Rural Health Advocacy Project

Submission by the Rural Health Advocacy Project. Version 2

National Health Insurance Bill, 2018

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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, 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 rural areas.

3. The NHI aims to achieve justice in healthcare access for all based on need. To achieve this aim we need to take into consideration the healthcare package as well as social justice considerations. In so doing the benefit of the NHI must extend

[1] Peters, D.H., Garg, A., Bloom, G., Walker, D.G., Brieger, W.R. and Hafizur Rahman, M., 2008. Poverty and access to health care in developing countries. Annals of the New York Academy of Sciences, 1136(1), pp.161-171.

beyond free access to health benefits at the point of care but must also ensure that it is accessible to all, regardless of socio-economic conditions. In defining "access for all" it is imperative that we do not only speak of financial access at the point of care; "access for all" should refer to adequate access in terms of financial, physical and acceptable access. This is of particular importance for rural healthcare, where access may not be at the doorstep as in urban areas. Instead, rural communities face significant barriers to care including topography which impacts on distances travelled. Similarly, rural communities are also more sparsely populated meaning that facilities often do not have the benefit of economies of scale associated with more densely populated urban areas. Accordingly, rural healthcare is more expensive and rural communities are also more likely to be referred than their urban counterparts. It is therefore crucial that NHI must consider and enable coverage innovations and solutions that bring healthcare in reach of remote communities; that ensure that rural communities experience "dignified pathways to higher levels of care" and that protect rural communities from catastrophic healthcare expenditures accessing facilities, such as high costs of transport.

4. On 21 June, the South African government released the National Health Insurance Bill which marked the next transition in the path to Universal Health Coverage (UHC). The achievement of UHC is predicated on a functioning universal health system[2]. A 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. 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 equal 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.

5. As a point of departure, we would like to begin with contextualising the proposed reforms within a health system approach starting with defining a health system from a South African context. 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”.[3] Such a health system is:

[2] https://www.parliament.gov.za/storage/app/media/Pages/2017/october/High_Level_Panel/Commissioned_reports_for_triple_challenges_of_poverty_unemployment_and_inequality/Diagnostic_Report_on_Access_to_Quality_Healthcare.pdf (Accessed September 2018)
[3] High Quality Health Systems in the era of the Sustainable Development Goals South Africa Country Report (Under Review)

- *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.
- *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.

6. 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.

Community Participation and Accountability

7. A key aspect on which the Bill is largely silent is the extent to which communities will participate in the design, delivery and oversight of the NHI. The Bill excludes communities from direct oversight of the Fund, the Ministerial Advisory Committees, the Contracting Units for Primary Care and the expanded district health management offices proposed in the NHIF. In this respect it is useful to consider the World Bank guidelines (2008)on effective governance of mandatory health insurance schemes which include[4]:

    1. Coherent decision making structures
    2. Stakeholder Participation
    3. Transparency and Information
    4. Supervision and Regulation
    5. Consistency

Rural Implementation Context

[4] http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/Peer-Reviewed-Publications/GovMandatoryHlthIns.pdf

8. Section 4 introduces the objective of the Bill which is the establishment of the NHIF and in its subsections provides some insight to the mandate of NHIF. Section 4(b) introduces the concept of the single purchaser and the obligation of the NHIF to plan for the equitable and fair distribution and use of healthcare services. The Bill does not consider the varying implementation contexts within the country, particularly in rural areas where the populations are widely dispersed and landscape topography impact on the ability to realise their health needs. Currently district health budgets are based on historical utilisation figures and as such do not consider unmet health needs. Accordingly, in the determination of budgets the NHIF must explicitly account for the varying rural implementation context in its purchasing of appropriate health care services.

9. Section 5(g) bestows upon NHIF the responsibility to ensure that funding levels are appropriate for the levels of funding for each level of care. The NHIF will purchase health care services from provincial departments of health and private sector providers with the former, as per the White Paper, being the principle provider. It is unclear however, how the NHIF will determine the appropriate level of funding. Given the infrastructure-inequity gap between rural and urban areas, it must be clearly spelled out how the NHIF will ensure that rural under-invested areas are sufficiently funded to address historical legacies.

