Submission by the
Faculty of Medicine and Health Sciences
Stellenbosch University
on the NHI White Paper
(published December 2015)

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In the Government Gazette No 39506 dated 11 December 2015, the Minister of Health (“the Minister”) invited public comment on the National Health Act, 2003 White Paper on National Health Insurance.

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

1. **About the Faculty of Medicine and Health Science**

The Faculty of Medicine and Health Sciences is a faculty at Stellenbosch University, which is ranked among the top 3 universities in Africa as a Research-intensive higher education institution, with a strong development agenda. Stellenbosch University’s Strategic Priorities show its commitment to South Africa and why it is committed to universal access to healthcare.

The Faculty’s principal aims are to enrich the learning, research and community engagement experience and to develop future medical and health sciences professionals who through innovation and leadership will promote health, prevent disease and provide optimal healthcare and rehabilitation. In doing so we strive to ensure that our activities are informed by the best available evidence, and that our programmes remain relevant to and benefit local communities, our country and the African content. The Faculty remains committed to addressing the top three health challenges in South Africa. Further Information regarding the Faculty of Medicine and Health Sciences is contained in Appendix A.

As a result the FMHS is ideally placed to provide comment and input into the proposed NHI system, and will focus this submission to the areas of:

- Introductory remarks
- Comments on Chapters of the White Paper
- Training and teaching
- Service delivery
- Research and Evaluation

In this submission comments are limited to aspects that are of particular concern to the constituency presented by Stellenbosch University’s Faculty of Medicine and Health Sciences (“the FMHS”). Its constituents include –

- Academia, involved in the critical element of education, training and skills development for and in the SA health sector;
- Public Sector employees involved in various levels of health care service delivery, from primary health care to quaternary care (at the central hospital);
- Researchers, involved in clinical research, as well as public health and health systems research.
- The Social Accountability of the faculty such as the Hope@Maties initiatives that focus on university preparation programmes for previously disadvantaged learners, bursaries etc.
The Faculty undertook a consultative process in the formulation of this submission, inviting all leaders from across the Faculty to participate in a Faculty-wide workshop to discuss, interpret, interrogate and debate the NHI White Paper, as well as formulate the Faculty response and possible contributions towards assisting the National Department of Health in the formation of an optimal health system for South Africa. This submission was compiled on behalf of the Faculty by the Centre of Health Systems and Services Research and Development (CHSSRD) in the Division of Community Health.

Recommendations are indicated in bold font. All references in the text below and in footnotes are available from the Faculty on request.

2. Introductory remarks on the NHI White Paper

The FMHS fully supports the principles of solidarity and universal access to healthcare for all. It agrees that the realization of this right cannot be achieved without overcoming inequity of access to healthcare, and addressing the concerns and challenges of the current public and private health sectors. The FMHS understands that addressing these challenges are as much part of the creation of a system of universal access to quality healthcare, as is a future fully-fledged system of financial coverage for healthcare for all.

It is also understood that the imperative to enhance and strengthen health care rights are found in two rights in the Constitution of the Republic of South Africa, viz. the right of access to healthcare, as well as the right of access to social security (i.e. the safety net that should cover all persons from financial hardship in the event of ill health) (Section 27). The Constitution further provides for the right to access to healthcare for certain vulnerable groups. In Section 28(1) (c) which concerns the rights of the child, it provides for an unqualified right to access to healthcare for children. In Section 35(2) (e), it provides for the right to medical attention for prisoners. In addition, sexual and reproductive rights, rights to non-discrimination and the rights of access to housing and environmental rights are also constitutionally entrenched. All aspects of the NHI would require measurement against these standards.

The rights contained in Section 27 have to be realized progressively. The Constitution also requires legislative- and other measures to be implemented to this effect.

