NHI White Paper (2017) Summary

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Note to HealthMan Clients: This is purely a summary of the NHI White Paper. It does not critically analyse any of the aspects contained in the White Paper. Clients are encouraged to read the White Paper in entirety.

NHI White Paper (2017) Summary

EXECUTIVE SUMMARY:

1. This White Paper lays the foundation for moving South Africa towards universal health coverage (UHC) through the implementation of National Health Insurance (NHI) and establishment of a unified health system.
2. South Africa aims to make significant strides in moving towards UHC through the implementation of NHI based on the principle of the Constitutional right of citizens to have access to quality healthcare services that are delivered equitably, affordably, efficiently, effectively and appropriately based on social solidarity, progressive universalism, equity and health as a public good and a social investment.
3. The White Paper on NHI recognises that good health is an essential value of the social and economic life of humans and is an indispensable prerequisite for poverty reduction, sustained economic growth and socio-economic development.
4. National Health Insurance will transform the financing of healthcare in pursuit of financial risk protection.
5. National Health Insurance will extend population coverage, improve the quality and quantity of services that the population will be entitled to, as well as provide financial risk protection to individuals and households.
6. Transforming the health care financing system also requires changing how revenue is collected to fund healthcare services and, even more importantly, how generated funds are pooled and how quality services are purchased.
7. To successfully implement NHI requires that an NHI Fund must be established through legislation. The sources of revenue for the Fund will be through a combination of pre-payment taxes derived from general taxes and complemented by mandatory payroll and surcharge taxes.
8. Comprehensive healthcare services that are delivered based on scientific evidence will require a strengthened and reorganised health care system. The health care system will be reorganised in the areas of strengthening primary health care (PHC).
9. Strategic purchasing requires that health care providers are accredited based on stipulated criteria and in contracting these providers, alternative reimbursement strategies such as capitation or PHC services and DRGs for in-hospital services are applied.
10. The population will be registered and issued with a unique identifier linked to the Department of Home Affairs identification system to enable users to access health care services.
11. NHI requires the establishment of strong governance mechanisms and improved accountability for the use of allocated funds.

NHI SUMMARY

1. National Health Insurance (NHI) is a health care financing system that is designed to pool funds to actively purchase and provide access to quality, affordable personal healthcare services for all South Africans based on their health needs, irrespective of their socioeconomic status.

2. NHI represents a substantial policy shift that will necessitate massive reorganisation of the current health care system, to address structural changes that exist in both the public and private sectors.

3. NHI will cover services that are delivered on a people-centred integrated healthcare service platform to ensure a more responsive and accountable health system that takes into account socio-cultural and socio-economic factors whilst prioritising vulnerable communities.

4. The population will be registered at designated health facilities using the unique identifier linked to the Department of Home Affairs identification system.

5. Preparatory activities on NHI were aimed at strengthening of the health system and service delivery platform.

6. The Office of Health Standards Compliance (OHSC) was established for the inspection and certification of health facilities to ensure compliance with the norms and standards regulations.
7. Central hospitals will be transformed into national assets operating as training platforms, research hubs and centres of excellence locally, regionally and internationally.
8. The NHI Fund will be created to actively and progressively purchase personal healthcare services on behalf the entire population.
9. Health facilities that are compliant with certification requirement of the OHSC and meet set criteria will be accredited by the NHI Fund as part of strategic purchasing. In the latter phases of implementation, NHI will also contract with certified and accredited private providers at higher levels of care based on need.
10. Emergency Medical Services (EMS) and National Laboratory Health Services (NHLS) will be contracted for personal health services by the Fund in the latter stages of implementation.

FEATURES OF NHI

11. **Progressive universalism**: All South Africans will have access to needed promotive, preventive, curative, rehabilitative and palliative health services that are of sufficient quality and are affordable, without exposing them to financial hardships.
12. **Mandatory prepayment of health care**: NHI will be financed through mandatory prepayment which is distinct from other modes of payment such as voluntary prepayment and out-of-pocket payments.
13. **Comprehensive Services**: NHI will cover a comprehensive set of health services that will provide a continuum of care from community outreach, health promotion and prevention to other types and levels of care.
14. **Financial risk protection**: NHI will ensure that individuals and households do not suffer financial hardship and/or are not deterred from accessing and utilising needed health services.
15. **Single Fund**: NHI will integrate all sources of funding into a unified health financing pool that caters for the needs of the population.
16. **Strategic purchaser**: NHI will purchase services for all; and will be an entity that actively utilises its power as a single purchaser to proactively identify population health needs and determine the most appropriate, efficient and effective mechanisms for drawing on existing health care service providers.
17. **Single-payer**: NHI will be structured as an entity that pays for all health care costs on behalf of the population.
18. **Publicly Administered**: NHI will be established as a single fund that is publicly administered and publicly owned.