10. In the 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".[5] 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.[6] 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 and 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:

[5] National Health Insurance White Paper 2015
[6] Ibib

- 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
- 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 also 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 then the risk-adjusted capitation formula used in the payment of service providers must include a rural adjuster.

11. Section 5(k) introduces a performance based reimbursement scheme by indicating that the NHIF must pay providers in accordance with the quality and value of the service provided. Rural communities have, overall, consistently received lower quality of care as a result of continued under-investment in the rural service delivery platform. Much needs to be done to ensure equal quality; we should not allow a situation under the NHIF where different populations receive a different quality of service. The prioritisation of rural populations proposed under section 54 of the Bill provides an opportunity to address this under-investment and there needs to be an explicit prioritisation of rural facilities in the identification of health system strengthening initiatives in the current phase of the NHI.

12. Additionally section 5(k) needs a specific reference as to how quality will be assessed and by whom. This would contribute to greater transparency in decision making and build trust in the operations of the fund. Similarly, there are a number of ways to assess value; it could refer to the monetary value of the service provided or it could refer to the perceived value added. The intended interpretation needs to be explicit.

13. Section 6(h) also deals with the issue of quality and suggests that a consistent use of quality be used throughout the Bill. The use of reasonable quality in this section is open to interpretation and could result in the provision of varying levels of quality of services being purchased across the system. In the current delivery context,

services in rural communities are primarily delivered by public sector facilities and in the absence of alternatives, there is a real risk that variations in quality could manifest here.

14. Section 5(s) subsection 2 is in line with section 195 of the Constitution, which states that the exclusion of any specific reference to equity in addition to cost effectiveness may be detrimental to the rural health context. As discussed, the rural health implementation context is varied. There are inter provincial variations as well as intra district variations within some districts, particularly those with a combination of urban and rural contexts. An over-reliance on cost effectiveness approaches without consideration of equity based approaches to healthcare will negatively impact on the funding of healthcare services in rural environments. Cost-effectiveness approaches have great value in choosing between alternative modes of adequate healthcare delivery, but should not be used to discriminate against or even exclude adequate healthcare access for specific population groups, such as on basis of geographic location/smaller economies of scale.

Governance, Decision-Making and Accountability

15. Section 5 describes the duties of NHIF in realising the goal of universal health access. Section 5(c) assigns the duty of benefit design to an appropriate committee of theNHIF. This appears incongruent with the Ministerial Advisory for Health Benefits committee envisioned under section 25 which is ascribed similar duties. Similarly section 5(g) also points to potential overlap between the Ministerial Advisory Committee on pricing. Failure to address the incoherence will significantly impact on coherent decision making.

16. Section 5(m) obliges the NHIF to account to the Minister of Health in respect of performance of its functions whereas section 25 defines the relationship of the NHIF with the Minister, the Department of Health and the Office of Health Standards Compliance as merely consultative. These provisions appear to be in conflict with each other and the former extends the Minister's powers beyond mere stewardship. Additionally, they create further complication in respect of the NHIF being accountable to Parliament. Therefore, there is a need to clarify the extent of the NHI fund's accountability to the Minister, the Board and Parliament.

17. Sections 5(o) and 5(r) appear to duplicate the role and number of government agencies, notably the Public Health Institute of South Africa, South Africa Health Products Regulatory Authority and the proposed South Africa Health Technology Assessment Agency. It is important to describe how the NHIF will interact with these publicly funded institutions.

