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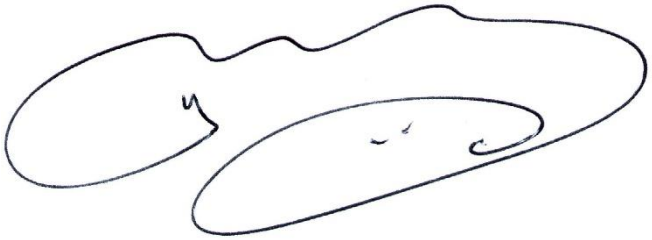
The Portfolio Committee of Health

SUBMISSION BY THE FACULTY OF MEDICINE AND HEALTH SCIENCES, STELLENBOSCH UNIVERSITY ON THE NATIONAL HEALTH INSURANCE BILL [B11-2019] published 26 July 2019

The Faculty of Medicine and Health Sciences, Stellenbosch University (SU), thanks the Portfolio Committee of Health for the opportunity to comment through the attached written submission.

Yours sincerely



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Submission by the Faculty of Medicine and Health Sciences Stellenbosch University on the National Health Insurance Bill

[B11-2019] published 26 July 2019

In the Government Gazette No 42598 dated 26 July 2019, the Portfolio Committee of Health invited public comment on the National Health Insurance Bill [B11-2019].

The Faculty of Medicine and Health Sciences, Stellenbosch University, thanks the Portfolio Committee of Health for the opportunity to comment through this written submission.

1. About the Faculty of Medicine and Health Science

The Faculty of Medicine and Health Sciences is a faculty at Stellenbosch University, which is ranked among the top three universities in Africa as a Research-intensive higher education institution, with a strong development agenda. Stellenbosch University's Strategic Priorities show its commitment to South Africa and why it is committed to universal access to healthcare.

Stellenbosch University's Faculty of Medicine and Health Sciences ("the FMHS") constituents include:

- Academia, involved in the critical element of education, training and skills development for and in the South African health sector;
- Public Sector employees involved in various levels of health care service delivery, from primary health care to quaternary care (at the central hospital);
- Researchers, involved in clinical research, as well as public health and health systems research.
- The Social Accountability of the FMHS such as the Ukwanda Rural Clinical School which prepares graduates for practice in rural and underserved areas, service learning in community context, bursaries, etc.

The Faculty's principal aims are to enrich learning, research and social impact and to develop future medical and health sciences professionals who through innovation and leadership will promote health, prevent disease and provide optimal healthcare and rehabilitation. In doing so we strive to ensure that our activities are informed by the best available evidence, and that our programmes remain relevant to and benefit local communities, our country and the African content. The Faculty remains committed to addressing the most pressing health challenges in South Africa.

As a result the FMHS is well placed to provide comment and input into the proposed NHI system. The Faculty undertook a consultative process in the formulation of this submission, inviting all leaders and staff from across the Faculty to participate, discuss, interpret, interrogate and debate the NHI Bill, as well as formulate the Faculty response and possible contributions towards assisting the National Department of Health in the formation of an optimal health system for South Africa. This submission was compiled on behalf of the Faculty by the Division of Health Systems and Public Health, in the Department of Global Health.

2. NHI Bill: an introduction to current concerns

The FMHS fully supports the principles of **social solidarity and universal health coverage (UHC)** as a globally accepted approach towards population health and financial coverage. The FMHS agrees that UHC cannot be achieved without overcoming inequity in access to healthcare, and addressing current concerns and challenges across the public and private sectors. The FMHS understands that addressing these challenges is as much part of the creation of a system of universal access to quality healthcare, as is a future fully-fledged system of financial coverage for universal healthcare. The FMHS supports the intentions of the NHI, but remains concerned that the proposed NHI is neither comprehensive nor coherent as it merely proposes a funding model for medical care. This is not equivalent to Universal Health Coverage (UHC), and will therefore not achieve the outcomes envisaged in the 2017 White Paper. UHC as defined by WHO not only incorporates access to quality health care, but also incorporates measures to address the social determinants of health, and to improve equity in health outcomes (Evans, 2012). It would be imperative that a proposed NHI ensures quality health services for all, implementing evidence informed guidelines for preventative and curative are, thereby helping to address the historical inequities of the past as envisaged in the NHI White Paper 2017.