PRINCIPLES OF NHI

I. Right to access health care
II. Social solidarity
III. Equity
IV. Health care as a Public Good
V. Affordability
VI. Efficiency
VII. Effectiveness
VIII. Appropriateness

19. The policy trajectory pursued under NHI must be based on the clear objective of entrenching income and risk cross-subsidisation mechanisms that will ensure that all citizens are provided with (1) adequate financial risk protection; (2) an opportunity to equitably benefit from the health

system; and (3) the ability to contribute towards the funding of the health system based on their ability to pay.

RATIONALE AND BENEFITS:

20. NHI focuses on ensuring progressive realisation of the right to health care by extending coverage of health benefits to the entire population, in an environment of resource constraint whilst benefiting from efficiency gains.

21. The benefits of NHI are multiple and include: improved financial risk protection through prepayment funding and reducing out-of-pocket payments; reduced inequities and fragmentation in both funding and provision of health services in both the public and private health sectors; improved access to quality health care; improved efficiency and cost containment through streamlined strategic purchasing.

22. Households will benefit from increased disposable income because of a significantly lower mandatory prepayment level than current medical scheme contributions.

23. The NHI reforms are premised on several key interrelated elements, namely:
    a. Micro-level reforms to increase efficiency and quality:
        i. active purchasing by a single strategic purchaser, using explicit contracts that set prices;
        ii. gate-keeping at a primary health care level
        iii. provider-payment reform that move away from a fee-for-service
        iv. AMRs include capitation for PHC and ambulatory care or case-based payment systems such as diagnosis-related groupers (DRGs) for in-hospital
        v. In situations where health care providers are salaried, the introduction of an activity-based bonus or capitation has been used to motivate employees

    b. Macro level reforms to control costs:
        i. Price controls to regulate health care inputs using reference prices for
        ii. Health care financing reforms that eliminate out-of-pocket spending and prohibiting low-quality benefits and benefit options that limit coverage and predisposing to catastrophic health expenditure;
        iii. Delinking health insurance as an employment benefit.

24. The health of a country's labour force can impact on its productivity levels. If NHI is successful in its aim to reducing bottlenecks in the provision of healthcare in South Africa, it could lead to an improvement in the health of the labour force in the long term.

25. Slowing the growth in health care costs also has macroeconomic benefits to the labour market and the general economy.

26. South Africa follows an evidence-based approach to health reforms by implementing a highly effective, fair and cost-effective NHI that promotes health care coverage and financial risk protection for households.

The Three Dimensions of Universal Health Coverage (UHC)

27. The World Health Organisation (WHO) provides guidance to countries on moving towards universal health coverage (UHC) and has identified three dimensions for progressing towards universal coverage namely:
    a) **Population coverage** - refers to the proportion of the population that has access to needed health services.
    b) **Service coverage** - Service coverage refers to the extent to which a range of quality health services necessary to address the health needs of the population are covered.
    c) **Cost coverage** - Cost coverage refers to the extent to which the population is protected from direct costs as well as from catastrophic health expenditure

SERVICES UNDER NHI

None of the lists of services mentioned below are a complete reflection of all available services, according to White Paper.

PHC Health Service Benefits:

a. Prevention and Health Promotion, including but not restricted to, providing information education and support for healthy behaviours
b. PHC outreach and appropriate home care;
c. Maternal, women and child health, including family planning and reproductive health services;
d. HIV and tuberculosis;
e. Chronic non-communicable disease; and
f. Violence and injuries.

EMS and Patient Transport (EMS will include both non-facility and facility-based emergency care)

a. Basic life support;
b. Intermediate life support;
c. Advanced life support;
d. Medical rescue;
e. Screen and triage;
f. Initial assessment, stabilisation, management; and
g. Cardio-pulmonary resuscitation, including in neonates.

Hospital-based services (Includes services provided through OPD units, day care services and in-patient admission):

a. Emergency medicine;
b. Internal medicine (including but not restricted to, cardiology and cardiovascular conditions, dermatology, neurology, infectious diseases);
c. Nephrology and renal disease, including but not restricted to dialysis ;
d. Oncology and cancer treatments;
e. Psychiatry;
f. Obstetrics and gynaecology ;
g. Paediatrics and neonatology ;
h. Surgery;
i. Orthopaedics; and
j. Organ transplant (including but not restricted to lung, liver, kidney and heart).

