School of Public Health (SoPH) of the University of the Western Cape (UWC)
Submission on the NHI White Paper

The proposed launch of the National Health Insurance (NHI) holds the promise of reducing the current health provision inequities and ushering in universal access to health care services, for all the people who live in South Africa. The School of Public Health (SoPH) of the University of the Western Cape (UWC) therefore unequivocally supports the principles of the NHI, of equity, social solidarity, universal access, mandatory prepayment, health care as a public good and the provision of effective comprehensive high quality care in an affordable and efficient manner, paid for via a single NHI Fund. Amalgamating the resources of the public and private health care sectors, is an essential step towards attaining equitable and universal health care services, within the context of a market based financial system. The heralding of the NHI provides the opportunity to strengthen health promotion and prevention and to re-focus curative health services to avoid the twin traps of over-servicing and over- investigation.

The planned primary health care re-orientation policy espoused by the NHI White paper is vital to achieving this and is so important that it is possibly a mandatory precursor to the successful implementation of the NHI. In addition to re-orienting curative health care services away from over-servicing and over- investigation, the laudable attempts by the White Paper to correct the current skewed tilt of providing a large proportion of primary level curative health services by specialists within tertiary and secondary levels of care is refreshing. However to successfully achieve this would require both an improvement in the quality and range of curative services provided by primary level health professionals, and an improvement in the referral and feedback loops between health professionals in the level of care hierarchy. The proposed primary health care re-orientation is also marred by the lack of attention to the socio-economic determinants of health. Although we acknowledge that the primary focus of the NHI is on the provision of the full range of health care services and that ameliorating the socio-economic determinants of health is largely in the domain of other sectors, ignoring them is untenable as they impact on and re-inforce the need for health services by increasing and shaping the burden of disease. The NHI simply must extend its influence to working pro-actively and collaboratively with other sectors to address them.

While the national health department and all champions of the NHI have our whole-hearted support, there will be many in direct opposition to it who will seek to undermine it and prevent its fruition. Resistance is likely to emerge from several quarters. It is likely that those who currently exclusively use private sector health services will be concerned that with the sharing of private and public sector resources within the NHI, their access to health services will decrease, and that the quality and timeliness of health care services will be significantly reduced, possibly to the point that they can no longer be assured of good health care when they need it. This concern then provides ideal breeding ground for

opposition to the NHI to grow in. Preventing and minimising this likely opposition would then require the NHI to provide the same or better quality health services in as convenient and timely a manner, or even in a more convenient and timely manner, as is currently available within the private sector. Not only should it provide this, but it should communicate that it will do so and provide believable reassurance that it is able to do so. Equally important in preventing resistance would be the constant emphasizing, via broad marketing including social media, the social solidarity role of the NHI and how it would assist their extended family and social circle members who currently might not have access to the private medical care which they enjoy, to also access high quality health care services.

Some private health practitioners may equally be resistant to the NHI as they believe that it might erode their independence on how to manage their patients and where they can practice and probably more importantly, would reduce their income, as the NHI would almost certainly pay less for a particular service than they can currently recover from patients and/or medical aids. These private health practitioners' responses are therefore likely to be a mix of various vociferous opposition activities and rhetoric, as well as the threat of (and possibly even actual) large scale emigration. Similarly private health care consortiums facing potential reductions in profits would react with oppositional propaganda and a threat of disinvestment from the country.

On the flip side are those willing to defend the NHI, which are the majority of people who stand to benefit substantially, with an increase in their overall health, if the NHI is implemented. However ironically, many of them could oppose the NHI, simply because they are not aware of the substantial benefits of the NHI and are lead astray by the propaganda of those opposed to the NHI. This disastrous situation can be prevented by more interactive engagement with the population and the provision of balanced information informing people of the benefits of the NHI in an easily comprehensible manner. Private health practitioners and private health care consortiums should be engaged with as well, to convince then that what they lose due to decreased remuneration per patient, can be made up by increasing their patient numbers.

A serious commitment to information provision consultations, and a thorough around the country engagement at community and other levels needs to be instituted, before the White paper is translated into a bill. In particular, communities through health committees, hospital boards, civic organisations and civil society groups, need to know the basic tenets of the NHI plan, so that they can be well informed to support its spirit and content. A database of organizations to work with, proactive plans and timeframes should be drawn up to do this.

In the desire to support the implementation of the NHI and the acknowledgement of the difficulties it will face, we at SoPH UWC feel that the following aspects of the NHI White Paper requires strengthening and we offer below our constructive suggestions for improvements.

