Rural Health Advocacy Project

Submission by the Rural Health Advocacy Project

National Health Insurance Bill, 2019

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1. The Rural Health Advocacy Project (RHAP) is a non-profit advocacy partnership, which advocates for equitable access to quality health care services. RHAP was founded in 2009 as a collaboration between the Wits Centre for Rural Health, the AIDS Law Project now SECTION27 and the Rural Doctors Association of South Africa. Our advocacy is informed by research and the voices of rural health care workers, communities and healthcare users. We derive our mandate from the Constitution of the Republic of South Africa which guarantees all people in South Africa the right to health care services including reproductive health and emergency medical services.

2. The relationship between poverty, healthcare and poor health outcomes has been well established; not only do poor people experience higher burdens of disease because of various social determinants, they also have less access to care. Globally, research continues to show that this is particularly acute for rural populations. These populations tend to carry a disproportionate burden of both communicable and non-communicable diseases and across almost all indicators experience worse health outcomes[1]. The South African context is no different and any transformative project, such as the National Health Insurance (NHI), must necessarily account for the unique demographic epidemiological and socio-economic factors that shape the lived reality of rural communities.

3. South Africa is introducing the National Health Insurance reforms to guide the country's transition to Universal Health Coverage (UHC). Some have argued that South Africa already has universal coverage of essential health services with a comprehensive set of

[1]David H Peters, Anu Garg, Gerald Bloom, Damian Walker, William Brieger, and Hafizur Rahman. *Poverty and access to health care in developing countries*, Annals of the New York Academy of Sciences, 1136, no 1 (2008): 161-171.

public sector entitlements[2]. This may be true in theory but when considered in respect of the dimensions of access which include physical access, affordability and acceptability of services, it is clear that rural communities, particularly those residing in the country's former rural homelands, have significantly less access to health services. In fact, they do not have universal access. Rural districts also perform poorly across a number of health indicators.

4. The National Health Insurance Bill was gazetted on the 26 July 2019 and provides the legislative framework for the country's transition to a universal health system with the goal of achieving and sustaining UHC. The Bill is being introduced during a period were trust in government and the capability of the state is extremely low following a period of abuse of state resources by a group of politically connected elites. The governing party continues to struggle to maintain unity following a fierce internal leadership contestation with the reformist president obtaining a slim majority. The most recent national election saw the governing party deliver its worst performance since the advent of democracy. The situation is compounded by the growth of ethnic based populist parties and a decline in support for the country's main opposition party. While voter turnout may have been a factor it is nonetheless clear that the electorate is losing patience with the political class and the health system transformation towards UHC through NHI presents an opportunity to return to first principles as recorded in the preamble of our constitution "to improve the quality of life of all citizens and to release their innate capabilities". Given the centrality of good health to the achievement of a better life there may never be a better time for reform.

WHY WE NEED REFORM

5. South Africa invests heavily in health with around 12% of the national budget allocated to the funding of health care services for the majority of South Africans who do not have access to health insurance. Services are mostly free at Primary Health Care level where the majority access health care services.[3] Access is also provided to higher levels of care at a relatively low cost, or no cost based on a means test, in a public-sector network of over 350 hospitals.

6. The majority of health funding is allocated to provincial governments through an unconditional provincial equitable share formula. This formula is essentially a composite index which includes weightings for education, health, economic output, a basic component as well as an institutional component. It needs to be emphasised that three of these five components are informed by population size which negatively impacts largely rural provinces which are susceptible to outward migration while facing higher costs of service delivery due to the rural context.

[2] South African National Department of Health, *South African Health Review 2018*, 2018. Durban: Health Systems Trust, 2018

[3] Di McIntyre and John Ataguba, *Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge?* Health Economics Unit, University of Cape Town, 2016.

7. Provincial health budgets are augmented by a number of conditional grants that support strategic investments such the response to HIV AIDS and TB as well as health facility revitalisation grants, tertiary services grant, health professional training grants as well as more recent grants such as the NHI indirect grants. With the exception of the indirect NHI grants all the grants are held nationally but spent provincially.