In order for legislation or policy to be constitutional, it needs to be reasonable\(^1\). In particular the policy or legislation must be capable of fulfilling the right and it must be comprehensive, coherent and coordinated. It must also be appropriately financed and resourced, as well as be reasonably conceived and implemented. It must be balanced and flexible and make provision for short, medium and long-term needs to be met and transparency is also an important feature. Lastly, it must make short-term provision for those in urgent need. Thus the NHI will need to coincide with these features.

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\(^1\) Constitutional Court case of Government of the Republic of South Africa v Grootboom, 2001 (1) SA 46 (CC).
With respect to these requirements for ‘reasonableness’, the FMHS is concerned that the NHI White Paper and plan is not comprehensive or coherent in that it essentially proposes a funding model for medical care. This is not equivalent to Universal Health Care (UHC), and will therefore not achieve the outcomes envisaged. UHC as defined by WHO does not only incorporate access to quality health care, but also incorporates measures to address the social determinants of health, and to improve equity in health outcomes (Evans, 2012).

The FMHS is also concerned that the magnitude of legislative amendments which would have to be made, including the key pieces of policy and legislation (e.g. in Human Resources and various pieces of regulations to- and section in the National Health Act) that are not implemented, are being under-estimated. These amendments in themselves could take many years, in particular as all the pieces of legislation (bar those relating to financing and labour matters) would require the attention of the Health Portfolio Committee in the National Assembly and the Social Services Committee in the National Council of Provinces.

Another facet of the limitations of the right to access to health care is ‘within available resources’. Thus the NHI has to consider the resources and the use thereof and there needs to be more clarity with regard to the resources available. This does not only concern the funding scheme, but also human resources, infrastructure and the quality of both.

Section 27(2) provides that “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.”

It is recommended that the roll-out plan of the NHI include realistic but firm timelines for both legislative and policy changes, which will introduce greater certainty and clarity on the implementation of Section 27 of the Constitution.

In general, the FMHS urges greater transparency and the building of a greater body of evidence in the process of developing and incrementally implementing the NHI. In particular by engaging with a broader group of stakeholders, the principles regarding efficiency, effectiveness and social solidarity as set out in Chapter 2 of the White Paper, would be better achieved. Furthermore, Chapter 3 of the NHI White Paper provides a problem statement, which identifies many of the structural problems of the health sector. The involvement of stakeholders through a formalisation of engagement in the process, may aid in alleviating these problems.

Existing and new research should, for example, inform the process. The NHI transformational process should be done in a transparent manner. Proposals and interventions should be evidence-based, and up for interrogation and discussion. The NHI will not be a once-off event, and should be seen as a continuum of health sector transformational activities. FMHS welcomes the appointment of the various work streams, but would urge the formalization of engagement with affected stakeholders in this process.
Stakeholder involvement could, for example take the following form. The work stream on the NHI Benefits, should involve central facilities (i.e. facilities designated as such by the Minister of Health) that are currently providing care at that level and in support of district levels of care. This is important, as this work stream is said to be basing the development of the NHI Benefit Package on the packages currently in existence in the public sector. The experience of the University of Stellenbosch in Evidence Based Health Care, and Health Technology Assessment (HTA) could also inform this work stream, which is part of its mandate.

The Western Cape Department of Health has some experience in interacting with the private sector in the provision of services. This experience could be of value to the work stream dealing with the public-private provider mix in the NHI, and incentives to providers to contract into the system.

The White Paper references other countries that have undertaken specific interventions. The FMHS would urge a thorough investigation, and impact assessment modulation prior to the adoption of any specific element from a comparator country.

3. Comments on Chapters

Chapter 1: Introduction and Background

Section 1.2.2 Progress since democracy
Although the background documents recent progress and achievements in delivery of health care in South Africa, it is silent on any evidence or lessons learnt from the NHI pilot sites. Before going to scale with a major health system reform, it is important to assess whether the country has been able to achieve any improvements on a small scale, which can inform further plans for a national process. Transparency about the progress or lack thereof in the NHI pilot sites is important to inform the further development of the NHI plan.

