CAPACITY AND ACCESS

Figure 2: Hospital beds per 10 000 uninsured population by province, March 2023 (all types of hospitals)



Plenty inequity in public service

per 10 000 uninsured [Source: DHIS] Strat: | DHIS 2000–2030 public sector

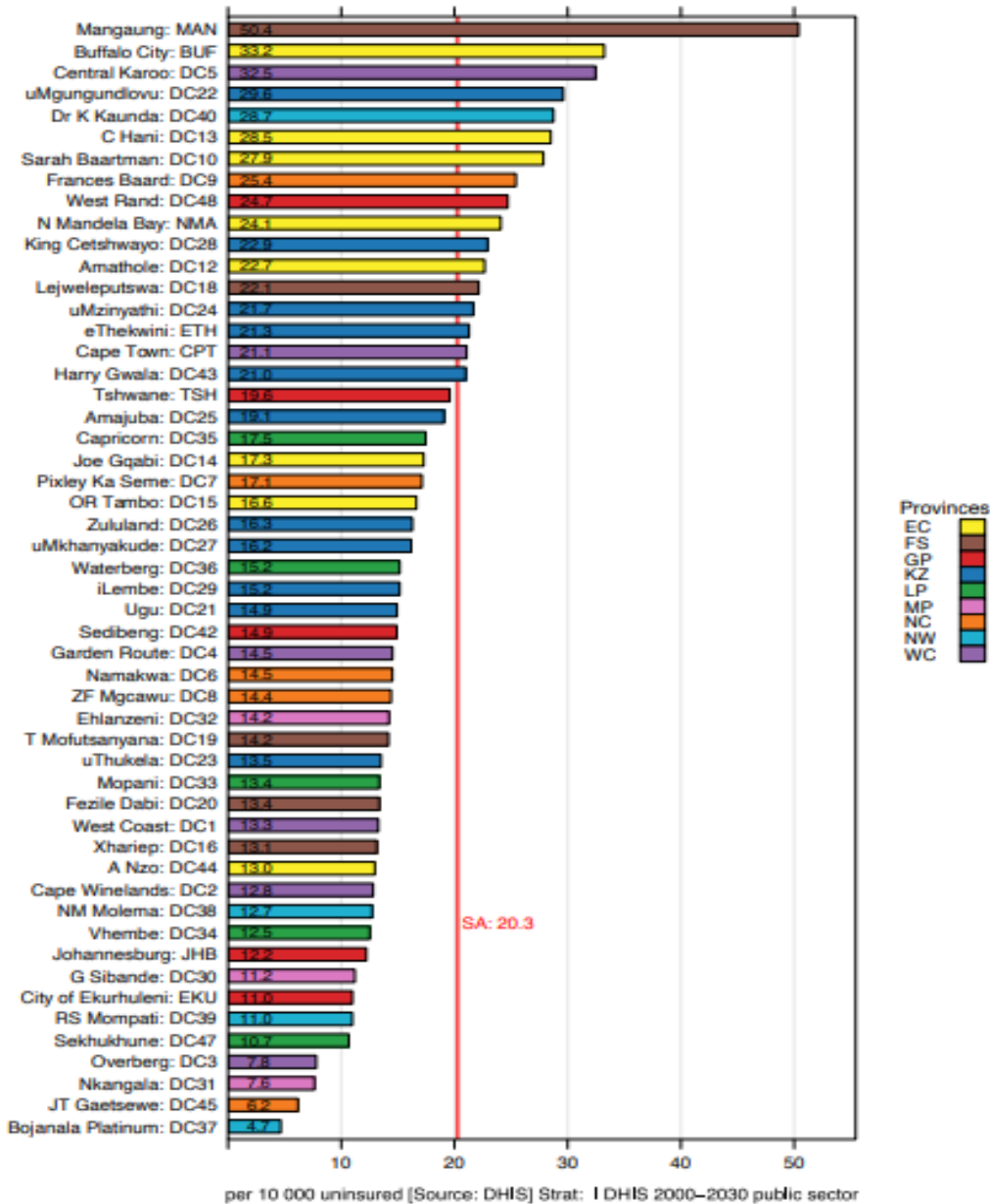


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Figure 3: Hospital beds per 10 000 uninsured population by district, March 2023 (all types of hospitals)



Access to public hospitals differs greatly from one district to another, whether urban or rural