   A major gap in current institutional arrangements is the relative discretion exercised by provincial governments in the allocation of resources. While the total equitable share that each province receives is informed for 27% on the basis of provincial health indicators including risk adjusted capitation to accounts for the need for health care services, a number of provinces allocate less than this 27% of income based on health need to the actual provincial health budget. Provincial allocations for health often only sustain district health services with small inflation adjustments each year despite relative expansion of health need.

8. A further constraint to the achievement to UHC is the existence of a two-tier health market. On the one end is the public sector which services the uninsured and largely poor communities that make up 84% of the population while on the other end is the well-resourced private sector servicing a mere 16% of the population. Both are reliant on the limited human resources for health and it is no surprise that the private sector has a larger ratio of health workers to patients than the public sector. Despite its fairly low population coverage, the private sector garners more than 50% of health care spending which includes significant out of pocket expenditure with estimates ranging from 25 -70 billion annually.

9. Accordingly, the Rural Health Advocacy Project is in full support of the principles of the proposed National Health Insurance which aims to unite the fragmented health system to achieve equitable access to all who need it regardless of socio-economic status. It is from this perspective that we comment on the Bill as we consider how the proposals for establishment of the NHI fund and related entities will help progressively realise the right to health in South Africa.

10. In its deliberations, the South African Lancet Commission on high quality health systems in the sustainable development era considered a health system to be of quality when it "achieves equitable health outcomes and a long and healthy life for all".[4] Such a health system is:

    - *Designed* to prioritise health promotion and protection, the prevention, treatment and rehabilitation of conditions that constitute South Africa's disease burden.
    - *Accountable* through effective leadership and governance.
    - *People-centred* in its approach to realising good health by facilitating patient, provider and community participation in health attainment.

[4] South African Lancet National Commission. *Confronting the right to ethical and accountable quality health care in South Africa: A consensus report*. Pretoria: National Department of Health, 2019.

- *Responsive* to patient needs by providing comprehensive care in a timely and safe manner resulting in quality outcomes.
- *Adaptive* to changing health needs through the collection, analysis and dissemination of *information*
- *Equitable* through allocations and distribution of resources that ensure quality health service delivery to all regardless of gender, sexual orientation, socio-economic status and/or geographic location.
- *Collaborative* with other sectors to address the social determinants of health.

11. While the objective of the Bill is the establishment of the National Health Insurance Fund (NHIF), given its primary function of being the principle purchaser of health care services, the operations of the Fund will likely impact on the functioning of the entire health system. What follows is a number of key concerns we have in relation to the Bill.

Governance Arrangements of the Fund

12. Chapter one of the Bill lays out its stated purpose which is the establishment of the National Health Insurance Fund which will be tasked with the responsibility of a single purchaser of health care services towards the achievement of Universal Health Coverage (UHC).

13. UHC is the aspiration that all people can obtain the health services they need, of good quality, without suffering financial hardship when paying for them. Health services cover promotion, prevention, treatment, rehabilitation and palliative care, all levels of service delivery (from community health workers to tertiary hospitals) and services across the life course. As such, they also address communicable and non-communicable diseases.[5]

14. South Africa is ranked amongst the most unequal societies in the world and this inequality is mirrored in the extent of unequal access to health care services. It follows then that different sectors of the populations are at different stages on the journey to universal health coverage. How the NHIF approaches the need for prioritisation of underserved rural communities will determine whether and how fast the NHIF will achieve equity for all who live in South Africa.

15. In an environment of low trust in public institutions, and to build trust, it is critical that decisions affecting UHC are navigated based on principles of inclusivity and transparency. In this respect it is useful to consider the World Bank guidelines (2008) on effective governance of mandatory health insurance schemes which include[6]:
    1. Coherent decision making structures
    2. Stakeholder Participation
    3. Transparency and Information
    4. Supervision and Regulation

[5] *World Health Organisation*, *Universal health coverage (UHC),* 24 January 2019, https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
[6] William D Savedoff and Pablo Gottret, ed.,*Governing Mandatory Health Insurance Learning from Experience (Washington DC: The World Bank, 2008).*

5. Consistency

16. The National Health Insurance Bill while principally concerned with the establishment of the NHIF through its establishment and ascribed mandate as single purchaser and single payer for health care services, introduces changes to existing provisions within the National Health Act (NHA) that governs the relationship between the National Department of Health and Provincial Departments of Health who have concurrent responsibility for the provision of health care services.