28. NHI Services will be portable, with mobile service organised in the CUP (Contracting Unit for Primary Healthcare).
29. Mental Healthcare will be integrated into PHC.
30. NHI will cover comprehensive integrated occupational healthcare services that are responsive to diseases and injuries.
31. NHI will not cover non-personal health care compensation, this will remain in COIDA.
32. NHI Benefits Advisory Committee will develop benefit schedules for the comprehensive services for all levels (primary, secondary, tertiary and quaternary).
33. NHI Services will not be based on a negative of positive list nor on a PMB type of package.
34. Detailed treatment guidelines, which are based on available evidence about the most cost-effective interventions, will be used to guide delivery of comprehensive services.
35. Access to services will be portable. Migrant populations must provide notice to NHI fund prior to embarking on a journey.

36. NHI will contract with accredited public and private providers at specialist and hospital levels based on need.

37. Patients who need to be treated by specialists or in hospitals will have to be referred by PHC providers to certified and accredited hospitals and specialists. This means, except in acute emergency medical contexts, patients cannot self-refer to a specialist or a hospital without being seen at the PHC level either at a clinic or by a general practitioner.

38. Hospital services will be provided based on the existing classification of hospitals in the public sector and taking into account the level of care to be provided. Level 1 (district) services will be provided by generalist medical (and dental) practitioners including surgical interventions under anaesthesia. Level 2 facilities (regional) will include services that can be provided by general specialists in anaesthesiology, general surgery, internal medicine, obstetrics and gynaecology, orthopaedics, paediatrics, psychiatry, diagnostic radiology, pathology and allied health services. Tertiary services will be rendered through level 3 facilities. The comprehensive health care services at this level will include sophisticated diagnostic and treatment services. The services will be provided by general specialists in anaesthesiology, general surgery, internal medicine, obstetrics and gynaecology, orthopaedics, paediatrics, psychiatry, radiology and diagnostic services such as pathology. Quaternary and other tertiary services will be rendered through national and central referral centres. The services rendered will include sub-specialist and super-specialist services.

39. Hospital and medical specialist healthcare services will be specified by the NHI Benefits Advisory Committee based on evidence of efficacy, quality, safety and cost-effectiveness. Accredited hospitals and specialists will deliver healthcare services in accordance with clinical protocols and referral guidelines.

40. Identified providers of health care services for priority areas such as Obstetrics and Gynaecology, Paediatrics and Trauma Services in the private sector will be contracted based on need. As NHI matures, these high priority services will be more widely available to the population from a wider network of accredited providers.

41. To ensure equitable access to medicines and related pharmaceutical products, NHI will in addition to public provision, accredit and contract with private retail pharmacies based on need.

42. The NHI Benefits Advisory Committee will determine the laboratory services to be covered under NHI. Laboratory services at the PHC level will be in line with the Essential Laboratory List. NHI will cover diagnostic pathology laboratory services provided that when referring patients to higher level of care, all previous relevant information including all the available and pending laboratory test results are provided to avoid unnecessary duplication. A number of interventions that include the implementation of a gate-keeping tool that identifies unnecessary test requests, provincial verification of billing, an alternative financing model for training and a review of the current fee for service model used for billing. The goal is to change the way the NHLS is reimbursed in order to emphasize higher quality at lower costs—in other words, to improve value. The NHLS reforms are aimed at delivering an efficient laboratory service. There are three fundamental components to the reform:
    a. Defining an essential set of tests that will get funded. Currently, 127 tests comprise of 90% of the total volume of tests ordered across all public health facilities.
    b. Using clinical governance rules to manage demand and/or utilisation.

    The authorised requisitioning healthcare professional will be required to decide on and define the purpose or reason for each laboratory investigation taking into account the following factors:

    a) If the investigation is clinically justifiable
    b) Whether the previous results still have clinical relevance
    c) If the investigation is required to ensure patient safety

d) If the investigation is required for quality assurance purposes

43. NHI will cover radiology services that are delivered at primary, district, regional and tertiary levels as well as those radiology services that are delivered at central/national referral levels comprehensive healthcare services defined by the NHI Benefits Advisory Committee and based on need. Radiology services to be covered under NHI will be located at the lowest and most appropriate level that could sustainably deliver the services that have been determined by the NHI Benefits Advisory Committee.