The background also makes the argument that the failure to improve health outcomes such as life expectancy is due largely to financial limitations. However, South Africa’s health care expenditure per capita (including public sector) exceeds many other low and middle income countries who have achieved better health outcomes. The problem therefore goes beyond financing, and a NHI which focuses almost entirely on a financing model will fall short of addressing many of the fundamental problems in the health system which contribute to poor quality of care and poor health outcomes.

Section 1.3 International context
Reference should be made to the right to health in terms of international law, to which SA is a party. In particular, the International Covenant on Economic, Social and Cultural Rights provides for the right to health in Article 12. It also provides that State Parties to the present Covenant take steps to realise this right, including “(d) The creation of conditions which would assure to all medical service and medical attention in the need of sickness.” The content of the right is further informed by General Comment No. 14 of 2000. It recognises the right as a fundamental human right which is interlinked with other rights such as dignity and
equality. Importantly, it elaborates on the normative content of the right and holds that it includes availability, accessibility (in terms of non-discrimination, physical accessibility, economic accessibility and access to information), acceptability and quality. These four elements are fundamental to the right, and in terms of the NHI where quality is of particular concern, this General Comment emphasises the importance of quality.

Although the White Paper refers to several countries which have implemented NHI, it fails to provide evidence that the implementation of such NHI systems have improved access to quality healthcare or achieved improvements in health of the population.

Chapter 2: Definitions, Features and Principles

Key concepts such as Universal Health Coverage (UHC), Primary Health Care (PHC) and quality of health care are not defined in the White Paper. The implied definition of UHC, by only focusing on financing of medical care, falls short of the more comprehensive definitions of UHC advanced by WHO and the Sustainable Development Goals. These definitions extend UHC beyond equity in access to health care and financial risk protection, to also incorporate equity in utilisation of quality health care, equity in health outcomes and include addressing the social determinants of health.

Thus an NHI as a financing system for personal health services falls short of providing a comprehensive health care system which responds to the burden of disease in South Africa.

PHC is not defined, and in subsequent chapters there is confusion about the definition and scope of PHC, with it being incorrectly interpreted as a level of care. This needs to be clarified.

The requirement for access to quality health care requires a clear definition of quality of care, to ensure that this is an inherent requirement of any plans to improve access to care.

The importance of a patient- or person-centered health system is increasingly stressed internationally. The proposed NHI model fails to recognize the centrality of the person, and in the quest for efficiency of a financing model and system, omits to address the needs of the people served by or contributing the system, as communities, patients, and health professionals.

Chapter 3: Problem Statement

The high burden of disease and structural problems of the health system are identified as persistent problems in the South African health system.

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The proposed NHI proposal is largely focused on financing of health care delivery, and reinforces a focus on the financing and delivery of clinical care at the expense of prevention. The White Paper should elaborate on whether prevention and addressing risk factors contributing to the high burden of disease will be financed through NHI, and what processes will be used to achieve this. In particular, it is unclear how the present NHI White Paper will change the conditions in low income and underserved communities which give rise to a huge burden of potentially avoidable health conditions.

In order to change the dire living conditions of a large section of the urban and rural populations in South Africa and, in so doing, reduce the burden of diseases related to poverty, the NHI plan will have to rely on the effective functioning of the local authority system, as well as other government departments responsible for housing, food security, and social welfare. Unless the funding model makes provision for many other government partners that are effective and efficient in delivering their mandates, the NHI plan will fail to deliver the envisaged improvements.

The problem statement fails to highlight the needs and failures of the health system to respond to the needs of vulnerable groups including children, the elderly and disabled. The gender dimensions of the burden of disease also merit attention, with women bearing a higher burden of many diseases and as the impact on society.

**Chapter 4: Rationale and Benefits of NHI**

The research evidence to date suggests that models of UHC can improve access to and use of necessary care, and reduce financial risk and out of pocket expenditures in Low and Middle Income Countries (LMIC’s). However there is insufficient evidence to date that it improves health outputs (e.g. skilled birth attendance, Lagomarsino, 2012) or health outcomes. Any evidence of effects on outcomes such as maternal and child health is limited and context specific (Moreno-Serra, 2012).