17. Chapter 4 of the NHI Bill lays out the functions and powers of the NHIF. It introduces the notion that the primary line of authority over the fund is with the Minister of Health (from now on 'the Minister'). Recognising the responsibility for stewardship of the health system the exclusion of the advisory role performed by the National Health Council as envisaged in chapter 3 of the NHA weakens the governance. While in its current form the council is composed principally of provincial MEC's for health and their heads of department as well as the Director General and DDGs, membership could be extended to include representatives of private sector providers. This would allow for broader stakeholder participation in the design and governance of health systems.

18. Chapter 5 informs the establishment of the NHIF board as well as its composition. While mandated to protect the interests of health care users it is surprising that no provision is made for the inclusion of health care users or civil society within the 11 member board. It is also unclear to who elected board members would be accountable. The oversight function of the board will be vastly improved with the inclusion of community representatives. While imperfect it may be useful to consider the establishment of a broader representative body similar to the South African National AIDS Council where representatives are elected by their respective sectors and have accountability to the sectors who elected them.

19. It is general principle of good governance that the chair of the board is almost always elected from amongst members of the board. There is no rationale for the Minister to be tasked with the appointment of the board chair. Accordingly it would be in the interest of good governance and public trust for this section to be amended accordingly.

20. Chapter 5 of the NHI bill lays out the role of chief executive officer as well as the appointment of the CEO. Given the importance of the role of the CEO in the effective running of the NHIF it may seem logical for the minister to approve the appointment of the CEO after consulting cabinet. However, we argue that it may be in the public interest for the appointment to be made by the board, as having the appointment made by the minister would imply an accountability to the minister instead of the board to whom the CEO should be accountable.

21. Chapter 5 also imposes a number of accountability lines for the CEO. It requires the CEO to account to the board as well as parliament as least once a quarter. Additionally the CEO is also required to meet the Minister, the Director General and the CEO of the Office of Health Standards Compliance at least once a quarter. While this suggests a

fairly high level of transparency it is not clear as what he/she will be required to report on and, crucially, the extent to which information presented will be available for public scrutiny.

22. Chapter 7 introduces a set of ministerial committees intended to support the Minister in his role as steward of the health system and of the National Health Insurance Fund. These are the benefits advisory committee, the pricing committee and the stakeholders committee. The Minister is instructed to set up these committees in consultation with the NHI Fund board. Both the benefits and the pricing committee now includes expertise in patient rights which is an improvement on previous versions of the Bill. However there are no provisions to inform how members will be recommended for appointment. The benefits advisory committee and its predecessor described in Section 57 of the Bill is tasked with the design of the NHI package.I n the design of the package the committee will be faced with difficult choices. Section 27 of the constitution affords everyone access to healthcare including sexual and reproductive health with the caveat that the state is obligated to progressively expand this right within available means. Given that an extensive public sector benefit package already exists it is essential that the committee ensures that at the very least these benefits are not eroded in the design of the package. The situation is complicated by the extensive benefit package in the private sector which are currently not available in the public sector. Consideration should also be given to the varying implementation contexts particular in rural areas where more that 95% of the population are reliant on public sector health services. Continued under investment in access to healthcare in rural areas has translated in diminished service delivery capacity. This has resulted in rural communities enjoying limited access to the full quantum of services offered elsewhere in the public and private sectors. The underlying principle for distribution of healthcare resources should be that all people have adequate access to healthcare. Accordingly we suggest that instead of a narrow package that expands over time, we should start rolling out a comprehensive package of services to particularly vulnerable groups including but not limited to rural communities, children, people living with disabilities including mental health, women and the elderly, and expand progressively from there to the general population.