44. Services to which there is no coverage, such as elective cosmetic surgery, must be paid for in full by the user.

REORGANISATION OF THE HEALTH CARE SYSTEM AND SERVICES UNDER NHI

44. The provision of healthcare services will be through an integrated system involving accredited and contracted public and private providers. The reorganisation is aimed at achieving: a) improved health (level and equity); b) responsiveness; c) financial risk protection; and d) improved efficiency.

45. The health system is organised into three areas of health care service delivery. These are:
    i. Primary Health Care (PHC) Services;
    ii. Hospital and Specialised Services; and
    iii. Emergency Medical Services (EMS).

46. PHC starts in the communities and in addition to the clinics, multidisciplinary networks of practices in the private sector will form part of the first level of contact. Facility based services offered at community clinics and Community Health Centres (CHC's) and multidisciplinary practices will conform to the Ideal Clinic model. PHC services will be comprehensive and integrated and will be supported by a strong feedback referral system and planned patient transportation between the levels of care where appropriate. The referral system will be upward and downward (bi-directional).

47. PHC Re-engineering is a key health reform that is implemented through four streams namely:
    a. Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs);
    b. Integrated School Health Programme;
    c. District Clinical Specialist Teams; and
    d. Contracting-in of private health practitioners at non-specialist level.

48. NHI aims to provide coverage to quality health services for all South Africans. Therefore, NHI will accredit and contract eligible health facilities that meet nationally approved standards. To meet these standards, health facilities must be certified by the Office of Health Standards Compliance (OHSC).

49. A uniform level of quality for Emergency Medical Services (EMS) and Facility-based Emergency Care will be provided across the country according to nationally determined norms and standards in relation to the level of care, staffing requirements, prescribed equipment, suitability of response vehicles and ambulances and other relevant components based on the level of care. Emergency care delivery will be multi-disciplinary and team-based. The clinical teams need to have the competencies to assess, stabilize and provide essential acute emergency care and clinical interventions for all presenting clients.

50. Taking into account the need for separating purchasing functions from provision of services and given capacity constraints in financial management and planning, it will not be feasible to delegate management to individual PHC facilities. The Contracting Unit for PHC (CUP) located at the district level and in a co-operative management arrangement with the district hospital linked to a number of PHC facilities thus creating a contracting unit for the NHI.

51. Central hospitals are a platform for conducting research, the training of health workers as well as being centres of excellence for innovation nationally, continentally and globally. They are a national resource and irrespective of the province in which they are located, must provide health services to the entire population. Central hospitals will be reformed to be semi-autonomous. Full decentralisation of their management functions and responsibilities will be prioritised to ensure their effective functioning and sustainability. Central hospitals will be required to establish cost centres. These cost centres will be responsible for managing meaningful units of business activities (Functional Business Units) and the related cost drivers at the level where the operations/activities are directed and controlled. In line with regulations on management and governance of hospitals, central hospitals will be governed by appropriately constituted Boards. Central Hospitals will become a competence of the national sphere of government which will require new governance structures.

52. As is the case for central hospitals, the roles, functions and responsibilities of management and governance structures for the district, regional, tertiary and specialised hospitals will have to change. For establishment of minimum competency requirements and continuous professional development of health managers, all health facility managers will be required to have a health management qualification.

Health Workforce

53. A number of strategies have been implemented to increase the production of health professionals, including expanding the platforms for international collaboration such as with the Mandela-Castro Collaboration Program in Cuba. Medical schools will also be supported to increase their intake of students as part of broader human resources for health production strategy of increasing health professionals' throughput.

54. The primary training platform for nursing training will be at nursing colleges located inside hospitals to provide a platform for practical training at the hospital bedside.

55. Adequate provision must be made for other (allied) healthcare professionals registered through the HPCSA to ensure that the needs of the population are met.

56. Whilst it is important to increase the quantity and quality of health professionals to meet local needs, it will be equally important to ensure that those recruited are satisfied and motivated enough to be productive and likely to be retained. Improving the quality of life of health professionals working in rural areas will require a multi-sectoral response to providing basic social infrastructure and amenities.