No.	Sections in NHI White Paper	Comments	Recommendations
1	Not yet addressed in the White Paper.	**Communication and active partnering with stakeholders and the general public.** It is our experience that very few people within the general population know about the proposed NHI, that even fewer know of the existence of the NHI White paper and even less are familiar with the contents in the White paper. While many health services providers are aware of the NHI White paper, knowledge of and engagement with its contents has been minimal. We note that the National Department of Health has produced summary pamphlets explaining the proposed NHI in simple and clear terms, however this does not seem to have increased the reach of or engagement with the White Paper. It is clear therefore that to obtain high levels of support for the NHI a much greater degree of 'buy in' needs to be garnered from key stakeholders (possibly provincial, district and local health departments; trade unions; health professional bodies; academic institutions; medical schemes; private sector health consortiums; public hospital boards, health committees; and civil society organisations) who could then through their membership and links with the general population increase knowledge of an engagement with the NHI. This will aloe a wide range of people to voice any concerns they have and make constructive suggestions in a far more interactive manner than a passive one-off commentary on the White Paper. A wider range of active and interactive consultation and partnering with a diverse range of stakeholders, including most importantly the general public, to garner support for and defence of the NHI (though not uncritically) will dramatically improve the chances of adoption and smooth implementation of the NHI.	A specific mechanism and process of ongoing stakeholder involvement, engagement and interaction needs to be instituted, to assist with popularizing, defending and implementing the NHI throughout its various phases. Who the stakeholders are and how each will be engaged needs to be established and some initial suggestions on this issue are listed in the 'comments' section. This process of engagement must be open to revision as the plan for implementing the NHI proceeds and unfolds. This process must also be accompanied by public and timely access to information: on the progress of implementation, and on the contracting and performance of providers.
2	Para 54 Para 117 - 123	**Health care services for all** The White paper proposes that refugees, asylum seekers, foreign	The spirit of internationalism and constitutional rights protection of poorer economic migrants who are

		nationals (commonly called ‘illegal residents’) and temporary residents be excluded from the NHI. Clearly these groups of people despite not being citizens of South Africa, have a right, as humans, to health care services. They also contribute substantially to growing the economy of the country and hence indirectly via economic activity and directly via value-added tax and income tax, contribute to the fiscus, from which the bulk of the funding for the NHI will be derived. Hence denying them access to services, the financing of which they have contributed to, is quite immoral. Additionally, given the numbers of people involved and their obvious current and future needs for health care services, this proposal is clearly unworkable, as the constitution of South Africa states in section 27 that: “No one may be refused emergency medical treatment”. This means that if people are denied regular basic clinic and hospital outpatient services, they will simply access emergency services instead, thereby further clogging already over-burdened emergency services with patients who would more effectively and efficiently be catered for via clinic and hospital outpatient services. They would clog emergency services by attending even when it is not an emergency and also in many cases they would present with very serious emergencies, due to their condition having worsened precisely as a result of a lack of basic health services. The non-emergency cases would prevent the real emergencies from being attended to timeously and they would eventually later return as real emergencies themselves, due to a lack of continuity of care as a result of receiving care at disparate emergency centres. The real emergencies are likely to have very complicated problems all of which could probably have been prevented with basic primary care. Hence excluding these people from the NHI will actually result in an increasing magnitude and severity of the burden of disease for a large group of people and will ultimately result in the collapse of emergency services, which then threatens the health of everyone.	undocumented, temporary residents, refugees and asylum seekers (in the case of the latter beyond the limited services offered in the current proposals) needs to be upheld. It must be made clear that no health care services will be denied to these people if they cannot pay for them. The implementation of this needs to be monitored, and a complaints procedure set up in a way that it is likely to be effectively used. This should be run and monitored by an independent institution such as the human rights commission and the information made publically available. Alternatively and more simply, why not just include all people living and working in South Africa within the NHI. The NHI would then cover everyone except tourists and foreign students. Procedures for issuing people without any documents, with NHI cards, would then have to be established.