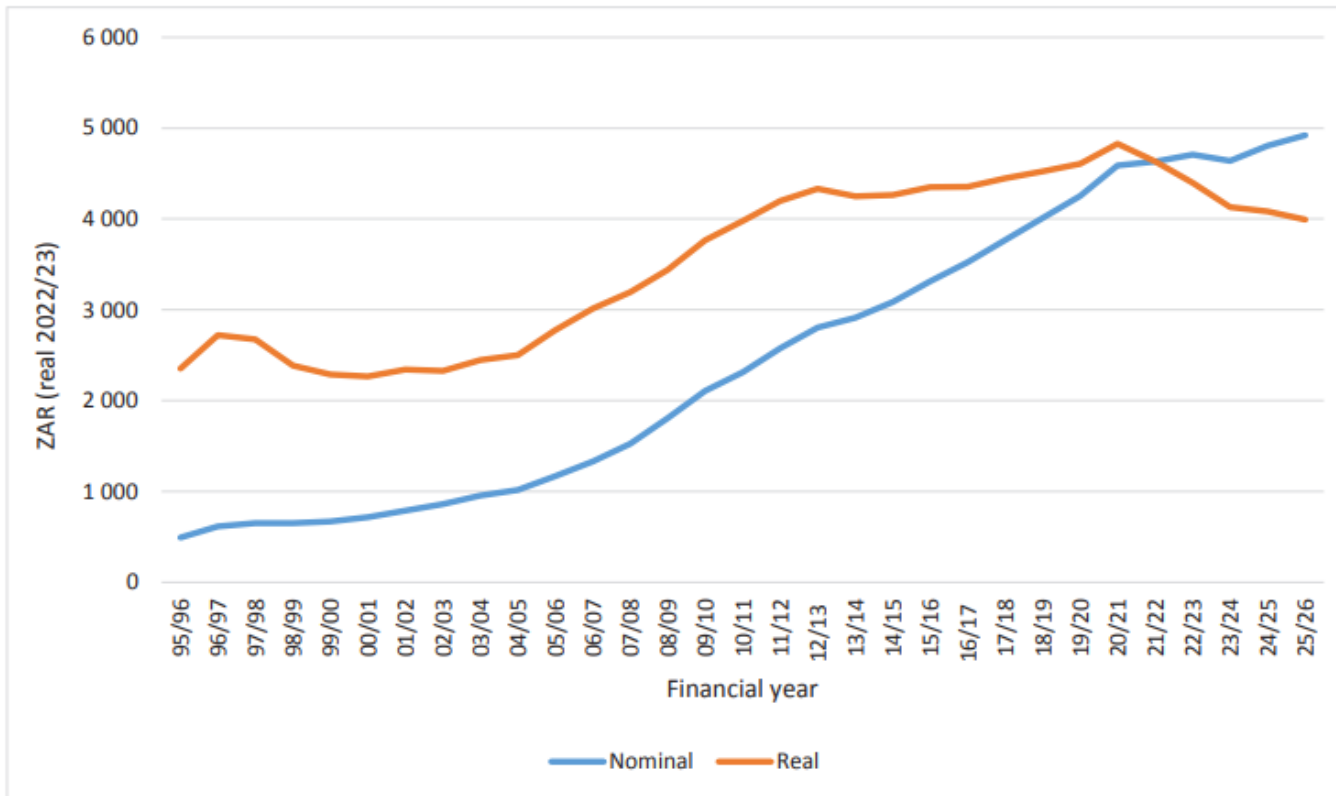
Ekurhuleni
Johannesburg

Are amongst the worst





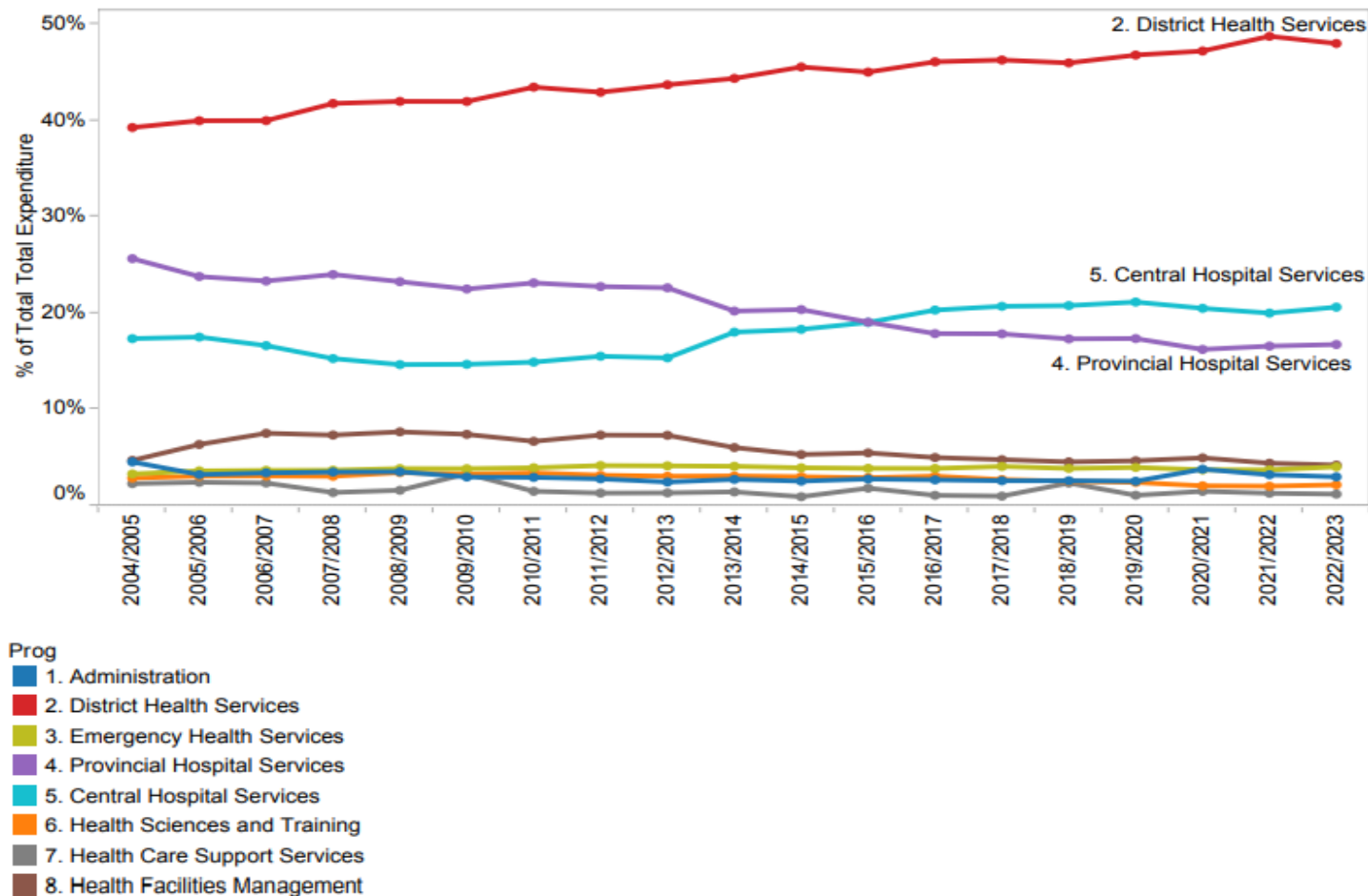
Figure 1: Provincial health expenditure per capita, 1995/96–2025/26



Real public health expenditure (allocations from fiscus) per capita are decreasing since 2019/20

Source: Authors' calculations based on published provincial budgets

Figure 2: Percentage of provincial health expenditure by programme



Maintained clinic services but hospital spending decreasing (hence the bad press)

Source: BAS



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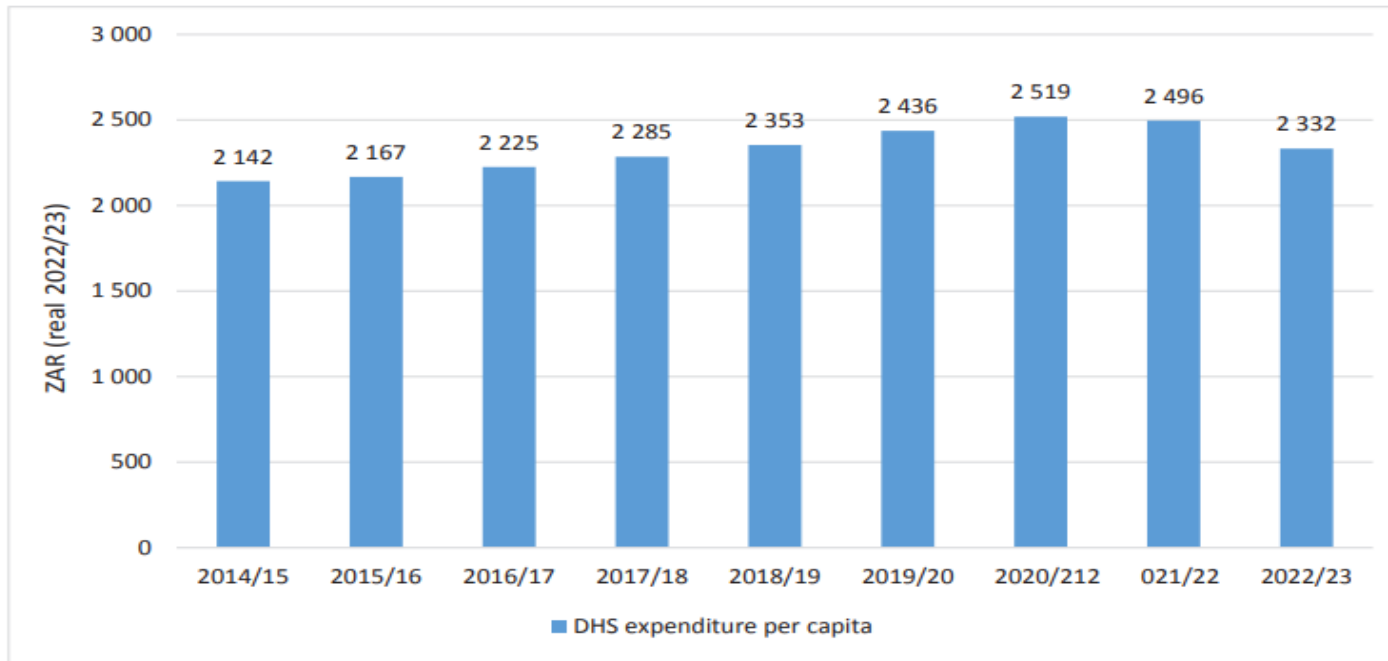
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SECTION A: SERVICE CAPACITY AND ACCESS

Figure 4: Provincial and LG DHS expenditure per capita (uninsured real 2022/23 prices), 2014/15–2022/23



But per capital spending in Primary Health Care is decreasing as the population increases

(Private dependents remain 9m for past >5 years)

Source: BAS



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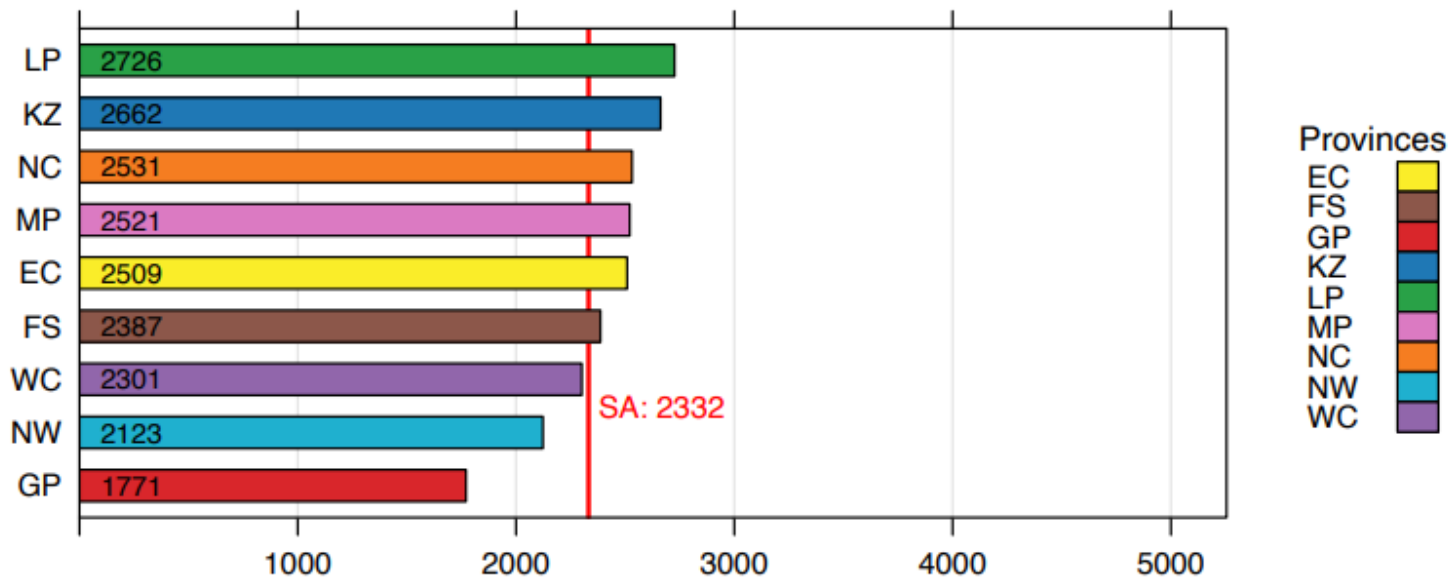
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SECTION A: SERVICE CAPACITY AND ACCESS

Figure 5: Provincial and LG DHS expenditure per capita (uninsured) by province, 2022/23