It is important to note that indeed, **health systems are complex and adaptive** and any change has extensive ripple effects, which can be destabilizing. The challenges faced in the health sector are wide-ranging and significant, and policy developments to date have been an important step toward quality health services for all. However, an urgent response to the declining state of public health sector services, which addresses the root causes of poor performance beyond improvement of resources, is needed if the NHI is to stand a chance of achieving equitable quality health care. Furthermore, the NHI White Paper 2017, explicitly envisaged a “unified health system” eliminating fragmentation. However, the NHI Bill 2019, through its one-to-one contracting mechanisms with providers, whether practitioner groups or health facilities would inherently serve to fragment the system further.

In this context, multiple concerns have been raised about the NHI as proposed in the Bill in its current format, which is unlikely to achieve the outlined goals as stipulated above. The lack of meaningful public participation in the determination of benefits and in shaping the NHI to date is a serious concern. FMSH is encouraged by the numerous parliamentary public hearings around South Africa, facilitating public participation and engagement, particularly from civil society, to ensure that the community can provide into in shaping the NHI overall. In addition, there is a need for investment in strong community participation structures including health committees and hospital boards at local level, aggregated up the system to district, provincial and national level, so that community voice and the voice of civil society broadly can input to shaping the NHI as a whole. Furthermore, provincial public health system managers have not yet been part of the development process. The involvement of public health system managers to date has been sub-optimal, negating the extensive experience and value that senior public health system managers could add.

Whilst the NHI scheme is welcomed conceptually, the Bill lacks clarity and detail on a number of issues, including 1) funding, 2) public participation and engagement, 3) governance and accountability arrangements, 4) marginalized roles of provinces and districts, 5) addressing social determinants of health, and 6) discrimination against non-African citizens. Also, the Bill contains several important contradictions with the White Paper NHI Policy published in 2017. The FMHS remains concerned that the NHI as proposed appears to move away from WHO policy frameworks in that it fragments the health system through a range of contracting arrangements of providers at national and district levels. This stands in conflict with the structure and purposes of an integrated health system, since clinics, community health centers and hospitals are inter-dependent. Importantly, the lower level facilities must protect the higher level facilities from overload through a community based focus on prevention. Secondly, there is a lack of clear commitment to health system strengthening as the foundation of the NHI. Even with the pooling of resources, there needs to be strong mechanisms that support leadership, management and ethical governance to ultimately improve public value. A third concern is that the NHI does not seek to protect existing good practices, as exemplified by some provinces running functional health systems within existing constitutional and statutory frameworks. In addition, the NHI fund as proposed will add layers of costly bureaucracy and administration, which could significantly increase the administrative complexity and burden on the system. Also, prevention and promotion, as well as the key stewardship role of the Department of Health for population health, appears to be marginalized by a preoccupation with hospital care, tertiary services and benefit packages dominated by curative care. Lastly, there is a need for greater focus on equity across the whole health system.

Before the public health sector can participate in the NHI, it will need to be strengthened substantially, especially in terms of physical infrastructure and human resources, including skills in leadership and governance. At district level, managers will be expected to identify population needs and appropriate

services required, as well as negotiate contracts with providers in both the public and private health sectors. Given the parlous state of management in many districts and provinces, expecting this level of skill at district and sub-district level is unrealistic. The development of a program to build capacity in management and leadership is an important first step. In addition, the funding of unfilled posts, which, have been subject to a moratorium preventing appointment of suitably qualified health workers, must be actioned urgently. The comparative excess of health professionals in the private sector will do nothing to readdress the problem if public sector posts are not being funded due to fiscal austerity measures, which must come to an end. Thirdly, investment in physical infrastructure, facility refurbishment, establishment of new facilities and purchase as well as maintenance of equipment should be performed based on needs and freed up from opportunistic “tenderpreneurship” that has become insidious in the health sector. These imperatives will require strong political will and significant funds. Government has little option but to provide such funding, since the current health crisis is untenable. Although the upfront financial commitment will be large, the returns on investment are potentially even greater, resulting in long-term health care savings, improved economic productivity of a healthier workforce, and the multiplier effect in the economy of having a larger number of employed people.

Linked to the above changes is the need for a plan for Human Resources for Health (HRH) to support the development of a robust public health sector, especially at district level and below, so that the NHI can operate effectively and efficiently in formerly underserved areas.