		In addition, not providing access to treatment for infectious diseases such as TB, HIV and STIs in the primary health care system, will have significant public health externalities, resulting in a burgeoning in incidence and prevalence of these and other infectious diseases, that are clearly not in the collective interest.	
3	Paras 161- 181	**NHI Pilot District sites** To prepare for the advent of the NHI pilot districts were established, but it is unclear what is happening and has happened in the NHI pilot sites to date. The processes of extending lessons to non-pilot sites is also unclear. In addition, whilst it was an eminently sensible idea to establish pilot sites, we note that there appears to be insufficient integration with these and other new programmes and initiatives that have been operating in these sites. For example, PHC-Re-engineering initiatives like the WBOTs and the Ideal Clinics initiative seem to be moving in parallel (to the main NHI activities) in the pilot sites. How is such a vertical approach going to be avoided in a future NHI?	Whatever pilot site data is available needs to be analysed and made available for public comment and the strengths and weaknesses that have emerged from the pilots and the lessons learned should to be built into the planning for the immediate future of the NHI.
4	Para 188 Para 327	**Socio-economic determinants of health and the National Health Commission** The NHI White paper focusses purely on health care services and the right to health care services rather than on health and the right to health. While the focus of the NHI should clearly be on health care services it would be a mistake to attend to it in isolation form the socio-economic determinants of health. Indeed while the lack of adequate quality health care services is a key socio-economic determinant of health, other socio-economic determinants such as income, employment, education, water, sanitation, housing, public transport, air pollution and nutrition are probably more important determinants of health. They would of course besides affecting health have a huge impact on the need for promotive, preventive and curative health care services. Neither acknowledging them nor interacting with them risks the NHI becoming a huge vertical health programme existing in a silo that ignores overall health and	It is noted that in paragraph 188 the National Health Commission is mandated to address health promotion and disease prevention and that in paragraph 327 it will exercise governance over the NHI Fund. T The role of the National Health Commission should be expanded to include efforts to ameliorate the socio-economic determinants of health by engaging collaboratively with all relevant government departments, academic institutions and civil society organisations. The National Health Commission should be mandated to provide clear practical steps to be taken address the social determinants of health including who would implement which steps and how they would do so. The roles of cadres involved needs to be specified within n

		wellbeing, which is surely the reason for its existence in the first place. We note the National Department of Health's efforts to reduce tobacco consumption via taxing tobacco products and banning advertising and the proposed tax on sugary drinks, however these seem not to be linked to the NHI in any way, except for a brief mention of a proposed National Health Commission in paragraph 188 and that it would address health promotion and disease prevention. However how the National Health Commission address health promotion and disease prevention and what its ambit would be is not mentioned and hence it is unclear what it will do. Clearly it should work collaboratively with relevant stakeholders to ensure that the socio-economic determinants of heath are comprehensively addressed.	each area and specifically the resources required and devoted to implementing the steps need to be specified and provided for.
5	Paras 129 - 131 Para 158 Paras 163 -168 Para 188	**Health promotion and ill-health prevention** Health promotion and ill-health prevention activities are mentioned in a few scattered parts of the White paper but with very little substantive comments on how they will actually be provided within the framework of the NHI. It is therefore not clear how South Africans will genuinely be able to gain access to the much-needed promotive and preventive services along with the regular curative, rehabilitative and palliative services – without the first two still remaining more of a good idea on paper rather than being provided for in practice. The establishment and expansion of WBPHCOTs is addressed and some data on their activities are provided but this data is too sparse, patchy and incompletely analysed to be helpful. In particular what health promotion and prevention activities WBPHCOTs should be undertaking compared to what they are providing needs to be reflected upon and measures to close the gap implemented. This is an activity which would overlap with the functions of the National Health Commission (paragraph 188) and the NHI Benefits Advisory Committee (paragraph 130).	Health promotion and ill-health prevention services need to be specified and their implementation and ongoing evaluation of implementation documented in terms of both downstream and upstream impact over time. This should be done by agreement between the NHI Benefits Advisory Committee and the National Health Commission.
6	Para 125	**The NHI basic package of care**	The NHI Benefits Advisory Committee must be

	Paras 129 - 136 Paras 139 - 144 Para 415	While the NHI comments on and promises that a comprehensive set of health care services, which will be updated periodically in line with new evidence, will be provided, it is astonishingly unclear on what actual services will be provided. It also seems to leave this critical task of establishing the NHI package of services to the NHI Benefits Advisory Committee. However it is unclear what this committee is and whether it has been constituted yet or when it will be constituted, who will be represented on it and within what timeframe it will decide on the NHI package of services. Clearly it is vital that this committee is fully representative of the beneficiaries of the NHI as well as the providers of services within the NHI, in order to arrive at a realistic assessment of needed services that can be provided within the ambit of financial, human resource and service provision logistics constraints. Even more worrying is that in the preparation for implementation of the NHI, via the phased implementation plan, the NHI Benefits Advisory Committee does not feature at all. There is no mention of when and how it will be constituted (is it in existence already?) nor by when and how it will decide on the NHI package of services. Paragraph 415 provides for the establishment of various bodies during phase 1 of the implementation but the NHI Benefits Advisory Committee is not one of them. Knowing what the NHI package of services will be is absolutely crucial to obtaining support for the NHI from the general population, public sector health staff and the private health sector. **Uncertainty about the NHI package of services is the key factor preventing people from fully embracing the NHI.** Keeping everyone in the dark is therefore highly counter-productive. Defining the NHI package of services is something that simply must be attended to with great urgency and attended to in a highly collaborative and inclusive manner. This is NOT something that can be left to a technical team.	constituted post haste (if not already in place) and should be representative of the beneficiaries of the NHI as well as the providers of services within the NHI. It should be provided with the necessary technical support and critical area expertise, financially and logistically capacitated to commence functions and rapidly deployed to establish a comprehensive fully detailed NHI package of services. This should be done within a tight timeframe so that it is accomplished rapidly. The agreed upon comprehensive NHI package of services should then be widely communicated and active widespread engagement processes need to be established to receive feedback on it from all quarters.
7	Paras 225 - 230	**Human Resource requirements for the NHI** While there has been great thought put into the financing of the	A detailed human resource provisioning plan, covering basic undergraduate training of various cadres of staff,