Given the resource demands, massive legislative and system changes required by this proposed model of NHI, and narrow focus on medical care, it is incumbent on the White Paper to provide credible evidence of the benefits, and return on investment in such an NHI.

The literature on UHC also suggests that in resource constrained environments, the emphasis of NHI should be on purchasing of prevention and primary early treatment, community and public health interventions to obtain the greatest benefits in terms of access to health care and improvement of health. The apparent exclusion of community and public health interventions as part of a comprehensive PHC approach from South Africa’s NHI plan therefore contradicts international evidence.

**Chapter 5: NHI Coverage**

Population registration linked to existing Home Affairs systems is supported; and inclusion of refugees and asylum seekers.
The core focus of the proposed NHI package is on personal health services. As many determinants of burden of disease are environmental – a major area of concern is excluded from services coverage. The failure to include social determinants, including environmental health, may also impact on compliance with international health regulations – given the global nature of infectious diseases and environmental health risks. Clarity is needed on how these aspects will be funded and integrated as part of the national health system.

PHC is interpreted as a level of care, rather than a comprehensive approach to promoting health and preventing disease. There is a complete absence of important principles of community participation, with engagement of communities in health limited to ‘outreach’ activities from health services. This falls far short of a developmental approach to health, as per the philosophy of PHC and the National Development Plan (NDP) of South Africa.

The White Paper should indicate what the basis of the service packages will be, and to what extent evidenced based guidelines and health HTA will be used to select appropriate services and technology. As needs may vary in different contexts, a centralized definition of service packages may not be appropriate, and flexibility to respond to the local burden of disease and population needs should be considered.

Service delivery should be adaptive and applicable to local needs, e.g. in areas where there are higher incidents of trauma and violence, and be able to adapt to surges, disasters, etc. in addition to specific regional needs (e.g. teenage pregnancies).

Protocols and DRGs that are designed centrally could lead to unintended consequences, impacting negatively on training and curricula. Service delivery in a central facility that also trains should first and foremost be set on evidence-based healthcare (EBHC) (also sometimes referred to as evidence-based medicine (EBM)). The “package of care” funded by the NHI should also not lead to interpretational issues as to how a patient should be treated.

Consideration should be given to the role of Indigenous Knowledge Systems (IKS) within the context of the NHI and its benefit package.

The massive reorganization of the health system to create a new financing platform underestimates the level of disruption to service delivery. It is essential to provide a clear plan for an incremental process which supports change management, and the progressive realization of any unmet rights.

The mechanisms of achieving broader population, service and cost coverage are not clearly described. The proposed financing model may in fact result in the converse. The current distribution of public and private health care providers is skewed towards wealthier urban populations. Access is therefore largely determined by geographical distribution of service providers, favouring higher socio-economic groups. No indication is given as to how the financing model will change this. The NHI may further limit access for the rural and peri-urban poor, as they will continue to be served by fewer and poorer quality health service providers who may
experience greater challenges in being accredited with the NHI. The rural and urban poor may inadvertently have less access to care in the NHI system than they currently have.

The NHI financing model may therefore perpetuate existing inequities in access, as it fails to address the fundamental problems of distribution of providers, and quality of care for different socioeconomic groups. In ensuring access, the White Paper therefore also needs to address the distribution of health professionals to rural and other underserved areas. The lack of human resources for health (HRH) in such areas limits access to quality health care and is a challenge to achieving universal coverage (Department of Health 2011 & World Health Organisation 2007). The failure to redistribute providers, to support retention of health professionals in underserved areas, and to ensure that providers in these areas are able to achieve the same levels of quality, may result in further inequities in access to quality health care.