A key recommendation is for a health system staffed by sufficient numbers of appropriately trained, adequately paid, well-supported and motivated staff at all levels, from community health workers to specialised medical services. This recommendation implies modernisation of human resource management systems in the public sector and improved conditions of service and pay for health care workers. In addition, there is the need for a Human Resources for Health plan that is developed by a wide range of stakeholders who have the whole system in mind rather than their own sectoral interests. The plan should ensure the development of a robust public health sector, to ensure that the NHI can operate effectively and efficiently in formerly underserved areas.

The role of universities in developing the next generation of health professions; as key contributors to research to address the health challenges of SA; and support of service delivery, is critical. The absence, in the Bill, of the universities in the afore-mentioned mandates necessitates an addition to the Bill which considers the governance between Health and Education, as well as the funding flows to underpin the interface between the entities. The experience of the NHLS that partly funds academic pathology through revenue from pathology services highlights the importance of an integrated Health/Higher Education System.

3. Specific Comments and suggested alternatives and/or solutions for B11-2019

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
Preamble			
1.	Preamble	Line: 'In order to', after 'achieve the progressive realisation of the right to access to quality personal health care services' add 'within a strengthened public and private health system' add a clause 'address the social and economic determinants of health to promote health and disease prevention through inter-sectoral collaboration and strengthening non-personal health care'	Although a strengthened health system is implied in the statement 'quality personal health care services' it should be emphasised as a separate point. Addressing the social and economic determinants of disease, which will include cooperation with and action by other sectors, is paramount to reducing the burden of disease, and the overall burden on the health system. A coordinated, whole of government approach which links with the NHI objectives is required.
2	Definitions	Whilst 'health care service provider' is defined fairly generically, the way the Bill refers to such providers appears to indicate health professionals, and important cadres such as community health workers, mid-level workers, and traditional healers do not appear to be included.	Clarity is required regarding health service providers such as community health workers, mid-level workers, and traditional healers.
Chapter 1: Purpose and Application of Act			
3.	Purpose of Act	2(a) states 'serving as a single purchaser and single payer of health care services' 2(a) after 'use of' add 'quality'	The purchaser and payer should not be considered as one structure until clarity on the single strategic purchaser and payer roles is provided. Furthermore, strategic purchasing by one structure without consideration for the role of the province and the importance of decentralised purchasing creates financial and administrative risks amongst others. Clarity is required regarding which institutional arrangements are to be put in place, and how this will be implemented to support the implementation of NHI, as significant

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
			restructuring and strengthening of the system are required. It is therefore proposed that these be developed concurrently with the Bill.
Chapter 2: Access to Health Care Services			
4.	Population coverage	4(1) add 'Asylum seekers, undocumented migrant, students and all children' Remove 4(2) Refrain from using the term 'illegal foreigners'. Replace with 'undocumented immigrants'	The proposed changes are in line with the current National Health and Refugee Acts. The Bill should also consider foreigners who reside in SA for purposes of studies. The suggestion for them to get private medical aid may not be feasible or they will only be able to receive emergency care or treatment for notifiable medical conditions. Students on visa should have access to 4(1).
5.	Registration as users	Add to 5 'passport, drivers licence' as another option for registration. Add to 5 'asylum seekers'. If it is not clear whether the details regarding this category will be covered in 4(1)(e) or (6) (5) Regarding 'proof of habitual place of residence'. Not all residences have proof of habitual residence. How this will impact the registration of the user is to be made explicit. The implications of not having any documents as stipulated in this section on registration of the user should be discussed in the Bill. (7) Details of the management and maintenance of the register, as well as registration of users at unaccredited facilities are required. (8) what will happen if the user does not have proof of registration?	The nature of the registration system (namely, paper-based or electronic, interoperability within health and with other sectors), and the readiness of the government sectors and the health system to implement such a registration should be carefully considered. Furthermore, significant investment and time will be required to establish a streamlined, effective and efficient system. This will therefore be best implemented in a phased approach. Appropriately trained staff will be required to ensure that smooth-running from data input, hard-and software support and central database and data warehousing levels.
6.	Health care services coverage	With regards to user access to accredited facilities as presented in this section, there is a risk for limited coverage of services and/or increased costs for users who have	The implications for rural areas is that there may be insufficient service providers or that users have to incur costs to travel to the accredited