23. In order to ensure that the interest of health care users is fully expressed it is essential that membership in the benefits advisory committee is extended to representatives of health care users. Additionally, membership should not be at the pleasure of the minister and his office but rather by way of a public call for nominations

24. The function of the health benefits pricing committee, which is intended to advise the minister on the determination of pricing needs, to be elaborated. The delivery of quality health care services is a fairly specialised business in the absence of any determination as to how the committee with arrive at appropriate pricing. In the absence of clarification, it may lead to a view that the NHI fund will exploit its position to set prices which could undermine the sustainability of the fund as health providers may opt out of the system.

25. The stakeholder advisory committee appears to have no function and it is the only committee that includes patient advocacy and civil society groups. The function and authority thus needs to be clarified.

26. Chapter 8 Section 32 assigns the role of management agent for the provision of health care services. The concept of management agent is not fully explained. What is also unclear is whether the function of management pertains to the facilities owned and operated by provinces or to all providers within a province. However, it does afford provinces a very important role and responsibility insofar as ensuring that communities are able to exercise their agency in the governance of health care facilities. Current provincial legislation in respect of the role and functions of clinic committees and hospital boards need to be refined to ensure that community involvement extends to actual oversight of facilities. This role must also extended to the contracting units for primary care.

27. Section 36 introduces the District Health Management Office (DHMO) and the full scope of the DHMO is included in the proposed amendments to Section 31 of the National Health Act. The functions of the DHMO are principally to provide oversight to the service delivery by contracted NHI facilities. Additionally, while outside the scope of the current Bill, there is a further important opportunity for improved public participation and governance by expanding the membership of district health forums beyond politicians and technocrats to include representatives of facility oversight structures such as clinic committees and hospital boards.

Eligibility and Conditions to Accessing the NHIF

28. Section 27 of the constitution guarantees EVERYONE access to health care services including sexual and reproductive services. The provisions set out in Chapter 2 of the NHI BILL represent a regression of this right insofar as the undocumented migrants who specifically excluded from access to health care services. While it may be understandable to limit access to health care services visitors as provision places a responsibility on visitors to the republic and international students to have appropriate medical insurance the case of documented migrants many of whom have been ordinarily resident in the country for some time needs deeper consideration. Current provision within the National Health Act do not specifically exclude undocumented migrants and the retention of current provisions in the NHI BILL would appear on face value to regress access to health care services which may be unconstitutional.

29. While not specifically excluded there is no consideration of the differential access to health care services within the country particular those of rural communities. In South Africa, rural areas have been disadvantaged through historical and structural neglect.[7]

[7] *Stuckler et al., Health Care Capacity and Allocations Among South Africa's Provinces: Infrastructure–Inequality Traps After the End of Apartheid*, 101, 1, (2011): 165-172.

This means that if social justice and equity are underlying principles in the NHI, which they are, then rural should be given priority when considering the expanded coverage envisaged in the NHI Bill. This will avoid a situation where current maldistribution of resources between rural and urban areas and public and private is perpetuated in the implementation of these reforms.

Rural-Proofing the District-Based Purchasing and Oversight Model

30. Section 37 introduces the Contracting Unit for Primary Care (CUP). The membership of the CUP includes District Hospitals, Community Health Centres, Primary Healthcare Centres, general practioners and allied health professionals operating in horizontal networks. We are concerned that it is unclear how the CUP will be coordinated or how the various levels will interact with each other. Given the broad commissioning powers afforded to the CUP, the addition of a sub-district oversight mechanism would support greater transparency in its operations.

31. In the NHI White Paper, the Department of Health proposed a system where all funds for PHC services will be pooled at the district level and services will then be purchased from both public and private providers. The allocation of funds to districts will be based on factors including, "the size of the population served, epidemiological profile taking account of target utilisation rates and average costs of providing a comprehensive range of personal health services at the PHC level".[8] Service providers will then be reimbursed on a risk-adjusted capitation system linked to a performance-based mechanism. The annual capitation amount will be linked to the size of the registered population; epidemiological profile; and target utilisation and cost levels.[9] This approach to the financing of PHC services would be a marked improvement from the historical and incremental approach to financing PHC services in the public sector. The difficulty with this, however, is that both the determination of budgets allocated to districts and then the payment of providers on the risk adjusted-capitation use, again, utilisation as a sole benchmark for need. These approaches do not account for unmet need that exists among the population not accessing healthcare and thus the importance of implementing interventions to improve access. It is also not clear that either model could account for variations in costs associated with the delivery of services in different contexts. As we have already argued, a number of factors make service delivery in rural settings more expensive. These include:

    - The distance between facilities and different levels of care renders supply chain, referral and outreach more expensive
    - Low population densities mean that rural facilities do not benefit from economies of scale, which results in higher per capita costs than in urban facilities

[8] South African Government, National Department of Health, *White Paper on National Health Insurance,* No, 39506, 2015, Government Gazette.
[9] Ibid

- The complexity of service delivery in rural settings (i.e. access and complexity of cases-mix) all renders the cost of providing services in rural communities more expensive.

These factors make rural providers seem less efficient. Artificially inflated per capita costs then make it seem as if rural providers are comparatively well funded when compared to their urban counterparts. This effect, if not properly mitigated, means that there is a significant risk that this approach will only serve to deepen real inequity between rural and urban facilities. Rural providers could potentially be disadvantaged by the performance component, which rewards providers for exceeding targets, if contextual differences are not carefully considered in the determination of targets and what constitutes good performance more generally. If this approach to the payment of providers at the PHC level is going to be effective, it is essential that the allocation of resources to the district and the risk-adjusted capitation formula used in the payment of service providers include a rural adjuster.

32. Section 35 introduces the basis on which the NHIF will reimburse service providers. Section 35 (1)(a) makes provision for the NHIF to purchase healthcare services from both public and private healthcare providers on the basis of need. This is in contrast with the White Paper, which proposed that the public sector would serve as the primary provider, with private providers acting only as a clearing house for excess demand. In the absence of any requirements for the issuing of certificates of need in the establishment of new health facilities, there is a possibility that we could see a proliferation on new facilities in potentially profitable urban areas and a continued under-investment in rural underserved areas.

FINANCIAL MATTERS

33. Section 11 1(e) authorises the NHIF to issue debt instruments, which, stated differently, means that the NHIF can enter into loan agreements, to issue bonds etc. As discussed above, there are a number of scenarios where a fund can run an annual deficit which is not unusual. The authority to enter into loan agreements can be used to offset these deficits. However, in the absence of guidance as to how these agreements will be authorised or the absence of limits to borrowing, it has the potential to negatively affect the financial sustainability of the NHIF. What is also unclear is whether these instruments would be underwritten by Government. Our recent experience with issuing of guarantees to state owned enterprises most notably Eskom demonstrate the inherent risks to blanket guarantees. The section needs to be revised to address this.

34. For the provision of health care in rural contexts, carefully considered budgets are essential to ensuring sufficient resources are available to deliver on activities and meet objectives. Due to various contextual factors, such as additional expenses associated with transporting goods to hard to reach outlying areas, service delivery in rural settings

is often more expensive than in urban centres.[10] There are also additional costs associated with attracting and keeping health care workers to rural areas. In this instance, added costs may include additional remuneration in the form of a rural allowance or the provision of subsidized accommodation[11]. On a per capita basis, service delivery also tends to be more expensive in rural areas because of diseconomies of scale.[12] As mentioned before, in South Africa, rural areas have been disadvantaged through historical and structural neglect[13].. And again, this means that if social justice and equity are underlying principles in the budget process, which they are, then rural should be given priority when deciding on allocations. In conclusion, to avoid a situation where health systems in rural areas are under-resourced, it is critically important that rural cost factors are accounted for in budgeting at all levels of the health system.

35. Section 35 subsection 2 proposes that all hospitals with the exception of the district hospitals, are paid directly on a Disease Related Group (DRG) basis. In the public system hospitals receive global budgets that are determined historically and for the most part budgets are only adjusted for inflation each year. In the private sector, reimbursement is on a fee for service basis. Neither approach is particularly good at promoting efficiency, effectiveness or equity in the provisioning of services at the hospital level. We therefore support the intention articulated in the Bill to move towards the DRG model, a case-mix approach to the reimbursement of hospitals in both the public and private sectors under the NHI.