18. Section 6 deals primarily with the proposed functions of the NHIF. Section 6(g) authorises the NHIF to enter into insurance contracts to indemnify the NHIF against

needs further clarification. As a comprehensive benefit fund, there is a risk that some benefits may be over-subscribed which in turn could place the fund in deficit. In the current medical scheme environment, these risks are mitigated with the maintenance of solvency reserves but in the absence of any provisions for this within in the Bill, it does raise concern. There is also a possibility that the NHIF could enter into reinsurance arrangements, a process where the NHIF may enter into insurance arrangements to cover these losses. It is not clear what the risks of this would be and as such it would be prudent to list the various insurance contracts the NHIF may enter into, so as to avoid the abuse of this authorisation.

19. Section 6(f) 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.

20. Section 13 is particularly confusing insofar as the independence of the Board is confirmed and it's accountability line to Parliament. The involvement of the executive in the operations of the NHIF is thus problematic as it extends beyond the governance and stewardship role of the Minister as described in the Act.

21. Section 14 subsection (5)(b) describes the composition of the Board. Both the WHO framework on good governance as well as the World Bank guidelines on the governance of mandatory health insurance (2008) recommended the inclusion of stakeholders in the governance arrangements. The proposed composition of the NHIF board is limited to technocrats and excludes the participation of healthcare users and civil society groups. Given the significant governance challenges experienced in state owned enterprises and government in general, the exclusion of citizen participation at board level is problematic and does not engender trust.

22. Similarly, the establishment of Ministerial Advisory Committees proposed in sections 25, 26 and 27 creates a duplicate and unwieldy governance structure for the NHIF. In respect of the Benefits Advisory Committee, the inclusion of the heads of medical schools, public and provider representatives while excluding any kind of user representation from neither business, organised labour or civil society groups goes against the principles of transparency and coherent decision making.

23. In respect of the pricing committee, the proposed membership structure suffers similar representation challenges in respect of user representation and goes against transparency and coherence of decision making.

24. The duplication of said committees within the operational structure of the NHIF adds to further conflation of roles in respect of governance, regulation and management of the fund.

25. Under section 32, the Minister's role is limited to governance and stewardship. This is generally considered an oversight function but the Minister's powers as discussed, extend beyond the realm of stewardship into the operation of the NHIF which is outside the spirit of good governance.

Eligibility and Conditions to Accessing the NHIF

26. Section 7 subsection(1) again enjoins the Minister in the determination of who is eligible for benefits purchased by the NHIF. While the Minister, in his role as steward of the health service, has an oversight and regulatory responsibility and this responsibility is afforded in the National Health Act 2002, and that the right to health is extended to everyone under section 27 of the constitution, it may be better to devolve eligibility and membership to be determined by an appropriate legislative sphere such as Parliament.

27. It is not clear which Benefits Advisory Committee is contemplated in section 11 subsection 3,4 and 5; is this the NHIF Benefits Advisory Committee or the Minister's Benefit Advisory Committee? While the Minister does have an oversight role in respect of the activities of the Fund and is responsible for the determination of health benefits under the National Health Act, the establishment of two separate bodies, one within the Minister's office and another within the structures of the Fund is problematic. What is needed is clearer guidance on the relationship between the Ministers Committee's and the operational independence of the NHIF. Failure to address this will negatively impact the functioning of the NHIF.

28. Section 8(e) subsection (2) places a limitation on the rights of unregistered refugees and asylum seekers to access health care services such as emergency medical services, services in respect of notifiable diseases of public health and paediatric and maternal health services at primary healthcare level. Health is a basic human right and the limitation on the level of care is problematic and discriminatory. It is unclear how a patient in need of care would be denied secondary care if needed without grossly violating their inherent rights. In it's current form, this section could be considered unconstitutional and represents a significant deterioration of service.

29. Section 8(e) subsection (3) places a further constraint to access services paid for by the NHIF insofar as persons accessing services are required to present proof of registration. This is problematic for unregistered refugees and asylum seekers in that the requirement for registration articulated under section 8 requires the presentation of identification document as described under section 9 subsection 3 (a)(b)(c).

30. Of further concern is that neither subsection 8 or 9 makes provision for the registration or eligibility of undocumented migrants to access any kind of health service. This exclusion goes against the recognition of access to health care services as a basic human right.