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
		to travel to other facilities should the facility they are meant to access not be/no longer be accredited. 7(2)(d) lists the referral pathway and (iii) states that failure to adhere will mean that the user does not require services. What happens should there be a medical emergency? Thus add additional clause that addresses management of the user should they present with a medical emergency.	facilities that may be out of their geographical areas. Another consideration is the registration of the user who is on vacation or not within their geographical are (eg for work purposes). Add a clause on how this will be managed.
Chapter 3: National Health Insurance Fund			
7.	Functions of Fund; Powers of Fund	The functions and powers of the Fund are broad and cover a wide range of activities and actions. The Fund will require a range of health, financial, legal, business and other technical staff, including administrative staff and strong operational and strategic managers. Strong and well-functioning administration systems are also required. Furthermore, there are about 4000 public health facilities in South Africa (excluding the private sector facilities).	For the Fund to execute its functions and powers, strong, efficient and quality operations must be in place, and service provision must be high-quality, acceptable, appropriate and timely. Greater clarity is therefore required regarding the administrative and technical support that will be required to support the Fund, and the structure and arrangements of the Fund both centrally and within decentralised structures to effect the abovementioned. How the Fund will engage with provinces and district-based structures should be made explicit.
8.	Powers of Fund	11(1)(h) We propose that an independent entity investigate complaints against the Fund.	This would aid improved governance, stewardship and accountability.
9.	Establishment of the Board	The Board is accountable to the Minister in the Bill. This chapter establishes the NHI Fund as a Schedule 3A autonomous public entity. The Minister has extensive powers in the current Bill (such as section 13.(8) and 13.(9) of this section). This may undermine the purpose and effective implementation and independent functioning of the Fund.	We propose that the Fund reports to Parliament and that the Minister's powers are reduced

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
10.	Constitution and composition of Board	13(1)(3) details on who the ad hoc advisory panel will be must be made explicit. It is not clear what the shortlisting procedure will be. 13(5)(a) details on what be 'a fit and proper person' constitutes should be provided. Propose that it be stated that the person should not have a criminal record, should not have been convicted for fraud or corruption. 13(5)(b) add 'public service administration, business management' Given the importance of community participation, someone who represent civil society should also be on the Board. Section 15(c) states that the Board must advise on comprehensive health care services to be funded by the Fund through the Benefits Advisory Committee'. Sufficient expertise should be on the Board to ensure that this is possible. 13(5)(e) More details should be included such as shares or stakes in insurance industries, pharmaceutical companies, involvement in tobacco or sugar industries etc.	
Chapter 4: Board of Fund			
11.	Functions and powers of Board	Section 15(b-d) states that the Board is to advise the Minister on 'the development of comprehensive health care services to be funded by the Fund through the Benefits Advisory Committee; (c) the pricing of health care services to be purchased by the	The Board members should be selected so that they are able to fulfil these functions. Furthermore, it is not clear whether the Board can co-opt or contract advisors to assist with this activity. This should be added to the section

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
		Fund through the Health Care Benefits Pricing Committee of the Board; (d) the improvement of efficiency and performance of the Fund in terms of strategic purchasing and provision of health care services'.	
Chapter 5: Chief Executive officer			
12.	Appointment	Clarity regarding the appointment is required. Section 19(1) states that the CEO will be appointed through a transparent and competitive process. However in Section 2 it states that the decision will be made by the Minister who must approve the recommendation of the Board.	
13.	Responsibilities	Section 20 (2) (e) (ii) add 'Provinces' before 'District Health Management Office'.	
Chapter 6: Committees Established by Board			
14.	Technical committees	It is not clear if the Technical Committee is comprised of members of the Board. It is assumed that it is not given that the following is included in Section 24(3) (a) the person much be 'fit and proper'.	If outside members are to be appointed then the appointment criteria should be similar to those of the Board members (see above section), including having proven expertise in the area and not having a criminal record. It should be stated whether additional expertise can be bought in, or an expert can be co-opted into the Committee. Civil society should be represented on Committees as far as is reasonable.
Chapter 7: Advisory Committees to be established by Minister			
15.	Advisory Committees Established by Minister	FMHS welcomes this change from the 2018 Bill, that health service benefit determinations and pricing are separated from the Fund, and incorporated into the roles and functions of Advisory Committees, as well as the establishment of a Stakeholder Advisory Committee. However, clarity and details	Transparency regarding selection and appointment for all are required. The role, including powers, roles and capacity of the person appointed by the Minister on each Committee should be stipulated. Civil society should be represented on the Committees, and the