FINANCING NHI

57. The Costs projections are still adapted from costing in the Green Paper:

	Average annual percent increase	**Cost Projection R 'm (2010 prices)**
Baseline Public Health Budget: 2010/11		109 769
Projected NHI expenditure:		
2015/16	4.1%	134 324
2020/21	6.7%	185 370
2025/26	6.7%	**255 815**
Funding Shortfall in 2025/26 if baseline increases by:	2.0%	108 080
	3.5%	71 914
	5.0%	27 613

58. The implementation of NHI will result in growth in public care health financing. The most preferred option for revenue generation for NHI will be predominantly funded through general revenue allocations, supplemented by: (1) a 2% payroll tax payable by employers and employees,

and (2) a 2% surcharge on individuals' taxable income. The regressive aspects of a value-added tax increase would contradict the principles upon which NHI is based.

59. Furthermore, the component of the Road Accident Fund (RAF) and the Compensation for Occupational Injuries and Diseases (COID) covering provision of healthcare services will be a source of revenue for NHI.

60. However, it is necessary to take into account the reality that irrespective of how comprehensive the NHI entitlements will be, some personal healthcare services will not be covered.

CHANGING LANDSCAPE OF INTERGOVERNMENTAL ARRANGEMENTS

61. The current system of public health provision, shared between national, provincial and local government, will need to be reconfigured in line with the policies contained in the White Paper and the principles contained in the Constitution.

62. Any reconfiguration of how public health functions are assigned and regulated amongst the three spheres of government will necessitate the concomitant reforms to intergovernmental fiscal relations in the health sector.

POOLING OF REVENUE

63. NHI will be established as a single-payer and single-purchaser fund responsible for the pooling of funds and the purchasing of personal health services on behalf of the entire population. The NHI Fund will be publicly administered and the administration costs will be kept to a minimum. Pooling of financial resources will strengthen the NHI Fund's purchasing power resulting in the reduction of costs of delivering personal healthcare services and expansion of the scope of personal healthcare services offered to the entire population.

64. The NHI Fund will operate at a national level as a single payer and single purchaser that is publicly administered. The NHI Fund will have specific technical functional units, namely:
    a. Planning and Forecasting Unit
    b. Benefits Design Unit
    c. Price Determination Unit
    d. Accreditation Unit
    e. Purchasing and Contracting Unit
    f. Procurement Unit
    g. Information Technology Unit
    h. Provider Payment Unit
    i. Performance Monitoring Unit
    j. Risk and Fraud Prevention Unit
    k. Legislative Unit
    l. International Cooperation Unit

65. Appropriate governance mechanisms put into place for the NHI Fund, which will function as a Schedule 3A public entity. The NHI Board will not be a stakeholder representative body, but a Board with a specific mandate of ensuring that the NHIF is functional, effective and accountable.

Containing costs and improving management

Supply-side measures

66. International experience shows that the way in which hospitals and service providers are paid influences health expenditure patterns. Costs can be contained through volume-based global budgets and case-load payment systems for hospitals, such as DRGs, introduced in many countries without leading to deteriorating quality of care. Capitation payments rather than fee-for-service charges for general practitioners and other primary care providers have typically succeeded in containing overall costs, without leading to cost-shifting to higher levels of care. Other supply side measures include coverage rules and pre-authorization, two common methods used by

purchasers to limit unjustified tests and therapies and nudge providers towards proven standard treatment pathways.

Demand-side measures

67. The focus in South African health policy on primary healthcare is a critical and necessary element in reducing the disease burden as far as possible. Entry into the health system at the lowest and most appropriate level should be incentivized through reliable local services. Evidence suggests that General Practitioner gate keeping can lead to the effective curtailment of therapies that are not clinically- or cost-effective.

PURCHASING OF HEALTH SERVICES

68. A key element of the NHI reforms is to create a purchaser-provider split by creating an institution that will strategically purchase healthcare services. The NHI Fund will receive and pool funds that it will use to strategically purchase services for the entire population.

69. The accreditation process will require providers to firstly meet the minimum quality norms and standards and be certified by the OHSC, and where relevant by the appropriate statutory professional council. Accreditation by the NHI Fund will be based on the health needs of the population and will require provider compliance with specific information and performance criteria.

70. The NHI Fund will establish Clinical Peer Review Committees with transparent and accountable processes to mitigate the potential impact of perceived inflexibility of treatment guidelines by clinicians.