		NHI, the same cannot be said for the human resource element. This is surprising as provision of health care is a highly labour intensive process and moreover it requires skilled labour, and more importantly it requires a large variety of highly skilled labour. Thinking through and providing answers to the effective human resourcing of the NHI, is therefore vital. Obviously human resource provisioning ties in intimately with the NHI package of services, as sufficient numbers and cadres of staff would be required to ensure that the full package of services can be provided to everyone. This is imperative as currently there is no mention of some health cadres, e.g. dieticians, making one wonder how key nutrition related preventive care services would be provided. In addition, the current training of health professionals is poorly oriented to the needs of the NHI, and approaches to the development of mid-level cadres are ad hoc and uneven. Finally the implications and tensions of integrating private sector and the public sector human resources within the NHI would have to be resolved.	recruitment, deployment, ongoing education and training, mentoring, retention and monitoring, should be attached to the White Paper and should be taken careful cognisance of when developing the NHI package of services, with which it should be fully integrated.
8	Para 187	**The role and capacity of the District Health Management Offices** Health systems that achieve good health outcomes invest heavily in the base of their health system, in primary health and community based services and in strong district health systems. The NHI is relatively silent on the extent of decentralized decision-making, and size and functions of the DHMO and there is the danger that functions will be excessively centralized (see point below). Provided with appropriate frameworks, capacity, and support and oversight from other levels, the District Health Management Offices are best placed to manage the purchase of health services within their jurisdiction.	The DHMO needs to be sufficiently capacitated to enable coordination and oversight of provision, maintain a comprehensive orientation (personal and public health) to health services and ensure that the fundamental values of NHI – equity, solidarity and universality - are safeguarded. The DHMO should ideally be the agency responsible for purchasing district health services. It needs to engage with appropriately constituted governance structures with sufficient authority.
9	Paras 190-212	**Disempowerment of the provincial health departments** It is noted that the provinces are ‘disempowered’ in the process of the establishment of the NHI as the proposed district health authorities assume prominence in the provision of primary and	The reasoning behind the approach of side-lining provincial health departments should be made transparent, so that greater understanding of the view and meaningful discussion of the merits and demerits of

		secondary health services and the national health department assumes responsibility for tertiary and specialised hospitals. While several provincial health departments have functioned poorly in the past, it is unclear why there seems to be an imperative that provincial health departments should be side-lined and relegated to providing ambulance services and possibly environmental health services, rather than supported to perform optimally. Side-lining provincial health departments while district health authorities are still being established and unlikely to be fully functional, seems reckless. Similarly the national health department, which has hitherto had mainly policy development and oversight functions, is unlikely to easily become a sufficiently supportive operational structure within which newly decentralised fledgling self-managed hospitals can be cushioned. Finally continuity of care might be threatened were the provincial layer to rapidly shrink before commensurate maturation of the district health authorities and decentralised hospitals allows fully functionally continuity of care linkages.	the approach can be engaged with.
10	Paras 249- 335	**Financing of the NHI (Operational Expenditure)** How the NHI will be sustainably and affordably financed is one of the key concerns of people. It is therefore encouraging that financing options are dealt with in detail, but a bit worrying that no clear decisions have been made and that despite the obvious depth of investigation in this area, some financing options seem not to have been considered at all. Of critical importance is that the financing mechanisms used to fund the NHI should not be regressive and hence the use of value-added tax (VAT) to finance the NHI should NOT be an option, as it is highly regressive and inequitable. A financial transaction tax would be simple, efficient, progressive, (equitable), transparent and buoyant, thus meeting all the tax design principles espoused by the NHI, yet it is not even mentioned in the financing options!	The NHI should be financed by a combination of a low percentage financial transaction tax, a small but progressively rising increase in income tax and a small increase in company tax. The exact combination of these and the effective tax rates required for each of these needs to be costed in detail. This combination of taxes will ensure sufficient, simple, efficient, progressive (equitable), transparent and buoyant (sustainable) financing of the NHI.