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
		regarding the powers, roles and capacities of the various members of the Advisory Committees is required.	Stakeholder Committee should have adequate representation from civil society.
Chapter 8: General Provisions Applicable to Operation of Fund			
16.	Role of Department	Section 32(1)(c) add 'non-personal' between 'additional' and 'health services' Section 32(2)(a): The role of the provinces is presented as management agents. Section 32(2)(d) states that Minister will 'establish District Health Management Offices as government components'.	Provinces should be playing a stewardship role. Clarity regarding the role of the provinces is required. The role of the province is once again not clear. This should be the role of the Provinces in terms of establishment and oversight.
17.	Role of medical schemes	In terms of Section 33 clarity is required in terms of what is meant by 'medical schemes may only offer complementary cover to services not reimbursable by the Fund'.	
18.	Purchasing of health care services	In terms of section 35 (2), the Fund can only purchase services from accredited and contracted hospitals.	If facilities did not receive accreditation due to factors related to funding or support (e.g. inadequate infrastructure etc.), what will the funding/financing arrangement be to ensure that these facilities can be improved to meet accreditation standards?
		Whilst the strategic purchasing of health care services by the Fund is intended to reduce costs and improve value of health services and impact on health outcomes, any single buyer system like the NHI Fund, on its own that is without complementary supply-side regulation cannot succeed. In a mature and long-standing single purchasing system like NHS in the United Kingdom, all public and private providers that provide care paid for by the NHS are regulated by Monitor, the independent supply side regulator (now part of	The Health Market Inquiry found a private healthcare market that is characterized by high and rising costs of healthcare and medical scheme cover, and significant overutilization without stakeholders having been able to demonstrate associated improvements in health outcomes. The HMI also found a poorly regulated and coordinated supply side. To remedy this, the HMI proposed and independent supply side regulator, who's job will be to: • assist provinces in issuing licenses for hospitals

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
		NHS Development) as well as by the Competition and Markets Authority, the competition enforcement agency.	• assist with a process and a platform for price setting for doctors – (Multi-Lateral Negotiating Forum) • conduct or contract out research looking at cost-effective healthcare interventions, including technology • assist and facilitate reliable information on quality of health and health outcomes measurement Implementing the HMI recommendations, in particular supply side regulation, will be an essential step towards creating an environment where the purchaser, the NHI Fund will purchase from a private healthcare market that is competitive with lower costs and prices, and more value for money for the South African population. All healthcare purchasers including the NHI fund, will required providers to be properly regulated in order to achieve affordable access to quality care.
19.	Role of District Health Management Office	In terms of section 36, the district Health Management Office must be established as a 'national government component' for the provision of primary health care services at district level The Bill refers to the establishment of the DHMO in terms of section 31A of the National Health Act, whereas section 31 (1) (a) of the NHA speaks to district health councils with a different role and function to that envisaged for the DHMO.	Evidence shows that current district level services are not sufficient in terms of resources of technical capacity to managed additional financial, technical and operational functions. Clarity is required on how this level will be strengthened. Furthermore, to whom district level structures are accountable is not clear. The provinces are completely excluded from this section and chapter, which would be in contravention of sections of the Constitution as well as National Health Act.
20.	Contracting Unit for Primary Health Care	The relationship between the CUPs and the district, the Fund and province is not clear, given that Section 37(1)(b) states that is 'is the preferred organisational unit with which the Fund contracts for the provision of primary health	Clarity must be provided in the Bill as to the governance and relationships between entities. Principles should be developed to ensure cost-effective contracting, such as, for example avoiding open-ended commitments in provider payment arrangements.

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
		care services within a specified geographical area.'	The expertise needed in such a unit needs to be specified, as with the advisory committees. Who will constitute this office? (i.e. what competencies are required to deliver on the mandate of this office?) This unit is also prone to capture, fraud and corruption as it is linked to product service provider appointments etc. How will these be mitigated against?
21.	Accreditation of service providers	Reliance of accreditation and certification in section 39 without a clear plan on how public sector health facilities will be strengthened to be able to meet the requisite standard, and provide services on par with some private sector facilities would disadvantage the public sector.	The Bill should state the process of assessment of each facilities to ensure that it has sufficient financing to meet certification and accreditation standards. Will the Fund provide finances 'upfront'? How will this impact on or affect the certification and accreditation processes? This section of the Bill is a vitally important one and is critical to the Fund and NDOH meeting their objectives. Substantial resources, activities, processed and policy direction is required to not only ensure that certification and accreditation is seamless, but also that services are adequately and efficiently delivered by these facilities. Detailed plans on how the health system will be strengthened to support what is proposed in this section is required. Failure of the Office of Health Standards Compliance, the NDOH, the Fund and the various other levels of care in the health system to efficiently organise themselves and deliver care will have major consequences. It is proposed that this be piloted and phased in during implementation. Provincial stewardship will be vital for seamless and coordinated service delivery.