    DRGs are groups of patients who have been treated for the same condition (based on diagnosis, procedures, and age), co-morbidities and individual needs. The use of DRGs provides a means of defining and measuring a hospital's case mix complexity. Normally, the term "case mix complexity" is used to refer to a set of patient attributes which include severity of illness, risk of dying, prognosis, treatment difficulty, need for intervention, and resource intensity. The more complex the case mix, the more costly to manage; sufficient funds will then be allocated under the NHI. As part of the transitional arrangements it is important that the various DRG groups be defined and agreed and we urge that these are piloted in rural districts so that any rural specific considerations can be included in the final policy.

36. Some concerns with the use of DRGs as the primary mechanism for reimbursing rural hospitals is that it is a method that uses in-patient numbers to determine utilisation. Utilisation is then, again, used as a proxy for need. As is the case with other utilisation

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[10] Hilda R Heady, *A delicate balance: The economics of rural healthcare delivery*, 2002. Available at: https://jamanetwork.com/journals/jama/fullarticle/1844608

[11] Rural Health Advocacy Project. *The WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved recruitment and retention. The South African Context.* Johannesburg, 2019. Available at: http://rhap.org.za/hr4rh-who-guidelines-the-sa-context/

[12] Hilda R Heady, *A delicate balance: The economics of rural healthcare delivery*, 2002. Available at: *https://jamanetwork.com/journals/jama/fullarticle/1844608*

[13] *Stuckler et al., Health Care Capacity and Allocations among South Africa's Provinces: Infrastructure–Inequality Traps After the End of Apartheid*, 101, 1, (2011): 165-172.

methods, this approach can be anti-rural if the following issues are not dealt with appropriately[14]:

- Case mix complexity must not be evaluated on clinical criteria alone. The logistics associated with management of patients in rural areas increases the complexity and costs, for which more budget must be allocated.
- DRGs are concerned with in-patient numbers and case mix; but rural facilities spend proportionately more time and resources on comprehensive outpatient consultations than others, owing to the problems around continuity of care (referrals and admissions).
- Access to the health system will remain difficult in rural communities; this will mean outreach from the rural hospital will continue as a cost-effective method of health care delivery. This requires significant funding (transport, extra staff), and must be considered in addition to DRG funding mechanisms if equitable access is to be achieved
- Continuity of care and referral processes are, even if working well, more difficult between rural and their urban referral centres, resulting in greater treatment difficulty, higher resource intensity, and greater severity of illness (on average) being found at rural facilities, compared to similar urban facilities. The referral pathway needs to be costed and it essential that the referral path travelled by a patient is dignified with safe, comfortable overnight facilities and transport for rural patients travelling to specialist centres.
- Rural health needs are far greater than the current demand. It is vital to tie funding to health needs rather than demand.

Rural-Proofing the Staffing Approach

37. Section 38 (2) (b) defines the minimum criteria service providers are required to meet in order in order to be accredited by the NHIF which includes an appropriate staffing mix to deliver services defined by the Fund. In the determination of the appropriate staffing mix, we argued in our submission on the NHI White Paper that there are a number of factors that should be considered when accounting for rural health in the determination of human resource needs. Like other aspects of planning for rural, issues such as geographic remoteness, high levels of deprivation, under-developed infrastructure, the virtual absence of social infrastructure, and pervasive socio-economic deprivation all make it more difficult to attract and retain healthcare workers to rural areas. As a start, the determination of need or more specifically the determination of minimum staffing levels should be based on an assessment of factors beyond crude utilisation measures, such as bed occupancy or PHC headcount. Measures of utilisation cannot capture the complexity of service delivery in rural contexts where service delivery is often more time consuming as there are limited options for further referral. Rural healthcare workers are also required to have more generalist skill sets and perform tasks that would ordinarily be referred to more specialised cadres or levels of