		While company tax is briefly mentioned in paragraphs 272, 279 and 282 it is then not considered as one of the options for financing of the NHI in the White Paper! This seems quite illogical as it also meets all the tax design principles espoused by the NHI. In addition when the NHI takes effect, then the contributions which companies would have made to medical schemes to subsidise staff subscriptions, falls away and companies would effectively pocket this as profit, if some health tax is not instituted to claim these former medical aid contributions for the NHI Fund. Company tax should therefore clearly be one of the means whereby the NHI should be funded. The difficulty of financing the NHI within the current climate of slow economic growth needs to be confronted, as the costing in the White Paper seems to have been done some time ago, as it uses much higher estimates of economic growth rates than those currently obtaining. Using a low percentage financial transaction tax would be one way of ensuring sufficient funds for the NHI, despite a low economic growth rate.	
11		**Financing of the NHI (Capital Expenditure)** At present there is a dearth of health facilities and health staff within rural and peri-urban areas which translates into inequitable access to health care services by people resident there. To rectify this would require that the NHI have a capital budget for the construction, equipping and provisioning of appropriately equipped facilities. However the White Paper does not have any costing of the capital budget required for these essential preparations, except to mention that some funds for the implementation phase could be acquired from medical aid subsidies and presumably some of this income could be spent on capital projects. However even if this is the intention the amounts are clearly too meagre. Besides this catch-up capital investment required for rural and peri-urban communities, there will obviously be an ongoing need	Providing a proper costing of the amount required for the capital budget for the construction, equipping and provisioning of health facilities in currently under-served rural and peri-urban areas is vital for providing universal access to health services in an equitable manner. This budget once costed then clearly needs to be considered within the finance calculations with the same diligence given to that of the operational finances.

		for capital financing both for new facilities in response population growth and to changing population settlement patterns, as well as for regular maintenance and upkeep of existing facilities and equipment.	
12	Paras 176 - 181	**Public and private sector mix of services** The idea of the public sector working with the private sector is not elaborated In terms of their interaction within the system. The shift from the current system to the envisioned one is unclear and integration does not seem to be planned for other than that private sector health practitioners will be contracted by the NHI. There are questions regarding who will be the employer of public sector workers? Will it be the district health authority or the provincial health authority? Will district health authorities be independent economic units? How will they make the public health system made more attractive to entice skilled staff to it? Based on the findings of interaction within the pilot districts, the way in which the private and public sector will work seamlessly together, ensuring continuity of care for the patients, needs to be elaborated in detail and must be subject to revision as the NHI is implemented. The role of general practitioners, specialists and super-specialists in the private sector in transitioning to do some work in the public sector and ultimately employed full-time in the public sector, needs to be detailed. Ideally for ensuring equity and continuity of care the vast majority of staff in the NHI should be located within the public sector. This will not happen until the public sector becomes attractive to both patients and staff.	The following need to be documented in detail: how will private sector staff be attracted to the public sector and specifically what effective incentives will be used to entice them. Similarly details of how the current public sector HR management and governance will be strengthened to cope with an influx of more staff with different styles of work, as well as who the employer will be and how these staff will be managed and held accountable when working in the public sector, needs to be elaborated. Failing the ability to attract significant proportions of private sector staff into the public sector, details of how each level of private sector cadre will interact with those currently in public sector and more importantly how they will be persuaded that it is economically viable for them to attend to NHI patients, also needs to be thought through. In essence the whole integration plan needs to be detailed in full. It needs to be spelled out what the position will be of those private sector personnel not willing to work in the public sector. Will respect to the above, a clear plan for different provinces of the country needs to be detailed, noting inherent attractiveness of certain provinces/districts relative to others and taking into account equity in health personnel and services provision especially between mainly rural and mainly urban provinces/districts.
13	Paras 215– 218 Paras 331-333	**Certification and Accreditation** Certifying ad accrediting facilities is clearly necessary and hence the establishment of the OHSC was an important step towards	The core services of ‘health promotion and prevention’ activities and ‘effective diagnosis and treatment’ should be included in the quality assurance assessment.