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
22,	Information platform of Fund	The envisaged Information platform of the Fund in section 40 is vital to the measurement and assessment of success in achieving the desired equity, quality and performance outcomes.	The current Health Management Information System is primarily paper-based, is not interoperable and is not able to provide real-time information. Finance and human resource information systems require revision, and to a degree fall within the ambit of other ministries (e.g. Treasury). Statutory bodies' data bases require strengthening. Our data elements and indicators are not in line with the information requirements, and district-level staff are not proficient at using computers and other technology. A major concurrent overhaul of the HMIS is required. Current strategies should be fast-tracked and piloted. Legislation to ensure that the private sector complies is also required. Clarity is required on how the Fund will support the overhaul of the system.
23.	Payment of health care service providers	Section 41 indicates that payment should be 'all-inclusive' and 'based on performance', and that the Fund must determine the payment mechanisms'. FMHS welcomes this move towards delivering a more efficient and cost-effective health service. This is further confirmed in Section 10 (1) (k), where the Fund must 'ensure that health care service providers, health establishments and suppliers are paid in accordance with the quality and value of the service provided at every level of care'	It is well documented that fee for service reimbursement promotes perverse incentives. In the South African context, the Health Market Inquiry has shown that the fee-for-service reimbursement mechanism, ubiquitous in the private health care system, has contributed to excessive utilization. The Bill names specific forms of alternative reimbursement mechanisms (ARM), diagnostic related groups, capitation, and a capped case-based fee ('diagnostic related groups' has been replaced with 'all-inclusive' payments between the 2018 and 2019 bill). FMHS commends the bill for seeking to shift the system from fee for service to ARMs. However, we are of the view that naming the forms of ARM will limit innovation and create rigidity in the system. There are a number of ARM's with varied outcomes and degrees of risk sharing. We

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
			recommend the following wording be included: 'The Fund's contracting arrangements should include: risk sharing between health care service providers, health establishments or suppliers of health goods, and the fund; encompasses a value component [price and quality (outcomes)], and should comply with the Competition Act'.
Chapter 9: Complaints and Appeals			
24.	Complaints and appeals	Section 42(2) states 'The Investigating Unit established by the Chief Executive Officer in terms of section 20(2)(e) must launch an investigation to establish the facts of the incident reported and must make recommendations to the Chief Executive Officer as to the way in which the matter may be resolved within 30 days of receipt of the complaint.'	We propose that a mechanism for addressing certain types of complaints at a local level be instituted as these should be best managed at that level. FMHS proposes that the findings of the Investigating Unit must also be submitted to the Board.
Chapter 10: Financial Matters			
25.	Revenue	The sustainability of sources of funding is a concern, especially if the main source relies on a small taxpayer pool. How will this pool be affected by challenging economic times, high rates of unemployment and rising costs of fuel and food? There is already a concern about a decreasing pool of people able to maintain contribution to medical aid schemes, with those who continue contributing downsizing on benefit packages. There is also an assumption that private individuals are happy to make contributions to private medical schemes. Yet this is known to be a grudge expenditure due to uncertainties in quality that	We can start with maximising efficiency as the system stands through proper governance at all levels and in both public and private sectors. Eliminate wasteful expenditure and adopt lean management approaches throughout the system. Then by the time we ask taxpayers to contribute, the system has proven to be reliable. Whatever taxes are proposed thereafter, bring taxpayers into your confidence and make them understand the justification for asking them to do what they are asked to do.