Chapter 6: Organisation of Health Care

The FMHS in general concurs with the general outline of the proposed organization of the NHI. It is however, concerned about the lack of detail pertaining to the key areas in which the FMHS is involved namely, teaching and training, tertiary and quaternary service delivery, and research. The recognition that the public sector will continue to be the backbone of the health system is important, and perhaps should therefore be a reminder regarding where the main effort and focus should be in responding to inequities in access to quality health care.

In this chapter the definition of PHC is limited to a level of care as ‘first contact with the health system’ and completely misses the broader principles and elements of PHC which are fundamental to preventing disease and promoting health in communities. A focus on a curative hospice-centric tertiary model of care will continue to weaken the Primary Health Care system. The White Paper aptly describes PHC as the heart-beat of the NHI but its prioritization is questioned in the paper perhaps due to the lack of understanding of PHC and how to affectively address the determinants of ill health. These are not adequately identified and prioritized. Unfortunately the current model continues to address primary care services, the first point of entry that patients will seek care with little attention placed on PHC which is premised on the social model for health.

Effective primary care requires practitioners (whether nurses or doctor) who work as medical generalists (Kidd, 2014). Competency as a medical generalist in primary care has been defined as (Howe, 2012):

‘Medical generalism is an approach to the delivery of healthcare that routinely applies a broad and holistic perspective to the patient’s problems. Its principles will be needed wherever and whenever people receive care and advice about their health and wellbeing ... The ability to practice as a generalist depends on one’s training, and on the routine use of skills that helps people to understand and live with their illnesses and disabilities, as well as helping them to get the best out of the healthcare options that are available and appropriate for their needs. It involves: (a) seeing the person as a whole and in the context of his or her family and wider social environment; (b) using this perspective as part of the clinical method and therapeutic approach to all clinical encounters; (c) being able to deal with undifferentiated illness and the widest range of
patients and conditions; (d) in the context of general practice, taking continuity of responsibility for people’s care across many disease episodes and over time; ... (e) coordinating his or her care as needed across organisations within and between health and social care.’

Unfortunately we have not trained our primary care providers as medical generalists in South Africa.

Nurses are trained as clinical nurse practitioner in a 1-year diploma that does not deliver the type of generalist described above. Basic doctors leave medical school and are not required to perform any postgraduate training to become effective generalists. The ideal clinic model makes it clear that every clinic should have access to a doctor and that the multidisciplinary primary care team should therefore include a clinical nurse practitioner and a doctor. Both of these health workers should be well trained generalists.

Since 2007 South Africa has recognised the speciality of family medicine which seeks to train doctors (and in some places nurses and clinical associates) as expert generalists. Family physicians are trained as expert generalists in a 4-year MMed training programme. Well trained and expert generalists are required to work in primary care clinics and health centres if we are to provide a quality service. The national position paper on family medicine makes a clear call for family physicians to be trained and deployed in all health centres and sub-districts (Mash, 2015). All primary care doctors should receive some training in being or becoming generalists and to this end the discipline of family medicine has also developed a national Post Graduate Diploma in Family Medicine (2-years) (Mash, 2015). Re-engineering of primary health care needs to embrace the goal of ensuring that our primary care providers are well trained generalists and to the deployment of family physicians and primary care doctors with postgraduate training in family medicine and primary care.

The intentions of the ‘Ideal Clinic’ model are laudable, but the White Paper does not provide any link between this process and the OHSC’s standards, role and functions. It also does not address fundamental problems impacting on access to and quality of care, such as the distribution, competencies and attitudes of health professionals in the public sector. In the absence of national policies and frameworks supporting quality improvement as an integral activity in the health system, current efforts to improve quality of care tend to focus on audits, are punitive, do not have a development focus, and are fragmented and poorly coordinated. The NHI presents an opportunity to strengthen a national quality improvement focus for the health system, and needs more attention in the White Paper.

Poor continuity of care between levels of care is a major problem in the health system. The intention of improved referral systems (s160) is therefore encouraging, but it is not clear how the financing model proposes improving referrals. The barriers to continuity of care are not caused by under-financing, and a clearer pathway to improving referrals needs to be delineated. This section also conflicts with the proposed ‘gate keeping’ of referrals as a cost containment measure in chapter 8.