		this goal. It is useful that the seven domains for quality assurance are specified in paragraph 216, but the two domains of 'appropriate and effective health promotion and prevention' services to patients' and provision of 'effective diagnosis and treatment' of patients are missing. Since these are (and should be) the essential core functions of health facilities, they should definitely be added in as domains in which quality of care will be assessed. While certification will almost certainly result in a general improvement in the quality of care provided and will ensure a basic minimum level of quality of care at all facilities, it is a double edged sword. The problem is what happens to facilities that aren't certified and accredited? This doesn't seem to be fully interrogated. If a facility is not accredited and thereby is prevented from proving health care services, then what happens to the patients who were utilising that facility. Where do they go then? This would in particular be a serious problem in rural areas where the facility might be the only one within a large geographical area. Clearly even if services are sub-standard they are better than no services at all. Hence facilities that do not meet accreditation minimum standards should not be closed down, but should instead be assisted to function within the acceptable norms.	A plan needs to be in place as to what will happen if services are not certified – what steps will be needed to make them certifiable and what will happen in the meantime. We recommend that facilities should not close if the quality of care they provide is below the minimum level, but that instead the management and staff should be capacitated and supported to improve the quality of care. In addition to mentoring and support, close monitoring of performance, should be instituted until the facility is up to par and has remained at that level or improved even further. Who will provide the mentoring and support needs to be established and it seems that a specific unit for this purpose within the OHSC would allow continuity of assessment and support.
14	Para 126	**Access to private and public sector services** It is unclear who will be able to access private health care services and who will be able to access public services. The White paper only specifies that people will have to access primary care services that are closest to where they reside. This means in effect that if there are private and public services close to where they are then people could register at either. Similarly if there are more than one set of either private or public facilities close by then people should be able to register with any of them. But whether people will have this choice in principle is unclear from the white paper. Also, even if this principle is activated in practice those	Freedom of choice to register at a facility of one's choosing within broad parameters should be allowed e.g. if one lives in Soweto but works in Houghton, then one should be able to register at a facility in either area. The NHI should take into account geographical movements of people especially migrant and seasonal workers and allow them dual registration (perhaps with proportional capitation at each facility).

		living in poorer urban communities and those living in rural communities are unlikely to have any choice as there would in general be only one facility in the immediate area and sometimes there would not be any facility nearby. Additionally the issue of where migrant workers, seasonal workers and students in hostel residence would access services, needs to be clarified. These people would all shift residence for a portion of the year and hence provision needs to be made for them to access services at different locations during various phases of their migrancy. Finally would people who are homeless be able to register wherever they choose to do so.	
15	Para 120	**Practicalities of NHI card implementation** Procedures for obtaining a NHI card are unclear and specify only that it will be done at designated public facilities, hence the preparation for and ability to provide NHI Registration cards for everyone within the allotted timeframe is questionable. Also the problem of providing the NHI card to people without any background documentation due to being foreign nationals or homeless needs to be confronted and solved.	The feasibility of providing such a NHI card and the infrastructure and processes required to successfully accomplish this ought to be considered carefully. Consideration ought to be given to preventing the card from becoming an access barrier to health services, especially in the case of an illegal immigrant who does not want to register out of fear of getting caught– and because of this is then prevented from accessing health services through the NHI.
16	Para 56	**Inequity of health care access in the NHI** As there are vastly fewer health facilities and a far greater staff to population ratio in the rural areas than in the urban areas, and similarly for peri-urban areas compared to urban areas, inequitable access to health services seems predestined to continue under the NHI. This will indeed be the case unless fully staffed and equipped health facilities are rapidly provided in the rural and peri-urban areas. The provision of these facilities services would have to start now and that means that a capital budget (and linked operational budget to be activated once the facility is completed) has to be established and used. Clarity on what rural incentives will be enacted to entice staff to	Fully staffed and equipped health facilities need to be provided in the rural and peri-urban areas. Further clarifications regarding incentives to staff to work in the rural areas are needed.

		rural areas is needed.	
17	Paras 163-164	**Role of CHWs in the NHI** The orientation of the NHI to the primary health care approach and the formation of WBPHCOTs are particularly welcomed as these, if implemented effectively and with sufficient reach, are likely to have a huge impact on improving the health of people in South Africa. Sufficiently widespread deployment of effectively functioning CHWs within the WBPHCOTs is therefore critical, if they are to realise their potential impact. Importantly it must be recognised that currently CHWs throughout the country vary in how they were trained, how they are mentored and supported, in the responsibilities they have, in the number of households they are responsible for (indeed some are only assigned responsibility for individual people in the household rather than the actual household), in the activities they undertake, in the status they are assigned and in the remuneration they receive. Yet the White paper is silent on the recruitment, training, mentoring, deployment, supervision, remuneration, promotion and career path opportunities for CHWs. Surely all these have to be standardised if CHWs are to be effectively deployed. In particular the range of functions that CHWs should engage in (and of course be trained on) including health promotion, ill-heath prevention, basic curative care, home assistance, palliative care and referral criteria should be specified and standardised.	Detailed specifications on what the key functions of CHWs should be and how they should optimally be deployed needs to be enacted. If necessary a detailed needs assessment could be conducted to aid in this process. NHI pilot district information on CHWs should be revisited to assist in identifying the minimum ratio of population to CHW, and the ratio of supervisors to CHWs as well as the required attributes of a supervisor. Importantly when making these decisions one should seek out and consider inputs from CHWs themselves. Uniform conditions of employment with a non-exploitative salary level, standardised training and standardised supervision have to be provided to ensure that CHWs perform optimally.
18	Paras 405 - 427	**Implementation of the NHI** How one takes a well written policy document like this one and transforms it into something that can be implemented is of course the most important challenge. It is therefore very unhelpful that the current phased implementation plan is patchy and vague and several aspects of the NH are not addressed at all. Although implementation is addressed in the White Paper and it is specified in phases, not everything proposed in the paper is addressed in the 3 implementation phases and some things that are addressed aren't sufficiently clear.	A very clear implementation plan is needed for each element within the NHI. For every aspect of the NHI there should be a clear time frame of how it will be phased in. This will instill confidence that the NHI will be phased in seamlessly and it will allow people to determine whether the proposed timeframes are realistic.