No	Section	Comment and suggested alternative	Motivation and/or suggested solution
		have come to represent public healthcare.	
Chapter 11: Miscellaneous			
26.	Regulations	Section 55 – no mention is made of the Provinces	
27.	Transitional arrangements	In this section, a 'progressive and programmatic approach based on financial resource availability' is proposed with two Phases highlighted.	FMHS proposes that a monitoring and evaluation framework be established to guide implementation. We also propose that as far as is possible, evidence-based approaches be used to guide and learn from implementation activities. To this end, we propose an additional interim committee that focuses on health systems and services implementation, strengthening, research and evidence generation, synthesis and translation. This committee should provide guidance on the best implementation and research approaches based on local and international evidence. The Committee should provide inputs into key legislative changes to be made to support preparation for and implementation of NHI.
SCHEDULE – REPEAL AND AMENDMENT OF LEGISLATION AFFECTED BY ACT			
28.	Health Professions Act, 1974	Currently, Health Professionals may only be employed by public sector establishments under the Health Professions Act.	If private establishments are to be contracted by the Fund, the Act should be amended to allow for private sector establishments to employ health professionals, particularly given that the reason for not allowing employment of health professionals, viz. to avoid perverse incentives of over-servicing, is removed with ARM's.

4. Towards the Development of the NHI and realization of UHC: Principles and Recommendations

The FMHS of Stellenbosch University proposes in this submission that development of the NHI **adhere to the following principles:**

1) The provision of comprehensive, good quality health services built on a strong base of PHC and supported by an appropriate referral system for hospital care
2) Integration of efforts across multiple levels of government to maximize the health of the population
3) Cohesion, integration and responsiveness of health systems within specific geographical areas
4) Positioning the District Health System as an operating and contracting unit that integrates the planning, provision, monitoring and evaluation of health services from the public and private health sectors, with technical support from the provincial government
5) Positioning of Central Hospitals as a core provider of secondary, tertiary and quaternary care, via development of a national governance framework, to prevent fragmentation of the service delivery platform
6) Systemic level health system strengthening by establishing a culture of learning and ongoing quality improvement, taking into account issues of design, ethical leadership, a shared vision and values, and community connectedness
7) Strategic purchasing based on principles of competition, purchaser/provider splits and contracting to incentivize good performance
8) Inclusion of multiple stakeholders with diverse perspectives to secure collective ownership in defining the root cause of dysfunctional health systems over a process of consultation
9) Positioning the Accounting Officer and Provincial Department as an accountable intermediary to ensure UHC through mechanisms including ARM's, purchaser and provider splits and contracting
10) Clarity surrounding the rights, responsibilities and accountability of different entities and governing bodies, including the NHI Fund, NDOH and Provinces, considering aspects such as determination of benefit packages and costing, service norms and standards, as well as establishing transversal convenience contracts at provincial level relative to provincial realities
11) Transparency and the building of a greater body of evidence in the process of developing and incrementally implementing the NHI
12) Commitment to providing an enabling environment (governance mechanisms, financial resources and a stable clinical training platform) for the Higher Education Institutions to support the shared mandates of health professions education, research and service delivery
13) Alignment of the enrolment planning of the Higher Education Institutions with the Human Resources plan for Health specifically as it pertains to the absorptive capacity of the health services of such graduates as well as the extent, capability and supervisory capability of the national health system.

3 Conclusion

The NHI represents major and complex health system reforms, in both the public and private sectors. The strengths and weaknesses of health services, and the environments in which they function, differs greatly across the country. Implementation of the NHI Strategic intent should not be seen as an event but as a process that will evolve over time and should be flexible enough to result in differentiated models. A phased approach will allow the time and space for the Health Systems Strengthening interventions (HSS) within a fragile public health system to take root as well as for the incremental launch of carefully crafted innovative models in line with the NHI proposals. In this regard, the Western Cape and the Eastern Cape have partnered to provide urban and rural learning sites to give tangible options to improve service delivery and private sector contracting.

The current NHI Bill proposals, although welcomed in principle and seen as a necessary reform in the health system, are quite static with little recognition of the complexity of the system, possible unintended consequences and the need for flexibility and adaptability. The NHI is important to ensure quality health services for all. We are however concerned about how the NHI is being implemented. The transition process will put enormous strain on both the public and private health systems. How the NHI is implemented can destabilize not only Health systems, but the entire economy of the country.

The management and staff of the FHMS of the University of Stellenbosch are more than willing to participate in the work of the NHI Work Streams and to engage on any specific topic raised in this submission. It can offer its research, training, service delivery and governance expertise to assist the unfolding of the very important health transformation project of the National Department of Health.

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