[14] RuDASA, RHAP and partners. *Submission on the Green Paper on National Health Insurance: RURAL NOW!* Johannesburg, 2011. Available at: http://rhap.org.za/wp-content/uploads/2013/11/NHI_GreenPaper-RuDASA-and-partners_11-December-2011.pdf

care. A persistent issue with the determination of human resource needs in health planning in South Africa generally has been the neglect of categories of staff beyond nurses, doctors and pharmacists. Other cadres or health professional, such as those working in rehabilitation and dentistry, tend to be regarded as a 'nice to have' rather than a key component of a truly effective health system. In rural settings, the neglect of rehabilitation professionals (such as occupational therapists and physiotherapists), for example, has meant that most patients with disabilities seldom receive the support and care that they need. This often has the effect of preventing them from receiving care timeously and when they do eventually make it to a facility, their cases are often more complex and expensive to treat.

For Rural Rehabilitation Services, as a critical example, the following elements should be considered: [15]

1. By definition a comprehensive package of care must include rehabilitation services including mental health, eye care, audiology and other assistive devices. Integrated multi-disciplinary team work is essential for benefits to be realised.
2. Need, particularly where rehabilitation is concerned, cannot be based on utilisation rates, as
    (a) in many places these services have not existed and therefore no details available, and
    (b) many people with disabilities, by definition, struggle to access health services, and their needs are therefore underrepresented in utilisation data.
3. In the absence of adequate data on the nature and prevalence of disability in theSA population, a benchmarking from the few well-established rural rehabilitation services (e.g. Manguzi and Mseleni) Hospitals in Kwazulu-Natal) should be undertaken as a matter of urgency.
4. HR planning must prioritise posts for permanent senior therapists, both production level and management. There is increased enthusiasm among graduate therapists to work in rural areas, but such workers can only supplement, not create, effective, high-quality and sustainable services.
5. Rehabilitation HR must be concentrated at PHC level. There is merit in the rural district hospital being a hub for PHC planning and service delivery, and we propose that multidisciplinary teams of rehab professionals may be based at these institutions in order to provide and support community-based rehabilitation. Adequate resources, particularly transport, are essential for this to be feasible.
6. Appropriately skilled and supported mid-level rehabilitation workers, placed within WBOT's, are a central cadre of worker to deliver rehab services in rural communities, and have been shown to be effective in facilitating healthcare

[15] Rural Health Advocacy Project and Partners (RuRESA, RuDASA, Wits Centre for Rural Health, Ukwanda Centre for Rural Health, PACASA and UCT: PHC Directorate), *Rural Health Partner Network Submission on NHI White Paper,* 2016. Available at: http://rhap.org.za/wp-content/uploads/2017/09/RHAP-National-Health-insurance-White-Paper-Low-res.pdf

access for this hard-to-reach population. With the right planning, such workers could also deliver the bulk of psychosocial rehabilitation services envisaged in the Mental Health Strategic Framework.

7. Finally, private sector rehabilitation differs in several key respects from other types of private healthcare, and contracting proposals must address the unique situation of therapists, not simply apply the principles developed for doctors, dentists and other cadres. For a range of reasons, it seems unlikely that contracted private therapists will be able to make a significant contribution to rural healthcare. At present, creation of fulltime posts for permanent therapists in rural health facilities is a far more promising strategy.

38. In broadening access to care, it is understood that resource constraints often limit what is possible. We appreciate that there is also a need to contain costs while not compromising on care. There are cost-effective solutions to addressing both the need to improve service delivery while not compromising limited resources. Task sharing offers one solution to addressing this issue. Clinical Associates (ClinAs), for example, can alleviate much of the pressure on doctors by performing routine patient examination, diagnostics, therapeutic procedures, and inpatient care. In these instances ClinAs, under supervision, can be as effective as a doctor at a fraction of the cost. By performing more routine tasks, ClinAs free up the doctors time to perform more complex and specialised procedures. Similarly Community Health Workers (CHWs), under the supervision of nurses, can undertake routine PHC tasks, such as health screening, which then allows nurses to perform more complex diagnostic and curative tasks in the PHC setting.