		In particular it is unclear how and when the NHI Benefits Advisory Committee (overseeing the decisions on the all-important NHI package of services) will commence; how quality of care will be improved when the work streams to be established do not include a quality of care enhancing stream; and what the National Health Commission due to established in phase 1 will actually do within what timeframe regarding ameliorating the social determinants of health and shepherding health promotion and health prevention activities.	
19	Para 401	**Role of Medical Aids** At present the White paper only allows Medical Aid schemes to cover complementary services?? This is clearly unconstitutional and should be amended. There is no need to regulate what services the medical aids and medical insurance schemes insurance schemes can provide as the default medical services will be the NHI and any services that medical aids and medical insurance schemes cover are overlapping and additive.	Medical aids and medical insurance schemes should be allowed to function and offer cover for whatever type and mix of services they choose to cover. They could cover the same services as the NHI, or they could cover NHI services and additional services, or they could just cover services not covered by the NHI. Those who choose to use medical aids and medical insurance schemes insurance schemes will have to pay subscriptions over and above their NHI contribution.
20		**Private sector profiteering** Passing a plan like the NHI, while well intentioned may provide and opportunity for the private sector to accrue more profit in future as its market for medical aid has been saturated.	A clear, detailed plan needs to be drawn up to minimize potential private sector profiteering.
21	Paras 361-371	**NHI Information system.** The ability of the NHI Fund to develop and operate a huge centralised information system is questionable.	Look at how other similar large scale information systems in other countries were implemented (developed & operated) – and consider the lessons learned by those countries in developing the proposed NHI Information system.
22	Paras 372- 383	**Potential Fraud in the NHI** Although internal NHI fraud mitigation unit that would be pro-active established, is described in admirable detail in the White Paper and a Risk Engine for Fraud Mitigation with several specialised constituent units will be established, given the magnitude of the NHI Fund and the multiple financial interfaces,	Consider utilizing an independent accredited/reputable auditing company to monitor and report back on finance activities in addition to the internal unit and to watch over the internal unit.

		this might not be sufficient protection against the ever present threat of fraud and corruption.	
23	Para 119 – 120 Para 126	**Confidentiality of data on the NHI card** If used correctly and treated confidentially the information on the NHI card could serve as an extremely useful database for service evaluation, policy development and formal research. However the concern around how security and confidentiality of data on the NHI card will be assured, particularly when the data is in the nebulous hard to protect 'cloud', needs to be addressed.	Concern around how security and confidentiality of data on the NHI card will be assured, needs to be carefully thought through and reassuringly addressed in concrete terms.
24	Paras 343-359 Paras 372-383	**Provider Payment Options** All forms of provider payment mechanisms are subject to manipulation. Fee for service results in an over-supply of services and the provision of unnecessary and potentially harmful services as many services have unintended consequences. Similarly capitation payments have their problems with in particular under-servicing being a huge concern as well as and over-referring. DRGs in turn have the problems of inflating the level of severity, under-servicing, rapid discharging of patients and frequent re-admission all of which are clearly deleterious to patients and greatly increase the cost of service provision. Given that there is no silver bullet solution to this thorny problem the pragmatic mix of risk adjusted capitation moderated by performance recognition incentives; DRGS; and case-based fee adjusted for complexity seems a very pragmatic way to address this issue.	Constant vigilance to spot new ways of manipulating payment mechanisms to increase revenue by providers needs to be undertaken. This would of course be data heavy and would probably require a dedicated unit within the Risk Engine for Fraud Mitigation.
25	Para 186	**Role and Responsibilities of Clinic Committees** It is noted that "Functioning Clinic Committees will be established for all PHC facilities" providing "advice", playing "an advocacy role for the communities they represent" and focusing "on public health campaigns in the catchment areas of their respective clinics." We believe that the three roles/responsibilities outlined in this paragraph are too limited and fall short of what has been	There are important governance roles for Clinic Committees that should be included (in addition to three roles currently identified) in Paragraph 186. These include: • providing strategic direction (i.e. shaping the mission, vision, value, policies and programmes of the services and by implication the clinic) by participating in key strategic and operational