**Section 6.1.1 Municipal Ward-based Primary Health Care Outreach Team (WBPHCOTs)**

PHC re-engineering and its WBPHCOT’s is acknowledged as an important process to strengthen primary care in communities. The scope of their role should not be limited to providing basic services but should be a
comprehensive role from prevention to rehabilitation in communities. **Their role also needs to be supported by a human resource and financial plan, including details of how they will be managed, mentored, trained or supervised.** To date the competencies, training, remuneration, employment and conditions of service of CHW’s remain unclear. For this to be a ‘game changer’ more attention and detail are needed to clarify the human resource and financing of this model. Additional risks are the removal of scarce nursing skills from facilities to support the teams, and provision should be made for additional nurses to be appointed to support the WBCOT’s.

Community health actions (by means of community health care workers or other initiatives) cannot function without some sort of structure grounded in the community itself, such as a **local health committee.** The way such committees can be incorporated in a holistic health care system has not been sufficiently incorporated and supported in the NHI plan.

**Section 6.1.2. Integrated School Health Programme**

The expansion of health services to schools is supported. The focus however is largely on screening for a limited range of physical health problems and referrals for basic medical interventions. **As the major health risks in school-going children include mental health, violence and injuries, substance abuse, and sexual and reproductive health, greater clarity is needed on how the NHI will address these.** In particular, how the NHI proposes working with the Department of Basic Education (DBE) on strengthening life skills programme and existing services provided by DBE which focus on the healthy development of children and adolescents.

The lack of any reference to child health outside of school health services is a major shortcoming of the NHI. As a vulnerable section of our population that has specific rights in terms of the Constitution (s 28), and the group that health investments will generate the greatest longer term benefits for the country, this is a serious omission.

The White Paper should ensure the full integration of paediatric care and children’s rights, as set out in both the Constitution Section 28 and the Children’s Act, 2005, into all NHI service delivery models. Note that according to the Constitution Section 28 every child has a right to health care that will ensure survival and this should therefore be implemented immediately and is not subject to progressive introduction. The NHI should ensure not only improved survival, but also optimal development especially the first 1000 days of a child’s life, as a national priority, which is inadequately addressed in the current version of the NHI. Early intervention is probably the most cost-effective intervention to decrease the burden of disease both in children’s lives and adults’ lives. This should include a focus on early childhood development and nutrition, which is as important as the national immunization program. The UN Convention on the Rights of the Child, ratified in 1995 by South Africa, expects signatory states to prioritise child health. The current version of the NHI does not document the broader package of health care needed for children including these aspects, which means there is a risk that they will not be prioritized for the care that is their right. Some specific recommendations in this regard are as follows:

- What is needed is specified health care in all settings of health care, from primary care to emergency care to central hospital care with the necessary professional expertise in dedicated child friendly spaces.
There is a need to develop family-, child- and youth- friendly services especially in primary health care services, but across the board in all health care facilities.

- There is therefore a need for specific essential health care packages for children and adolescents, which differs from those necessary for adults.
- Children and their caregivers should be able to participate in the development of these child dedicated health care packages.
- The important factor of a comprehensive health care package of care for children is that it should address the continuum of care, starting in primary health care services which extend from curative to rehabilitative, mental and palliative care for children.
- The comprehensive health care package of care for children will have to be managed by the District Clinical Specialist Teams, the Ward-based Outreach Teams, the Integrated School Health Programs, as well as the specialist paediatricians and subspecialist paediatricians when necessary. This should also include health care packages for rare diseases.
- There is no mention of transport services for children, who are very vulnerable in that they cannot easily transport themselves to health care facilities. This is essential to ensure that children will be transported to health care facilities as the reality is that the majority of children live more than 30 minutes-drive from any health care facility.
- The expanded role of community health care workers should include adequate knowledge of the Integrated Management of Childhood Illnesses (IMCI) and therapeutic skills such as the provision of Vitamin A, oral rehydration solution, deworming tablets and nutritional assessment. Dispensing regulations currently do not allow community health care workers of dispensing these essential medicines, and would thus require amendment.
- The Integrated School Health Programme is an important intervention, but there is no description of an integrated health care programme for the first 1000 days of a child’s life, which is more essential for survival, normal development and less adult burden of disease.