Rand (real prices) [Source: DHB 2022/23] Strat: I BAS real 2022/23 prices

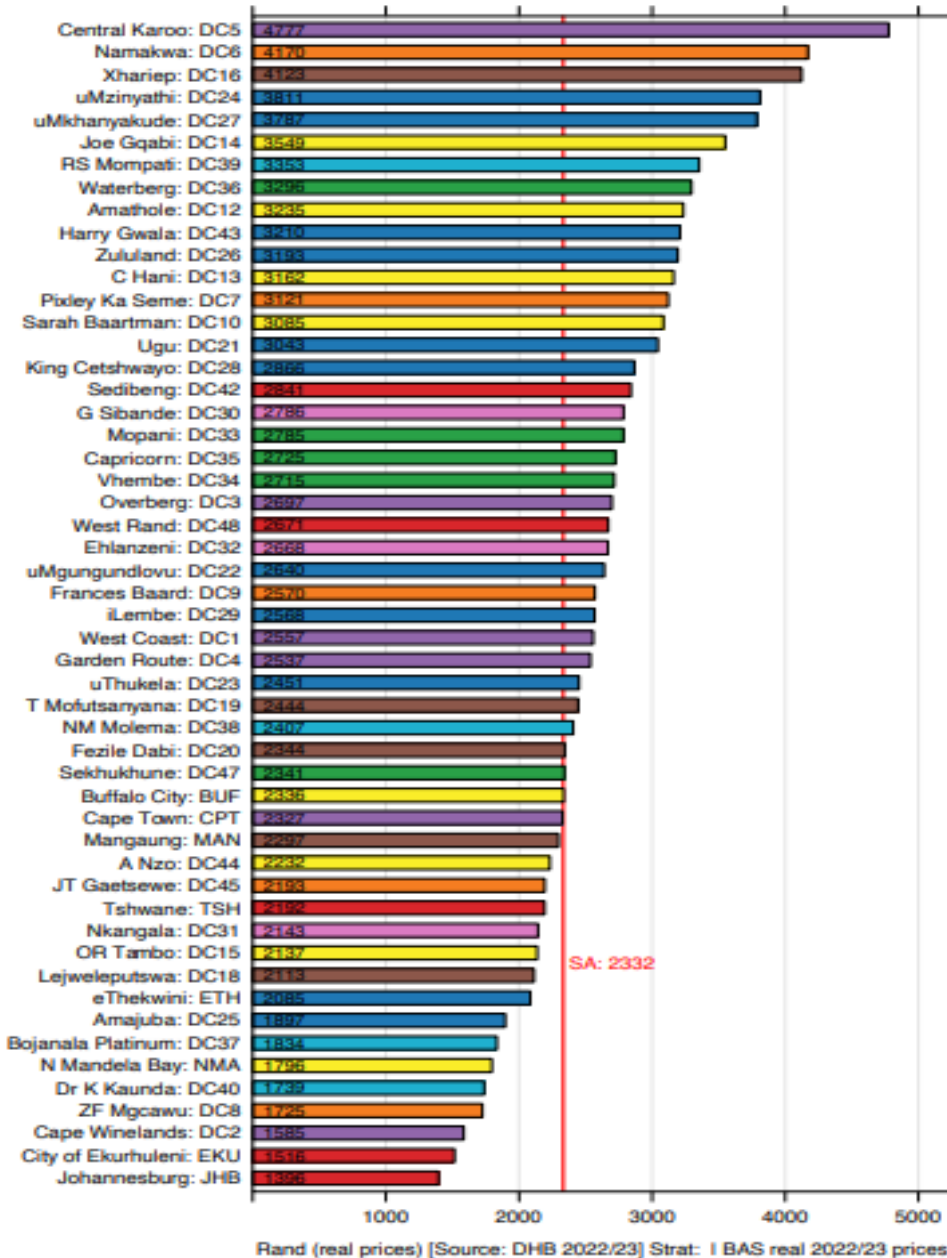


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Figure 6: Provincial and LG DHS expenditure per capita (uninsured) by district, 2022/23



Total PHC spend varies enormously

Inequity three times R1500 to 4500

(distances and density matter for efficiency but this is bad)



Summary of what we need to fix



- There is plenty of money being spent on health care in the country
 - >8,5% of GDP
 - R543 246bn public and private spend (2021/22)
 - Including donors R554 341bn (2021/22)
- Duplication is costly
 - Public 10 DoHs, SAMHS, others, plus 71 medical schemes (311 options)
 - Increases administration, creates perverse incentives, increased fraud, poor coordination of care
- Inequity of access to resources
 - Concentration in private sector
 - Intra-provincial and inter-provincial public inequity of resource allocation
 - Massive quality disharmony
- Poor systems for coordinated data management
 - Difficult to change direction, strategic planning and strategic purchasing



PART 2:

What is NHI all about?

Equity vs equality

If fairness is the goal, equality and equity are two processes through which we can achieve it

- **Equality** simply means everyone is treated the same exact way, regardless of need or any other individual difference
- **Equity** means everyone is provided with what they need to succeed

What is National Health Insurance (NHI)?



- NHI aims to achieve Universal Health Coverage (UHC) for all South Africans
 - “Every person gets the quality health care that they need, when they need, where they need and without incurring financial hardship”
- NHI (National Health Insurance) is a **health financing system** that is designed to pool funds to provide access to quality affordable personal health services for all South Africans, based on their health needs, irrespective of their socio-economic status
- Note:
 - The NHI Bill (Act) goes beyond enabling financing and enhances/amends the National Health Act – but **does not repeal it**
 - The NHI Bill (Act) enhances/amends other health Acts, including the Medical Schemes Act – but does not repeal them

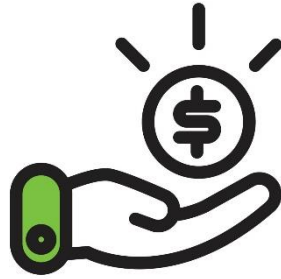
How will NHI work?



- NHI will pool all health resources into **one NHI Fund**
- NHI Fund will **purchase services (benefits)** on behalf of the whole nation from both the public and private health sectors
- The NHI Fund **contracts directly with service providers**
- The public (Users) must register with clinics and doctor/family practitioners to obtain services

- **It is not possible to address one part of the existing health dichotomy without addressing the other**, they are mutually dependent
- The whole system needs a 'face-lift' (revamp)
- There is a need for both systemic change and local changes

Big picture – Purchaser/Provider split

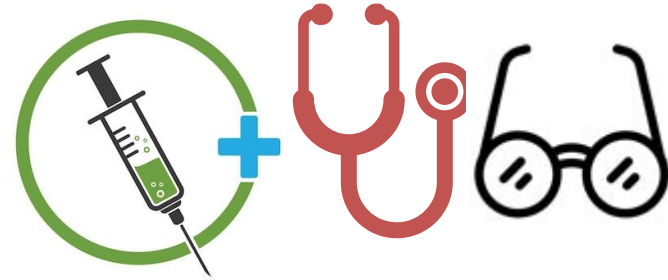


Purchaser of health care

NHI Fund Office

- Public Entity
- Administrative purchasing units

(Private Medical Aids -
complementary)



Providers of health care

Public
Private
PHC/Hospitals
Accreditation



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When will NHI be implemented?



- As soon as the Bill is assented to by the President sections can be proclaimed law (different dates)
- It will be **implemented in two phases** and 'fully implemented' in 2028/29 Financial Year



Many years of concentrated and consistent work



Broken up into manageable phases and parts each of shorter duration



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The NHI Fund



- Will be a Schedule 3A Public Entity (of PFMA)
 - Own Board and administration
 - Government agency but not part of the Public Service
- Must **purchase health care services**, determined by the **Benefits Advisory Committee**
- Chief source of income is **money appropriated annually by Parliament** in order to achieve the purpose of the Act from money collected and in accordance with social solidarity in respect of—
 - general tax revenue, **including the shifting funds** from the provincial equitable share and conditional grants into the Fund;
 - **reallocation of funding for medical scheme tax credits** towards the funding of the National Health Insurance;
 - **payroll tax** (employer and employee); and
 - **surcharge on personal income tax** introduced through a money Bill by the Minister of Finance and earmarked for use by the Fund, subject to section 57

Complementary Cover



- Third party payment for personal health care service **benefits not reimbursed by the Fund**, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act (as amended) or any other voluntary private health insurance fund

S7(4) Treatment must not be funded (*by the NHI Fund*) if a health care service provider demonstrates that—

- (a) no medical necessity exists for the health care service in question;
- (b) no cost-effective intervention exists for the health care service as determined by a health technology assessment; or
- (c) the health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the Minister.



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NHI Fund as purchaser



- The Fund will (progressively) purchase the majority of services (benefits) for all who live in South Africa
 - (s7(4) provides for benefits not to be paid for by the Fund)
- Fund will **purchase health** services for all based on need:
 - **must** purchase health care services, determined by the Benefits Advisory Committee, for the benefit of users
 - Fund must **transfer funds directly** to accredited and contracted central, provincial, regional, specialised and district hospitals (including private hospitals) based on a **global budget or Diagnosis Related Groups**
 - Funds for PHC must be transferred to Contracting Units for Primary Health Care at the sub-district level (**capitation**)
 - Emergency medical services provided by accredited and contracted public and private health care service providers must be reimbursed on a **capped case-based fee** basis with adjustments made for case severity, where necessary
 - Public ambulances services will be reimbursed through the **provincial equitable allocation**



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Accreditation of service providers



- **Health care service providers** and health establishments will be accredited to deliver health care services (benefits) at the appropriate level of care
 - (“Health Establishment” is defined in the National Health Act)
- Proof of **certification** by the Office of Health Standards Compliance (OHSC) and of registration by a health professional Council
- **NHI Fund must ensure that providers meet the needs of users** and must ensure service provider compliance with prescribed specific performance criteria
- Transition is provided for in S39(12) *“The Fund may grant **conditional accreditation** to a health care service provider or health establishment as prescribed by the Minister after consultation with the Office of Health Standards Compliance”*



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PART 3:

What are we doing in NDOH?