		recognized both nationally and internationally as best practice in relation to the principles of citizen or community participation in health and good governance. For example, in 7 of the 9 provinces (i.e. in those provinces where policies for Clinic Committees currently exist) Clinic Committees also play a role in providing strategic direction – by, for example ensuring that the strategic direction and the values of the health facility aligns with the needs of the community. They also have a role in relation to ensuring accountability – by, for example, monitoring the performance of the facility in achieving its targets and in addressing and resolving complaints.	planning processes of the clinic and district; • planning health service delivery, including the identification of community priorities for the attention of the services; • providing oversight and accountability by being involved in the monitoring and evaluation of the quality and responsiveness of the clinic's services and its achievement of its objectives and targets; and • being involved in the resolution of complaints.
26	Para 186	**Guidelines for Clinic Committees** It is noted that "Guidelines have been developed on how these Clinic Committees will be constituted, their responsibilities and how they will function". However, no further details (e.g. a reference / link to these guidelines) is provided. This is disappointing given that citizens, community representatives and organisations involved in advocating for the importance of **a strong** community voice in health and within the health services, would be interested in understanding these guidelines in the context of what is proposed with the **governance** of the NHI.	A suitable reference ought to be given for the Clinic Committee Guidelines (e.g. name of the guidelines, date published, the author etc.) so that interested stakeholders can access these guidelines. The way in which the Clinic Committee Guidelines, noted in Para 186, relate to or will replace the clinic committee guidelines that are currently in place in the majority of the provinces**,** ought to be clarified.
27	Para 213 & 214	**Hospital Boards** Mention is made of hospital boards having a "greater oversight function for improving quality of care, and adherence to national quality standards." There therefore seems to be inconsistency between the powers and functions accorded to Hospital Boards and to Clinic Committees – with the latter being given a weaker mandate and less authority in terms of its governance role.	The inconsistency between powers and functions given to Hospital Boards and to Health Committees ought to be resolved in a way that provides equivalent powers to both of these health facility governance structures. As with the Clinic Committees, guidelines relating to how Hospital Boards are constituted, what their responsibilities are and how they function – including how t**hey relate to Clinic Committees,** ought to be developed in consultation with relevant stakeholders.

		In addition, no motivation is provided as to why the overall purpose and role and the corresponding powers and responsibilities of these 2 governance structures ought to be different – and no reference is made to any equivalent guidelines outlining how they will be "constituted, their responsibilities and how they will function" (as was mentioned in Para 186 for the Clinic Committees).	
28	Para 186 Paras 213- 214 Paras 327-328	**Governance of the NHI** It is noted that a NHI Commission consisting mainly of technical experts, but with "civil society" members as well, is proposed as the governance structure of the NHI Fund. While this composition would probably provide sufficient depth of expertise and will no doubt ensure good evidence based practices form the backbone of decisions, it does not seem to provide even close to representivity of the general population, for whom the NHI Fund is constituted to provide funding for health services for. Surely a more representative structure which includes users of the NHI funded services and providers of those services should be included in and indeed constitute the major voice in the NHI Commission. In particular, as noted above, health committees and hospital boards given their proximity to and representivity of users of the NHI funded health services seem to be ideally situated for governance duties and representatives from them should be included in the NHI Commission. Similarly representatives of health care provider structures such as the district health authorities, provincial health departments, health professional societies and trade unions should have representatives in addition to the envisioned civil society groups. Eligibility criteria of civil society groups should also be clarified, for instance they should ideally be those actively involved within the health sphere.	Membership of the NHI Commission should be enlarged considerably so that it becomes a representative body in addition to a technocratic body and thereby can exercise its governance functions much more holistically ensuring the views of the users and providers of health services are taken full cognisance of. To this end the NHI Commission should ideally be constituted by health committees, hospital boards, district health authorities, provincial health departments, national health department, health professional bodies, health trade unions, health-linked civil society groups and the required technical experts in relevant areas.
29	Para 118-123	**Movement within the country and access to NHI** South Africans migrancy within the country and between countries within Africa has a long history and will continue. Access to health services when travelling is therefore critically important	The minister of Health has repeatedly emphasis the right to health as a human right, regardless of status. We recommend that the policy is explicit about specific the procedures and access to health services with respect to

			internal migrancy. We further believe that, as is the case at present everyone within our borders, regardless of status should enjoy free access to health services within the ambit of the NHI.
30	Para 231	**Medication availability** Medication availability in government pharmacies needs further clarity and detail.	We recommend that the policy details the essential medications and other medical supplies that will be available through government pharmacies and facilities, for which conditions and which unavailable and not covered. There should also be a statement supporting procurement and use of appropriate generic medications, where recommended and non-generics where recommended or only available. Processes should be outlined to ensure these are available. In addition, there should be a statement on ensuring there are no medication stock-outs in government pharmacies in all areas of the country. The policy should stipulate the procedures that will be in place to ensure this.

31 May 2016