71. Under NHI the provider payment mechanisms must contribute to a responsive health system by incentivising improved quality in the public sector whilst they also making delivery of healthcare efficient, affordable and sustainable. The NHI Fund will pay providers in a way that creates appropriate incentives for efficiency and for the provision of quality and accessible care. NHI will pay a uniform reimbursement strategy and there will be no balanced or split billing under NHI. The NHI Fund in consultation with the Minister will determine its own pricing and reimbursement mechanisms. Providers who wish to contract with the NHI Fund must comply with the stipulated pricing and reimbursement mechanisms.

72. The NHI Fund will use its various payment mechanisms to leverage the provision of efficient and quality services through linking provider payment to their performance and compliance with accreditation criteria. At the PHC level, the main mechanism that will be used to pay contracted providers will be a risk adjusted capitation system with an element of performance-based payment. The annual capitation amount will be linked to the registered population, target utilisation and cost levels. Contracted public and private providers will be paid in a manner appropriate to their contract which may include price and volume contracts. Consideration will be directed towards the introduction of complementary payment methods to enhance incentives for providers.

73. Services purchased from private specialists will initially be reimbursed using a capped case based fee adjusted for complexity. This will be continuously reviewed taking into account access and budget impact assessment. Purchasing of diagnostic services such as pathology and radiology services will employ a cost-based tariff schedule and volume contracts based on the needs of the catchment population and using a capitation based reimbursement model.

74. Payment related to Hospital services delivered would be determined through a system of case-mix activity adjusted payments (such as Diagnosis-Related Groups or DRGs).

75. EMS will be provided by accredited and contracted public and private providers. Payments for EMS will largely be a capped case-based fee with some adjustments made for case severity where necessary.

76. The NHI Fund will contribute to an integrated and enhanced National Health Information Repository and Data System. This system will be crucial for the implementation and effective management of the NHI and the portability of services for the population.

77. In implementing NHI, Health Technology Assessment will inform prioritisation, selection, distribution, management and introduction of interventions for health promotion, disease prevention, diagnosis, treatment and rehabilitation.

MEDICAL SCHEMES

78. With the implementation of NHI, the role of medical schemes in the health system will change and once NHI is fully implemented medical schemes will offer complementary cover to fill gaps in the service coverage offered by the NHI.

79. The State will identify all the funding for medical scheme contribution subsidies and tax credits paid to various state employee medical schemes and consolidate these into the NHI funding arrangement.

80. In the initial stages, all benefit options in the various schemes will be consolidated from the current 323 benefit options in 83 schemes to one option per scheme. Schemes covering state employees will be consolidated into one scheme, the Government Employee Medical Scheme (GEMS). The other activities to be undertaken will involve the creation of a uniform information system and standardisation of healthcare services across the medical schemes to be aligned to comprehensive healthcare services for NHI.

PHASED IMPLEMENTATION

81. The next phase extends from 2017 to 2022, which will focus on the development of the NHI legislation and amendments to other legislation.

82. The following institutions will be established during the second phase of implementation:
    a. Establishment of National Tertiary Health Services Committee
    b. Establishment of National Governing Body on Training and Development
    c. Establishment of Contracting Unit for Primary Healthcare Services
    d. Establishment of the NHI Fund
    e. Establishment of other Interim Structures in Preparation for the NHI Fund:
        i. Ministerial Advisory Committee on Health Care Benefits for National Health Insurance
        ii. National Health Service Pricing Advisory Committee
        iii. National Advisory Committee on Consolidation of Financing Arrangements
        iv. Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance

83. Activities to be undertaken by the Implementation Team include:
    a. Health Patient Registration Process (HPRS)
    b. Accreditation of Health Care Providers
    c. Development of Provider Payment Mechanisms
    d. Phased Implementation of Purchasing of NHI Service Benefits
    e. Legislative Reforms
    f. Establishment of Governance Structures
    g. Establishment of a fully functional NHI Fund
    h. Purchasing of Hospital Services to be Funded by NHI
    i. Introduction of Mandatory Prepayment for the NHI
    j. Contracting for Accredited Private Hospital and Specialist Services

CONCLUSION

84. This White Paper is aimed at achieving the goal of universal coverage in South Africa through the implementation of NHI. National Health Insurance seeks to transform the national health system

financing mechanisms. Moving towards UHC requires transformation of health service delivery and management, particularly to improve the quality in the health sector. Transforming the health care financing system requires changing how revenue is collected and even more importantly, addressing how generated funds are pooled and how quality services are purchased. The success of NHI will requires building a responsive health care system that is people-centred. Implementation of NHI will require amendment of related legislation and enactment of new laws to ensure that there is not only legislative alignment but also policy consistence across government departments and spheres of government.