Preparation for implementation



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Implications for NDOH (1)

(over and above National Health Act)



NDOH is responsible for the “*national health system*” which is defined in the National Health Act as “*the system within the Republic, whether within the **public or private sector**, in which the individual components are concerned with the financing, provision or delivery of health services*”

S3.(1) The Minister **must**, within the limits of available resources-

(c) **determine the policies and measures** necessary to protect, promote, improve and maintain the health and well-being of the population;

(d) ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic as may be prescribed **after consultation** with the National Health Council

S21. (1:) The Director-General must-

(a) **ensure the implementation of national health policy** in so far as it relates to the national department; and

(b) **issue guidelines** for the implementation of national health policy



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Implications for NDOH (2)

- **S7(1)(f) Central Hospitals**
 - (i) the Minister must request the Minister of Public Service and Administration to consider and assist in the establishment of **central hospitals as national government components** in accordance with section 7(5) of the Public Service Act, 1994 (Proclamation No. 103 of 1994);
 - (ii) where central hospitals are not established as national government components, the Minister must establish or designate central hospitals as organs of state in an appropriate form;
 - (iii) the administration, management, budgeting and governance of central hospitals must be made a **competence of national government**;
 - (iv) the **management of central hospitals must be semi-autonomous** with certain decision-making powers, including control over financial management, human resource management, minor infrastructure, technology, planning and full revenue retention delegated by the national government; and
 - (v) central hospitals **must establish cost centres** responsible for managing business activities and determine the cost drivers at the level where the activities are directed and controlled.
- **S57(4) Objectives that must be achieved in Phase 1 include—**
 - (a) the **migration of central hospitals** that are funded, governed and managed nationally as semi-autonomous entities;



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Implications for NDOH (3)

District Health Management Offices (DHMOs)

- S32. (1) The functions of the Department are outlined in the National Health Act and the Constitution, and include –
 - (e) integrating the annual health plans of the Department and the provincial and district health departments and submitting the integrated health plans to the National Health Council.
- S32. (2)(c) establish District Health Management Offices as government components to manage personal and non-personal health care services.
- S36. A District Health Management Office established as a national government component in terms of section 31A of the National Health Act

S55 Minister may make regulations regarding—

- (i) the functions and powers of a District Health Management Office;

Implications for NDOH (4)



Other Public Health Systems Strengthening

- Remunerative Work Outside of the Public Service (RWOPS)
- Health Establishment Licensing
- Infrastructure upgrading
- Quality improvement initiatives
- National Tertiary Health Services Committee (s57(3)(a))
- National Governing Body on Training and Development (s57(3)(b))
- Ministerial Advisory Committee on Health Care Benefits for National Health Insurance (s57(3)(c))
- Ministerial Advisory Committee on Health Technology Assessment (s57(3)(d))



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NHI Fund and NDOH Functions



The Bill provides for SEVEN main functions of the **Schedule 3A entity**:

1. User & Service Provider Management
2. Health Care Benefits & Provider Payment Design
3. Health Product Procurement
4. Digital Information
5. Risk & Fraud Management
6. NHI Fund (banking and treasury)
7. Governance and Administration, including
 - CEO Office (Incl Board & Committees)
 - Corporate Services
 - Finances (CFO)

Three Advisory committees, Board committees and Technical committees



Entities and Schedules of PFMA



PUBLIC INSTITUTIONS LISTED IN PFMA SCHEDULES 1, 2, 3A, 3B, 3C AND 3D AS AT 14 OCTOBER 2022

SCHEDULE 1

CONSTITUTIONAL INSTITUTIONS

1. Independent Communications Authority of South Africa
2. The Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities
3. The Commission on Gender Equality
4. The Financial and Fiscal Commission
5. The Human Rights Commission
6. The Independent Electoral Commission
7. The Municipal Demarcation Board
8. The Pan South African Language Board
9. The Public Protector of South Africa





MAJOR PUBLIC ENTITIES

1. Air Traffic and Navigation Services Company
2. Airports Company
3. Alexkor Limited
4. Armaments Corporation of South Africa
5. Broadband Infrastructure Company (Pty) Ltd
6. CEF Pty (Ltd)
7. DENEL
8. Development Bank of Southern Africa
9. ESKOM
10. Independent Development Trust
11. Industrial Development Corporation of South Africa Limited
12. Land and Agricultural Bank of South Africa
13. SA Broadcasting Corporation Limited
14. SA Forestry Company Limited
15. SA Nuclear Energy Corporation
16. SA Post Office Limited
17. South African Airways Limited
18. South African Express (Pty) Limited
19. Telkom SA Limited
20. Trans-Caledon Tunnel Authority
21. Transnet Limited

Any subsidiary or entity under the ownership control of the above public entities



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OTHER PUBLIC ENTITIES**Part A: National Public Entities**

1. Accounting Standards Board
2. African Renaissance and International Cooperation Fund
3. Afrikaanse Taalmuseum, Paarl
4. Agrément South Africa
5. Agricultural Research Council
6. AGRISETA
7. Artscape
8. Banking Sector Education and Training Authority
9. Boxing South Africa
10. Brand SA
11. Breede-Gouritz Catchment Management Agency
12. Business Arts of South Africa, Johannesburg
13. Castle Control Board
14. Chemical Industries Education and Training Authority
15. Commission for Conciliation, Mediation & Arbitration
16. Community Schemes Ombud Service
17. Companies and Intellectual Property Commission
18. Companies Tribunal
19. Compensation Fund, including Reserve Fund
20. Competition Board
21. Competition Commission
22. Competition Tribunal
23. Construction Education and Training Authority
24. Construction Industry Development Board
25. Council for Geoscience
26. Council for Medical Schemes
27. Council for the Built Environment (CBE)
28. Council on Higher Education
29. Cross-Border Road Transport Agency
30. Culture, Arts, Tourism, Hospitality and Sports Education and Training Authority (CATHSSETA)
31. Ditsong: Museums of South Africa
32. Education, Training and Development Practices SETA (ETDP)
33. Electricity Distribution Industry Holdings (Pty) Ltd
34. Energy and Water Sector Education and Training Authority (EWSETA)
35. Estate Agency Affairs Board
36. Fibre Processing Manufacturing Sector Education and Training Authority (FPMSETA)
37. Film and Publication Board
38. Financial and Accounting Services SETA (FASSET)
39. Financial Intelligence Centre
40. Financial Sector Conduct Authority
41. Food and Beverages Manufacturing Industry (FOODBEV)
42. Freedom Park Trust
43. Health and Welfare Sector Education and Training Authority
44. Housing Development Agency
45. Human Sciences Research Council
46. Independent Regulatory Board for Auditors
47. Information Systems, Electronics and Telecommunications Technologies Training Authority
48. Ingonyama Trust Board
49. Inkomati-Usuthu Catchment Management Agency
50. Insurance Sector Education and Training Authority
51. International Trade Administration Commission
52. iSimangaliso Wetland Park
53. Iziko Museums of South Africa
54. KwaZulu-Natal Museum
55. Legal Aid South Africa
56. Local Government Education and Training Authority (LGSETA)
57. LUTHULI MUSEUM
58. Manufacturing, Engineering and Related Services Education and Training Authority
59. Marine Living Resources Fund



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60. Market Theatre Foundation
61. Media Development and Diversity Agency
62. Media, Information and Communication Technologies Sector Education and Training Authority (MICTSA)
63. Mine Health & Safety Council
64. Mining Qualifications Authority
65. National Agricultural Marketing Council
66. National Arts Council
67. National Consumer Commission
68. National Consumer Tribunal
69. National Credit Regulator
70. National Development Agency
71. National Economic, Development and Labour Council
72. National Electronic Media Institute of SA
73. National Empowerment Fund
74. National Energy Regulator of South Africa
75. National Film and Video Foundation
76. National Gambling Board of SA
77. National Health Laboratory Service
78. National Heritage Council (NHC)
79. National Home Builders Registration Council—NHBRC
80. National Housing Finance Corporation
81. National Library, Pretoria/Cape Town
82. National Lotteries Commission
83. National Metrology Institute of South Africa
84. National Museum, Bloemfontein
85. National Nuclear Regulator
86. National Regulator for Compulsory Specifications
87. National Research Foundation
88. National Student Financial Aid Scheme
89. National Urban Reconstruction and Housing Agency—NURCHA
90. National Youth Development Agency
91. Nelson Mandela Museum, Umtata
92. Office of Health Standards Compliance
93. Office of the Ombudsman for Financial Services Providers
94. Office of the Pension Funds Adjudicator
95. Office of the Valuer-General
96. Performance Arts Council of the Free State
97. Perishable Products Export Control Board
98. Ports Regulator of South Africa
99. Private Security Industry Regulatory Authority
100. Productivity SA
101. Public Service Sector Education and Training Authority
102. Quality Council for Trades and Occupations (QCTO)
103. Railway Safety Regulator

104. Road Accident Fund
105. Road Traffic Infringement Agency (RTIA)
106. Road Traffic Management Corporation
107. Robben Island Museum, Cape Town
108. Rural Housing Loan Fund
109. SA Civil Aviation Authority
110. SA Council for Educators
111. SA Heritage Resources Agency
112. SA Heritage Resources Agency, Cape Town
113. SA Institute for Drug-free Sport
114. SA Library for the Blind, Grahamstown
115. SA Local Government Association
116. SA Maritime Safety Authority
117. SA Medical Research Council
118. SA National Accreditation System
119. SA National Roads Agency
120. SA Qualifications Authority
121. SA Revenue Service
122. SA Tourism Board
123. Safety and Security Education and Training Authority (SASSEETA)
124. Servcon
125. Services Sector Education and Training Authority
126. Small Enterprise Development Agency (SEDA)
127. South African Diamond and Precious Metals Regulator
128. South African Health Products Regulatory Authority (SAHPRA)
129. South African National Biodiversity Institute (SANBI)
130. South African National Energy Development Institute (SANEDI)
131. South African National Parks
132. South African National Space Agency
133. South African Social Security Agency
134. South African Weather Service
135. Special Investigation Unit
136. State Information Technology Agency
137. State Theatre, Pretoria
138. Technology Innovation Agency
139. The Co-operative Banks Development Agency
140. The National English Literary Museum, Grahamstown
141. The National Radioactive Waste Disposal Institute (NRWDI)
142. The National Skills Fund (NSF)
143. The Playhouse Company, Durban
144. The Social Housing Regulatory Authority (SHRA)
145. Thubelisha Homes
146. Transport Education and Training Authority
147. Umalusi Council for Quality Assurance in General and Further Education and Training
148. uMsonduzi Museum
149. Unemployment Insurance Fund
150. Universal Service and Access Agency of South Africa
151. Universal Service and Access Fund
152. Urban Transport Fund
153. Vrededorf Dome World Heritage Site
154. War Museum of the Boer Republics, Bloemfontein
155. Water Research Commission
156. Wholesale and Retail Sector Education and Training Authority
157. William Humphreys Art Gallery