39. Section 52 outlines a wrath of regulations for the consideration by the Minister in consultation with the National Health Council (NHC). Given time bound pressures linked to the implementation phases of the NHIF, as well as in the interest of transparency, we recommend the establishment of a task team that includes sector specialists and representatives of civil society to accelerate the review and tabling of these regulations. Careful consideration should also be given to the varying implementation contexts and specific consideration must be given to the inclusion of measures that ensure the complexities of the rural implementation context are fully considered.

40. Section 57 provides transitional measures during the implementation of the Fund and provide a number of opportunities to address the immediate crisis in the delivery of healthcare services in the public sector. It is important to note that we are already midway into the second phase of the NHI (2017-2022). This places significant pressure on the work of the transitional committees of which the members are yet to be announced, despite the fact that applications for participation in these closed in October 2017.

41. Given the ongoing crisis in the availability of human resources for health, the work of the National Governing Body on Training and Development proposed under section 54 is of particular importance. In addition to our proposals in respect of section 38 (2)(b) we

recommend that the committee considers the recommendations of the WHO 2010 guidelines on the recruitment and retention of health care workers which include[16]:

A. Education Recommendations

1. Use targeted admission policies to enrol students with a rural background in education programmes for various health disciplines, in order to increase the likelihood of graduates choosing to practice in rural areas.
2. Locate health professional schools, campuses and family medicine residency programmes outside of capitals and other major cities as graduates of these schools and programmes are more likely to work in rural areas.
3. Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas
4. Revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.
5. Design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.

B. Regulatory Recommendations

1. Introduce and regulate enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction thereby assisting recruitment and retention.
2. Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practicing in rural and remote areas.
3. Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in these areas.
4. Provide scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas.

C. Financial Incentives Recommendation

1. Use a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation, paid vacations, etc. sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention.

[16] WHO. *Increasing access to health workers in remote and rural areas through improved retention*. WHO: Geneva, 2010. Available at:

D. Personal And Professional Support

1. Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools, etc.), as these factors have a significant influence on a health worker's decision to locate to and remain in rural areas.
2. Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive and thereby increase the recruitment and retention of health workers in remote and rural areas.
3. Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use telehealth to provide additional support to health workers in remote and rural areas.
4. Develop and support career development programmes and provide senior posts in rural areas so that health workers can move up the career path as a result of experience, education and training, without necessarily leaving rural areas.
5. Support the development of professional networks, rural health professional associations, rural health journals, etc, in order to improve the morale and status of rural providers and reduce feelings of professional isolation.
6. Adopt public recognition measures such as rural health days, awards and titles at local national and international levels to lift the profile of working in rural areas as these create the conditions to improve intrinsic motivation and thereby contribute to the retention of rural health workers.

42. Section 57 (4)(f) outlines the immediate priority populations that are to be considered in the current phase. We welcome the expressed inclusion of rural populations as a priority population which effectively provides an opportunity to meaningfully address the service delivery backlogs present in rural health care as well as further prioritisation of the personal health services such as primary health care services, maternity and child healthcare services including school health services, healthcare services for the aged, people with disabilities. To do this effectively will require a reorganization of how rural health care is currently delivered and resourced.

    1. Firstly, the approach of budgeting in response to health need as opposed to historical utilisation will require a shift from the current largely passive approach to health care delivery to more active management of health needs by public health managers.
    2. Secondly, the clustering of health providers within a contracting unit for primary care also introduces a significant change from current operational practices. In the current district health system, district hospitals and primary healthcare clinics have different reporting lines with the latter reporting into sub district management and the former reporting into the district. Shifting to a more defined relationship between PHCWBOT, PHC, CHC and district hospitals will require a pendulum shift from current practices which will require significant capacity development within rural districts.

In conclusion, the proposals included in the NHI Bill mark an important step in the transformation of the health system but come at a time when the health system is under significant strain. As such, the reforms proposed cannot be considered in an a-historical manner and must heed the need of increased stakeholder participation in the design and delivery of these reforms. As Parliament considers the comments to the Bill, it should consider deeper engagement with these groups to ensure that the concerns and hopes are fully included in the Bill presented to Parliament.

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