31. The required registration and presentation of identification documents may also exclude unregistered South Africans from accessing services. Rural communities face significant logistical challenges in accessing public services, including the Department of Home Affairs. It is not uncommon for rural women to give birth at home and face significant challenges in having births outside of facilities, registered. The NHIF must put in places measures that address this rural reality.

32. Section 11 subsection 2(a) entitles users to register for services at a provider of their choice and said provider will be the user's first point of call. While affording of provider choice is to be welcomed, healthcare users should not be locked into this relationship. Firstly, registered users should be allowed to move fairly easily between providers should they be unhappy with the services provided. Secondly, the intent is for NHI benefits to travel with the user, there is thus a need for an express provision that describes how users will access services outside the catchment of their primary provider.

Role of the Provinces

33. The continued involvement of the provinces in the delivery of healthcare services as envisaged under section 33 subsection 2 is a missed opportunity to address the governance and stewardship failures experienced over years. The devolution of health care services to the sub-district level, through the creation of contracting units for primary care, as well the expansion of the district health management offices, supports the removal of the province as a coordinator of the provincial facilities. In the absence of an amendment of the inter-governmental financing regulations, provincial authorities will continue to be responsible for the maintenance of the health infrastructure and human resource development. By excluding the provincial authorities from the provision of health services, capacity currently residing in provincial departments of health can be moved closer to the point of delivery.This may also prove to be a cost-effective solution, freeing up funds for adequate access and benefits.

34. 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 the public sector would as the primary provider, with private providers acting 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.

35. Subsection 35(b) reiterates the role of the fund as strategic purchaser. We believe that the decision to build the NHI around a single purchaser of services is an important one. This will not only allow for the negotiation of lower prices within the health system, it will also provide a great deal of control over the basis for purchasing services. However, there are some challenges in the contracting of services. It is understood that services will be purchased on the basis of population numbers and adjusted for health need. Providers would then be paid in advance for the delivery of a defined package of services. What is unclear is how the funding will be impacted if providers fail to meet utilisation targets. This is of particular concern in rural areas where historically services have not reached communities.

Rural-Proofing the District-Based Purchasing and Oversight Model

36. 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 it may be useful to pilot these

in rural districts so that any rural specific considerations can be included in the final policy.

37. 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 used as a proxy for need. As is the case with other utilisation methods, this approach can be anti-rural if the following issues are not dealt with appropriately:

    - 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 should be considered in addition to DRG funding mechanisms.
    - 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.
    - Rural health needs are far greater than the current demand. It is vital to tie funding to health needs, rather than demand.

38. 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. As the functions of the DHMO are principally to provide oversight to the service delivery by providers, the fact that under the current provisions the DHMO reports to the provincial MEC for Health potentially creates a conflict of interest as the MEC also oversees provincial health providers creating an scenario where the MEC is both player and referee. The principal oversight role of the DHMO may be better suited to coordinate existing facility governance structures such as hospital boards and clinic committees which will support the achievement of its mandate. Additionally, while outside the scope of the current Bill, there is a further opportunity for reform by expanding the membership of district health forums beyond the current membership of politicians and technocrats.

39. 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 practitioners 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.

Rural-Proofing the Staffing Approach

40. 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 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 mean 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, as a critical example, the following elements should be considered:

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 the SA 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 health care 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.
8. 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 (Clin As), for example, can alleviate much of the pressure on doctors by performing routine patient examination, diagnostics ,therapeutic procedures, and inpatient care. In these instances Clin As, under supervision, can be as effective as a doctor at a fraction of the cost. By performing more routine tasks, Clin As 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.

41. 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 context and specific consideration must be given to the inclusion of measures that ensure the complexities of the rural implementation context are fully considered.

42. Section 54 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.

43. 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:

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.

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

44. Section 54 (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.

a) 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.
b) 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. The initial period provided for comment on this Bill did not allow for meaningful consultation and necessary preparation to consult with civil society stakeholders and users groups. As the department 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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