Any subsidiary or entity under the ownership control of the above public entities



157 Schedule 3A entities

5 under authority of Minister of Health



NHI Branch (precursor to Schedule 3A National Public Entity)



Establish 'nucleus' capacity in NDOH as a Branch

- 16 May 2022: Minister requested the Minister of Public Service and Administration to consider the NHI Branch alone
- 02 June 2022: MPSA approved the ***“Creation of a Transitional Functional Organisational Structure and Post Establishment, wherein the National Health Insurance (NHI) will be incubated as a Special Branch within the National Department of Health until such time that the NHI is listed as a Schedule 3A National Public Entity”***
 - 44 new technical posts were approved
- 09 June 2022: National Treasury approved the ***“Shifting of Funds to Compensation of Employees Budget: National Health Insurance”***
- Contested in court by Solidarity but awarded to Ministers with costs



Transitional Functional NHI Branch



- Internal reorganisation in NDOH with shifting of functions between Branches
- New components added as a result of the MPSA approvals
- In line with preparations for the Fund, NHI Branch (5 Chief Directorates) are now established:
 - CHIEF DIRECTORATE: USER & SERVICE PROVIDER MANAGEMENT
 - CHIEF DIRECTORATE: HEALTH CARE BENEFITS & PROVIDER PAYMENT DESIGN
 - CHIEF DIRECTORATE: HEALTH PRODUCT PROCUREMENT
 - CHIEF DIRECTORATE: HEALTH SYSTEMS DIGITAL INFORMATION
 - CHIEF DIRECTORATE: RISK IDENTIFICATION & FRAUD MANAGEMENT
- Operational budget through reallocation of voted funds plus **Indirect Conditional Grant**
- (**Direct NHI grant** is for Infrastructure and other systems strengthening in provinces)



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PART 4:

How do we transition to NHI?

Capacity to manage plus shifting funds



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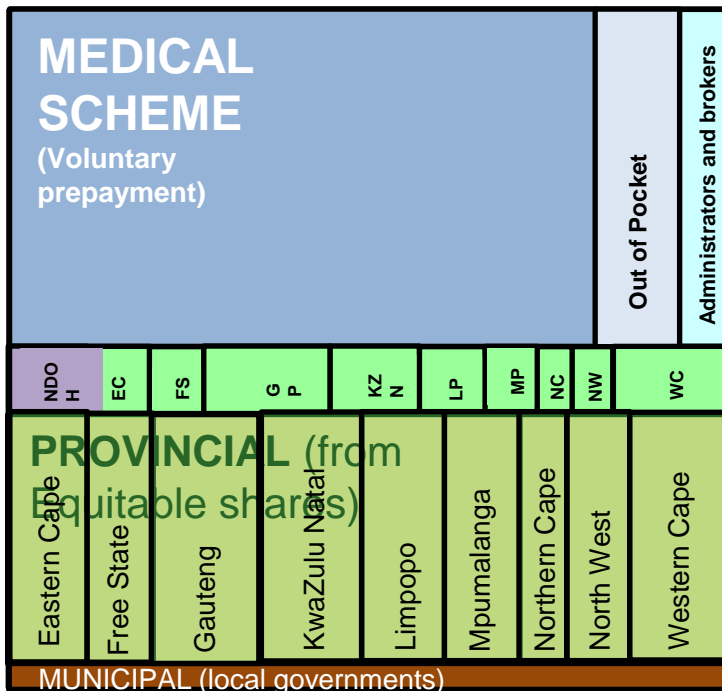


REORGANISE HEALTH SPENDING BY SOURCE – NHI IMPLICATIONS

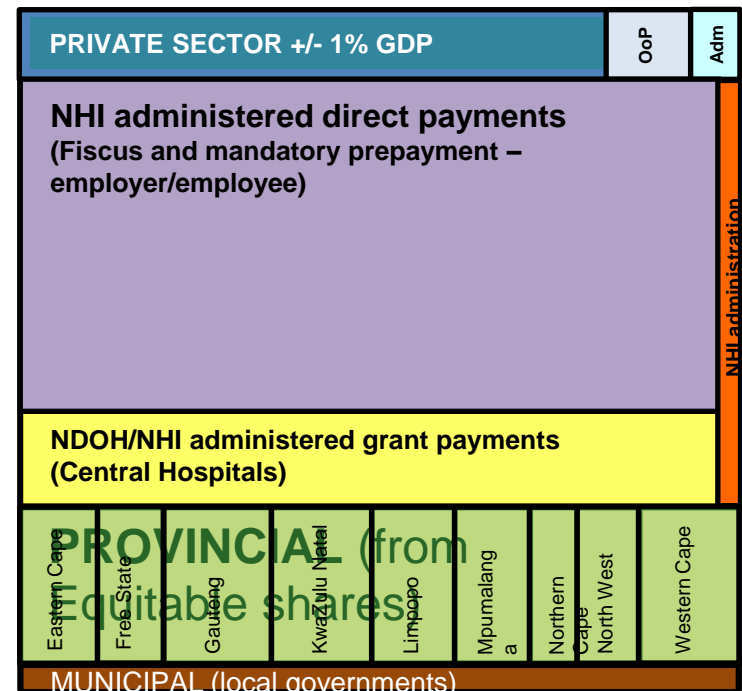


Illustrative on how to monitor and manage the transition of the Funding arrangements?

Health spending 2019



Health spending 2028



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Transitional provisions



- NHI Bill provides for 2 phases
 - 1. 2023 to 2026** – essentially to **establish the governance and administration**
 - A. Proclaim the parts of the Act that allow for a Board and other governance structures (S12 to S30)
 - B. Establish enough administrative capacity to manage essential NHI Fund functions (transitional funding)
 - C. Public sector strengthening
 - D. Private sector regulation
 - E. Funding shifts and costing
 - 2. 2026 to 2028** – continue strengthening provision and start to purchase benefits



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A. Proclaim the parts of the Act that allow for a Board and other governance structures



- President to assent to the Bill
 - May be advisable to obtain ConCourt approval to avoid protracted litigation
- Proclaim s12 to 30
 - Will **not** establish a Schedule 3A entity
 - S9 (entity); S10 (functions) and S11 (powers) will follow once there is a governance structure in place (Board, CEO, Board Committees)
- Governance Regulations (**s12 to 30**) are prepared and ready for legal review and publication, then, based on the regulations:
 - Board must be appointed
 - Board Committees must be appointed
 - Advisory Committees must be appointed
 - CEO must be appointed
 - All must be inducted and orientated, draft foundation policies adopted
- Draft Policies prepared – progress has been made



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B. Establish enough administrative capacity to manage essential NHI Fund functions



- NDOH Branch to be phased out and possibly replaced by PSA s7A NGC
- Section 7A national government component (NGC) as a possible transitional vehicle
 - feasibility to President (s7(5))
- Fund transitional costs: eg:
 - through a World bank loan, and/or
 - redirection of a portion of the tax credits
- Create Corporate Service capability
 - S7A NGC allows for parallel administration (except Internal Audit)
- Strengthen technical capabilities in line clusters
- Establish banking capabilities
 - Only in policy form until NHI Act S11 proclaimed

National Health Information System Requires Data and Information to solve



WHO received services –
WHERE - from WHOM - for
WHAT - at what COST

At ALL times!

Healthcare Encounters

National Health Insurance Bill
ISBN 978-1-4850-0609-1
Section 40

01 USER
(WHO)



Information from Health Patient Registration System (HPRS)

02 FACILITY
(WHERE)



Information from Master Health Facility List (MHFL)

03 CLINICAL PROVIDER
(WHOM)



Information from Provider Registry (PR)

04 HEALTH SERVICE
(WHAT)



EMR: Clinical Diagnostic and Procedural Coding. ICD 11, (ICHI) and (ICF)

05 COST
(HOW MUCH)



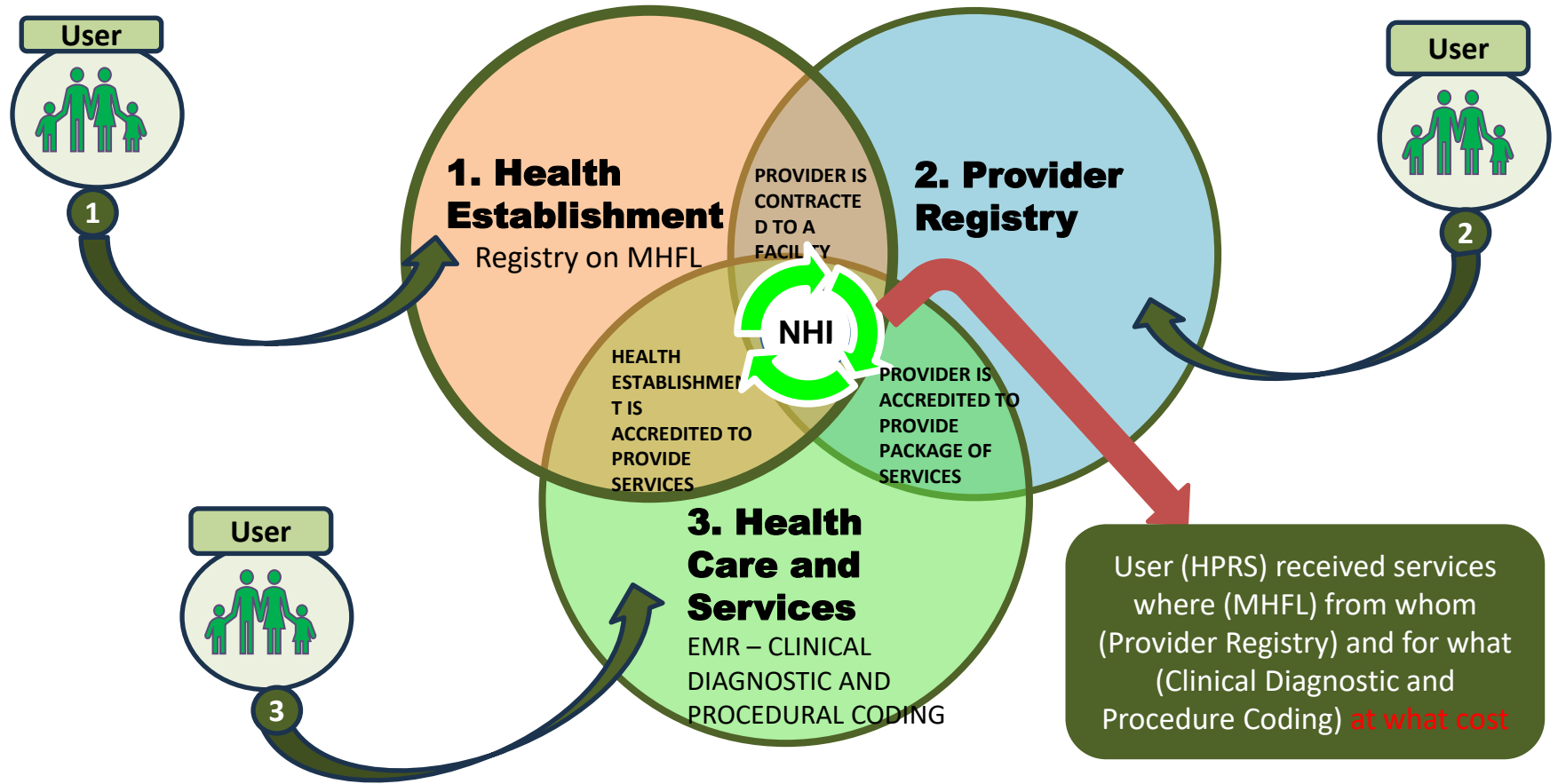
National Department of Health Benefits (NHI Fund)

National Health Information



National Health Insurance Digital Platform

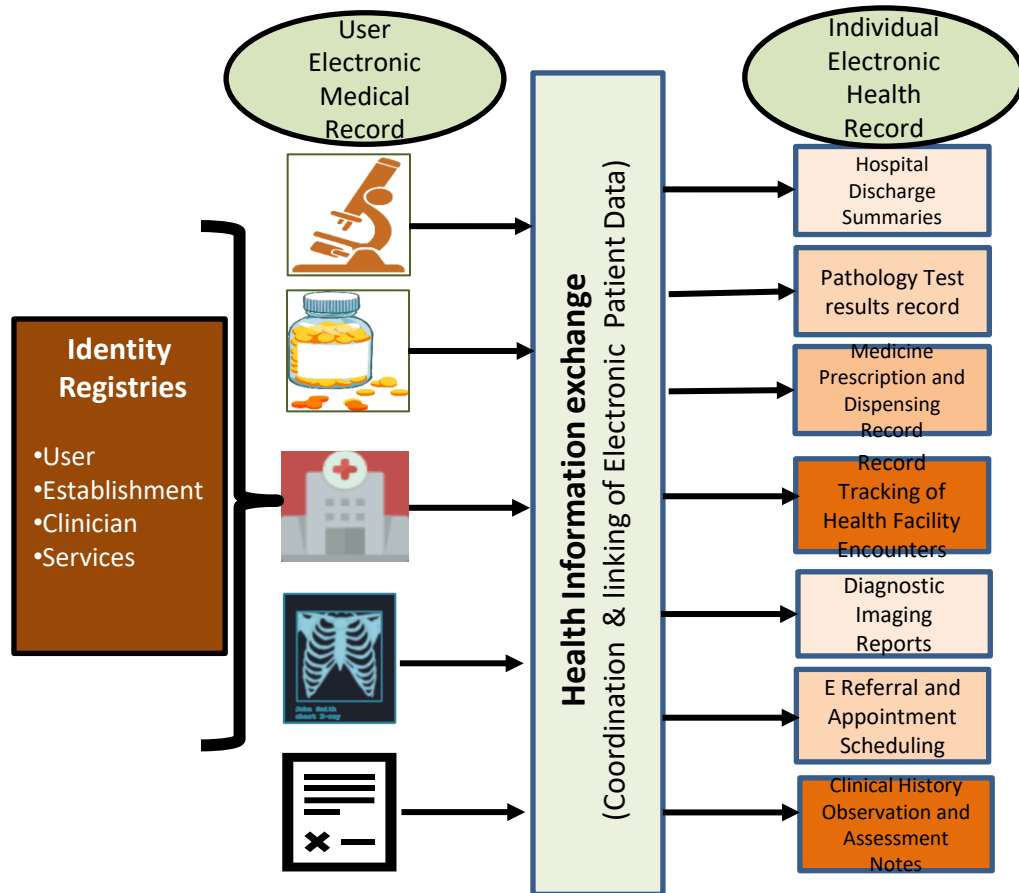




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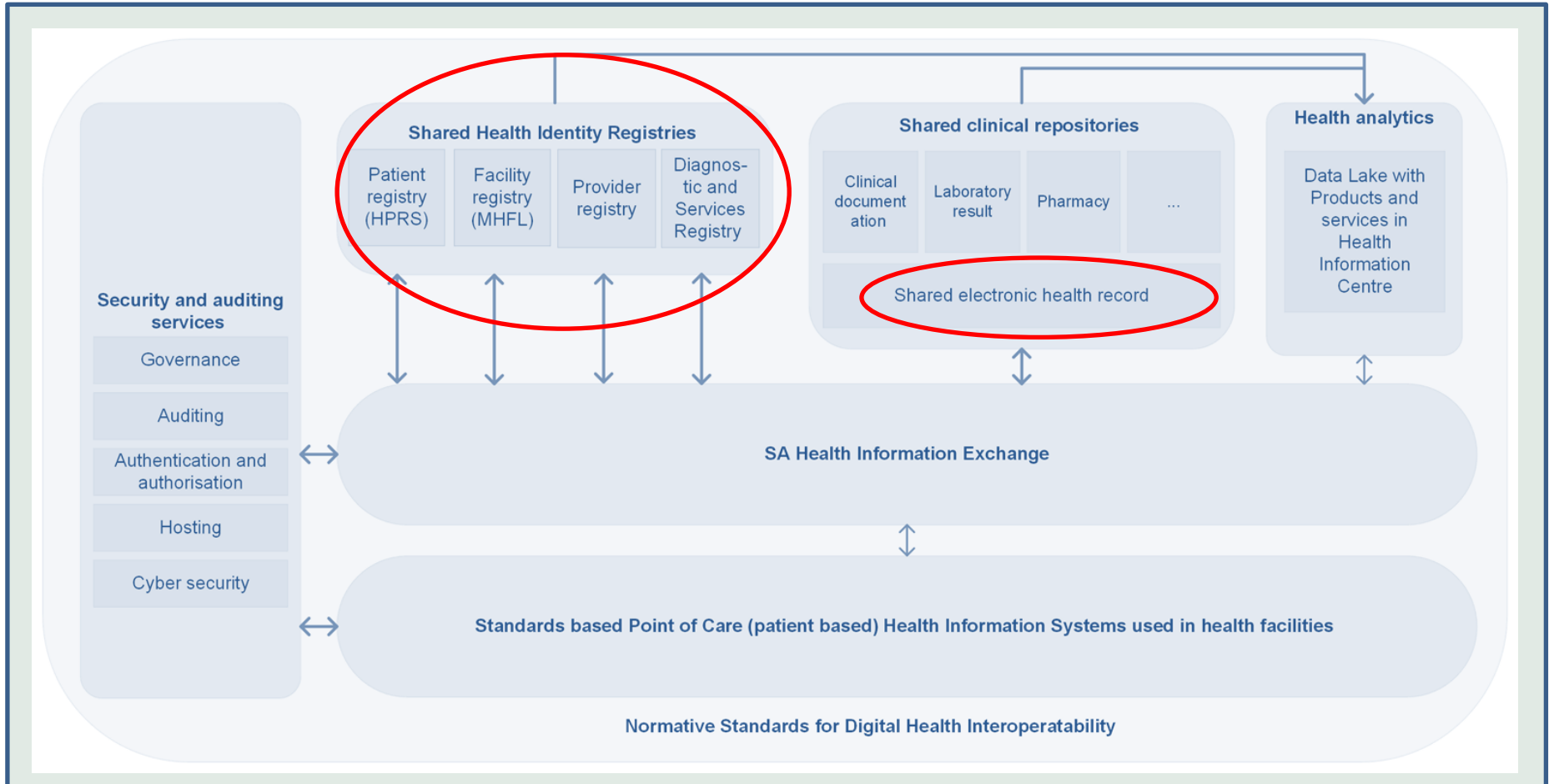
Shared Electronic Health Record



Phase 3
Patients has Access and Owns his/her Electronic Health Record

- Minimum Requirements:**
- Appropriate Computer Hardware at Facilities
 - Broadband connectivity
 - Central Data Repository
 - Information and Data Security
 - Change management – Health Worker Digital Literacy
 - Public Digital Literacy
 - Access Control Management
 - Digital Technical Support at Facility Level

NHI Digital Health Architecture

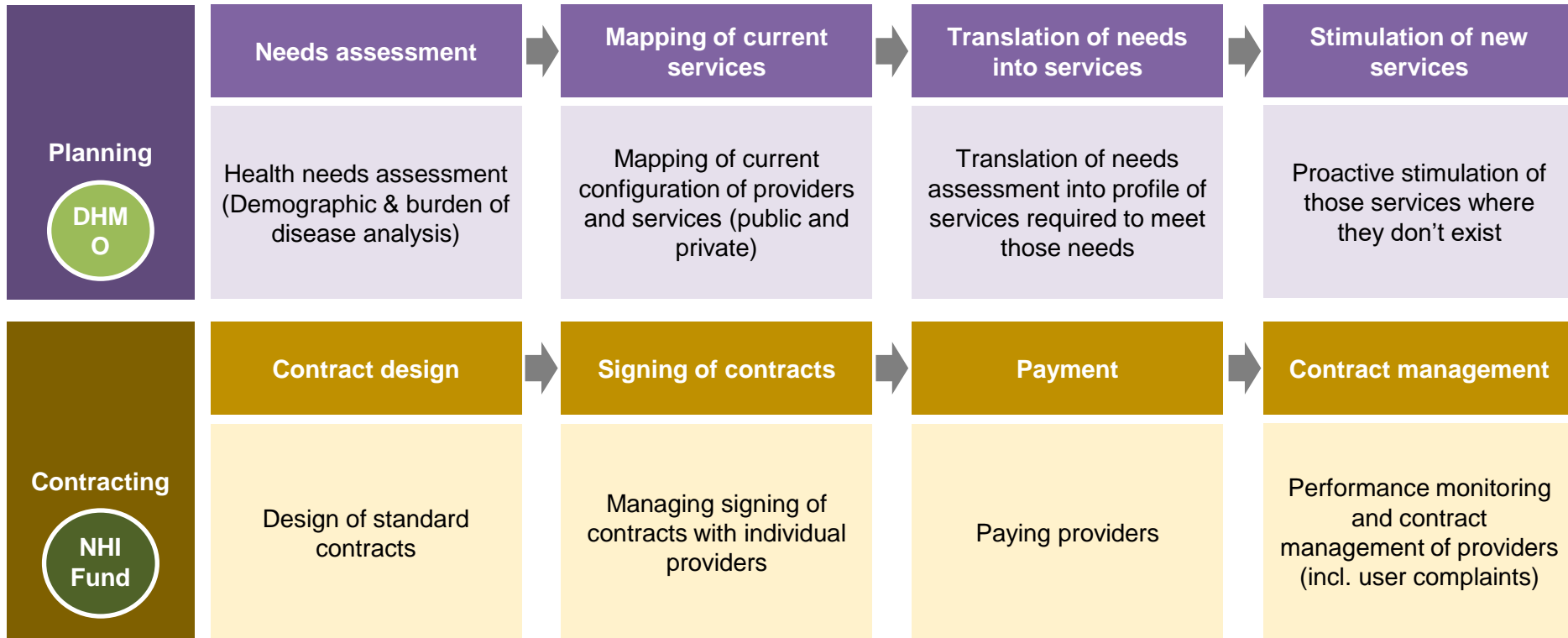


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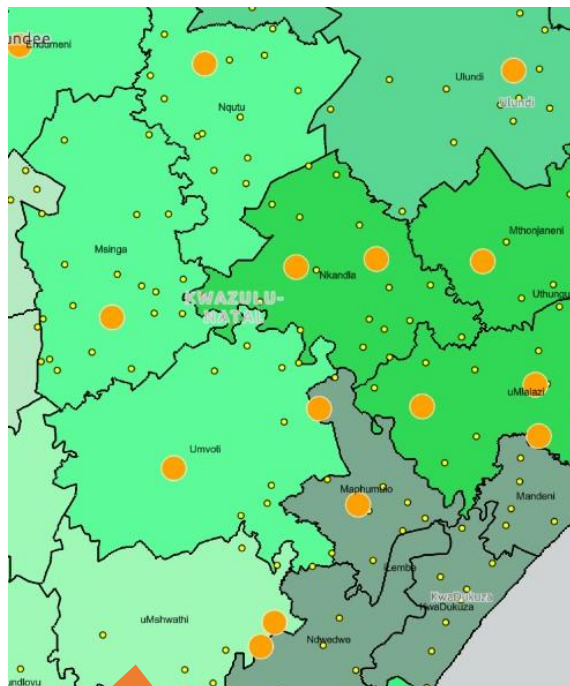
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Strategic purchasing functions for PHC will be split between DHMO and NHI Fund



CUP is principally a demarcated geographical area



Guidance will be developed on how to define CUP boundaries

What a CUP IS...

- CUP is level at which we think about geographical provision of primary health care services for a local population: whether there are sufficient/appropriate services within a geographical area; and whether services are fairly distributed between different geographical areas.
- CUP is a subdivision of a district and for now CUPs will follow subdistrict boundaries.
- Under NHI, budgets for primary health care will be allocated at CUP level. However, this budgeting process will be administrative; all funding will remain at the national level and be paid directly to health care providers by the central NHI Fund.

What a CUP IS NOT...

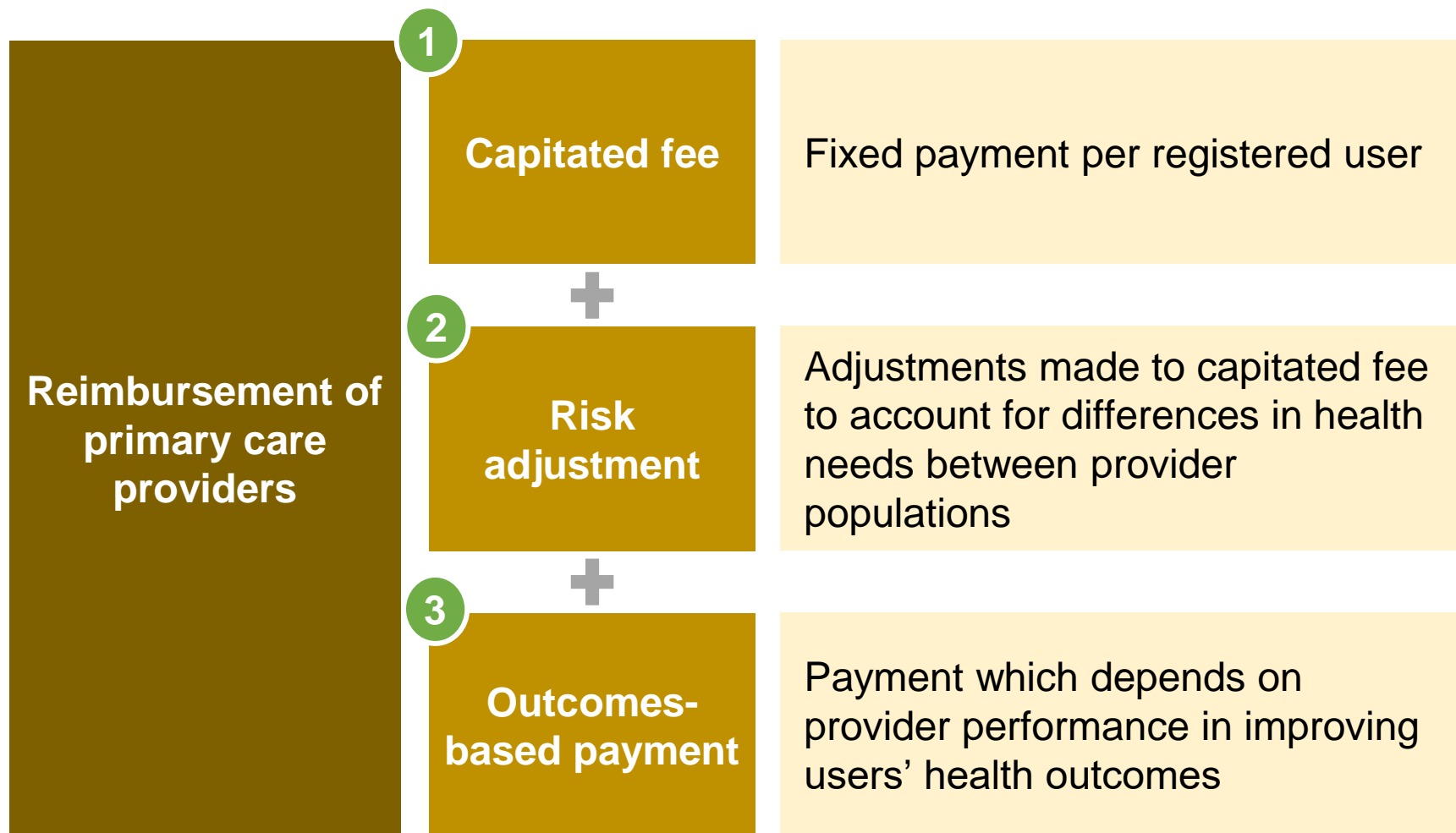
- A CUP is NOT the providers operating in the CUP area. A CUP is also NOT an institution with staff or physical premises.
- However, the NHI Fund may or may not choose to locate staff or suboffices of the Fund at the District or CUP level to facilitate the performance of the Fund's purchasing functions.



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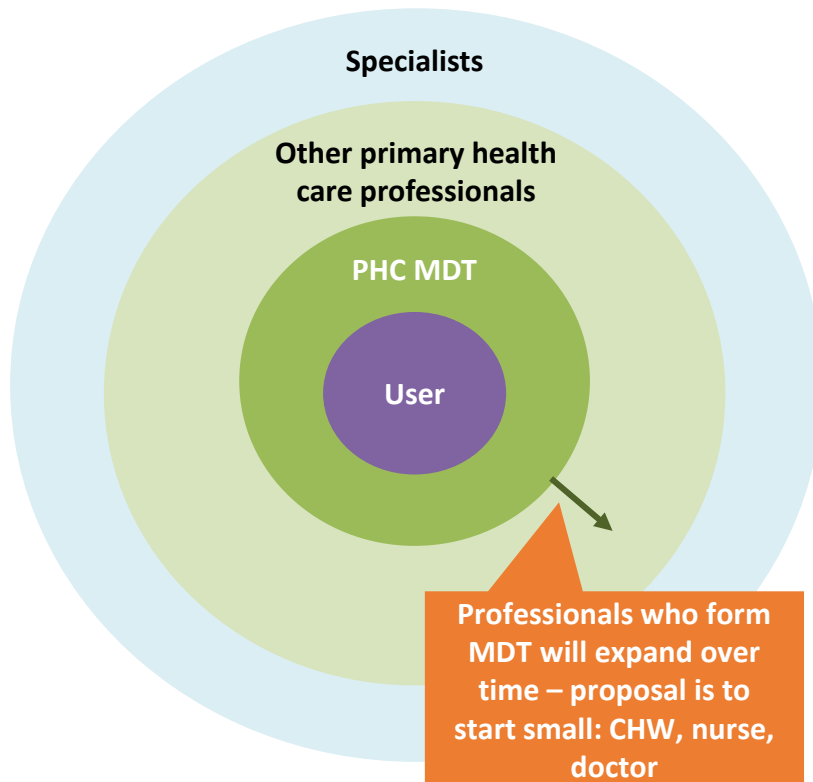
Proposed payment structure



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NHI Bill envisages primary healthcare being provided by multi-disciplinary teams



What is a multi-disciplinary team (MDT)?

- MDT is a group of healthcare professionals with different skills and expertise working together to provide joined-up, patient-centred care
- Members of the team can work together in the same building or work together from different locations as a virtual team

PHC MDT could include...

- WBOT professionals
- Nurse
- Pharmacist
- Clinical associate
- Doctor
- Oral health
- School health teams
- Allied Health Professionals
- ...

MDT reimbursed through team payment, not separate payments to individual professionals



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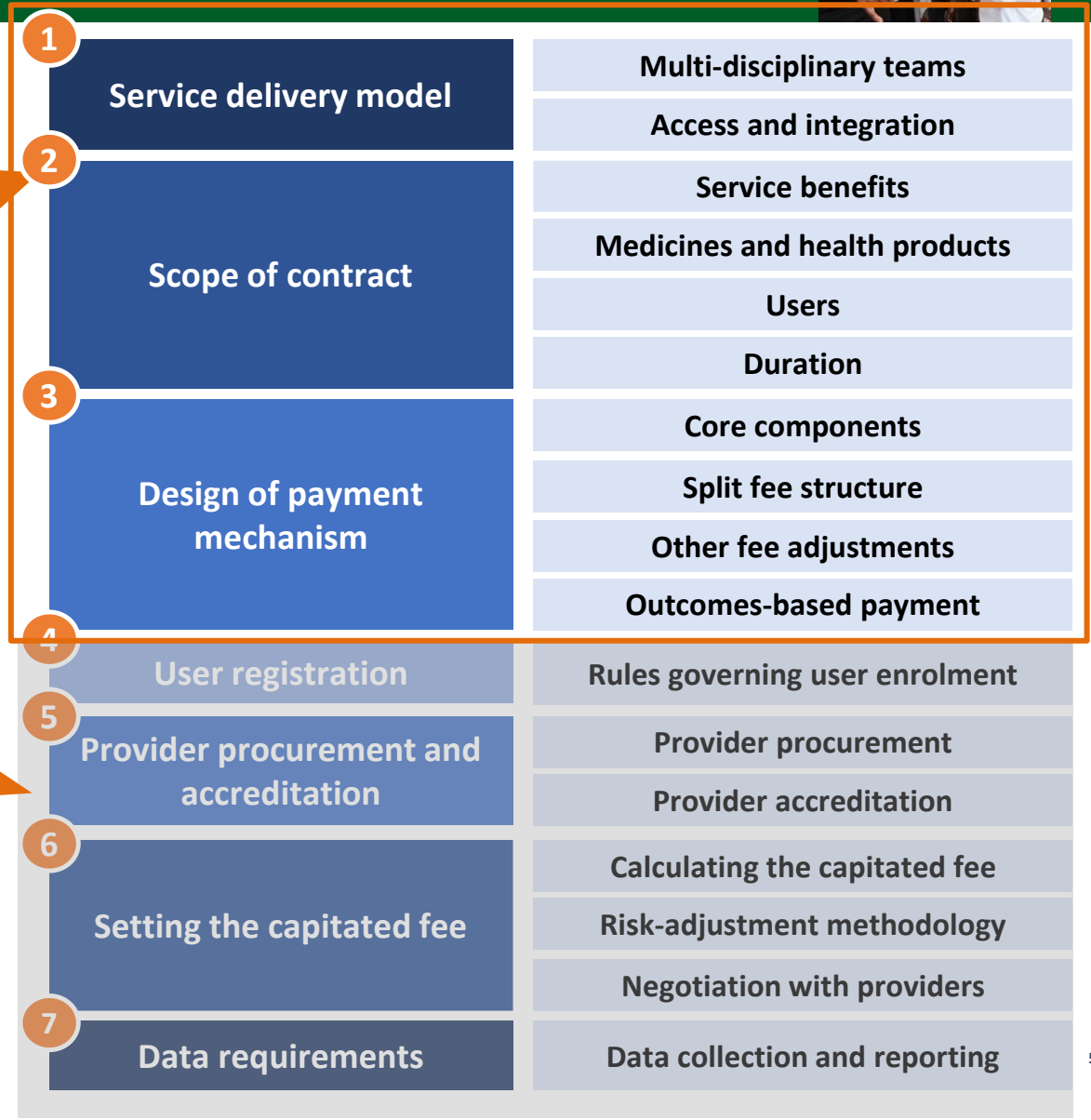
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Developing an outcomes-based capitation contract for PHC



Work in 2023/24 focused on 1, 2 and 3: developing service delivery model, scope of contract and payment mechanism design

Work the NDOH NHI Branch is now busy with for 2024/25: 4, 5, 6 and 7



CONCEPT ACCREDITATION – UNINSPECTED (CONDITIONAL)



Self-assessment completed and uploaded

STAGE ONE

One year

Self-selected peer assessment completed and uploaded

STAGE TWO

Two years

NHI Fund appointed peer assessment completed and uploaded

STAGE THREE

Two years



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CONCEPT ACCREDITATION INSPECTED




UNSATISFACTORY;
ALL NNV'S COMPLIANT
COMMITMENT TO
IMPROVE

LEVEL
ONE 

SATISFACTORY

LEVEL
TWO 

GOOD

LEVEL
THREE 

EXCELLENT **OR** PREV OHSC
INSP; ALL CN REQ MET 12M
AND SA SHOWS EXCELLENT
GRADING
AND
NHI INDICATORS MET TO
AT LEAST 50% OF TARGET

LEVEL
FOUR 

EXCELLENT AND ALL NHI
FUND MONITORING
TARGETS MET

LEVEL
FIVE 



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C. Public sector strengthening



- Central Hospital managerial autonomy
 - Cost centres
 - Boards
 - s7A feasibilities
- District Health Management Offices (DHMOs)
 - Functions
 - Delegations
 - s7A feasibilities
- Human Resources challenges
 - RWOPS, overtime, etc
 - Legality and ethics
 - Terminate – admin process

D. Private sector regulation (HMI recommendations)



- Benefit price regulation
 - Work with CMS and Comp Comm to establish the Multi-Lateral Pricing Forum
- Practice Licensing
 - Take over from BHF (with CMS)
 - Migrate to MHFL and Provider Registry
 - Reg 158 hospital licenses
 - S36 to S40 of NHA (Certificate of Need - CoN)
- Actions on Fraud
 - Health Fraud management Unit (HFMU) to be strengthened and NDOH join
 - Compulsory participation of all nine provinces
 - HSACF actions to be implemented

Multi-Year Funding Plan (cont)



- Time horizon is **multi-year**
 - FY2023/24 to FY2032/33 beyond
- Form of government for transition:
 - NDOH Branch
 - PSA s7A National Government Component (NGC)
 - PFMA Schedule 3A entity

- **Source of funds** for NHI functions

For each there are:

- Statutory changes to effect fund shifts
- Other prerequisites

- NDOH Indirect Conditional Grants
- NDOH Direct Conditional Grants
- PDOH Provincial Equitable Share
- Tax credits
- Medical schemes (Employer contribution public service and entities)
- Medical schemes (Employee contribution)
- Medical schemes (Employer contribution private employer)
- Medical insurance
- Correctional Services
- Workmen's Compensation contributions
- Road Accident Fund levies
- Out of pocket

Conclusion



- NHI Fund does not yet exist, and will not until there is a mandating law (NHI Act)
- Once the law is in place it can be expected that phase 1 (creating the governance and administrative capabilities) will take three years
- Limited paying of services may be possible to test PHC capitation but only if the conditional grant is amended
- During this time costing of the first MTEF period can be done and then annually depending on which sources of funds are shifted and when
- There will be administrative costs in setting up the agency
- Both public and private sectors must be subjected to greater scrutiny to curtail costs, waste, fraud and abuse and to improve quality
- Private sector regulation must be implemented
- Public sector infrastructure investment must be planned and approved nationally to avoid further waste and inequity

THANK YOU



NGIYATHOKOZA!

ro livhuwa!

dankie! ke a leboga!

ENKOSI!

inkomu!

thank you!

udo livhuwa!

ke a leboha!

ngiyabonga!

siyabonqa!



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