The White Paper does not place any specific emphasis on sexual and reproductive health, a human right protected in, amongst others, Sections 9 and 12 of the Constitution. One of Stellenbosch University’s distinguished professors, Sandy Liebenberg, has not only undertaken significant work on the realisation of socio-economic rights, but has as recently as March 2016, provided General Comment to the United Nations on this topic:\(^3\)

> ‘Due to numerous legal, procedural, practical and social barriers, people’s access to the full range of sexual and reproductive health facilities, services, goods and information is seriously restricted. In fact, the full enjoyment of the right to sexual and reproductive health remains a distant goal for millions of people, especially for women and girls, throughout the world. Certain individuals and population groups that experience multiple and intersecting forms of discrimination that exacerbate exclusion in both law and

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\(^3\) Committee on Economic, Social and Cultural Rights General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) E/C.12/GC/22
practice, such as lesbian, gay, bisexual, transgender and intersex persons (LGBTI) and persons with disabilities, the full enjoyment of the right to sexual and reproductive health is further restricted.

She also place emphasis on the social determinants of health, and hence the question is how the NHI will overcome these determinants:

‘In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distributions of power based on gender, ethnic origin, age, disability and other factors. Poverty and income inequality, systemic discrimination, and marginalization based on grounds identified by the Committee are all social determinants of sexual and reproductive health, which also have impacts on the enjoyment of an array of other rights as well.’

Prof Liebenberg points to specific challenges in this regard, such as:

- The unavailability of trained professionals with skills to provide the full range of sexual and reproductive health care; and
- The unavailability of goods and services on, for example, grounds related to conscience or culture.

She recommends that UN member states should implement “temporary special measures to overcome long-standing discrimination and entrenched stereotypes against certain groups and to eradicate conditions that perpetuate discrimination”.

As stated above, the NHI Benefit Package will determine the services, and services as a whole determine clinical outcomes, referral pathways, supply chain, staffing, policies, etc. Where there are current deficiencies, these would have to be addressed as part of the NHI phase in. In some areas, rapid “catch up” strategies may be needed. For this reason the FMHS calls for a revision of the Modernisation of Tertiary Services (MTS) Plan.

Service delivery also links to the training and availability of healthcare professionals. Certain professionals can take the burden from others, e.g. more mid-level workers, task-shifting, more nurse specialists, the question being “how can we improve the efficiency and effectiveness of our human resources in terms of skills mix and performance?” However, in this, the patient must remain central in the service delivery objective, i.e. there should be a competency as a result of the training provided.

Section 6.1.3 District Clinical Specialist Teams (DCSTs)
The DCST's role in supporting clinical governance should be clearly elaborated, as well as the competencies required to do so. The absence of Public Health medicine specialists to support population based planning and management of health services as part of the DCST is a major oversight, which again renders the NHI model as a purely financing model for medical care. This falls short of a comprehensive approach to health, which is informed by the burden of disease and addresses social determinants of health in communities. Poor management of hospital and districts are also the result of a lack of leadership and management.
Section 6.2 Strategies to enhance effectiveness of the health care system
The strengthening of management and governance of the district health system is supported. How the proposed NHI model will support this is not clear in the White Paper. **The NHI needs to highlight how it will ensure that managers who are appointed have the necessary competencies, or propose a process to ensure that existing managers acquire the appropriate competencies within a specified time period.** In particular, leadership and management competencies should be an integral part of the training of all health professionals. Further training and qualifications should be a requirement for appointment to health management posts at district and hospital levels within the NHI system. Several postgraduate health leadership and management training programmes have been developed by Higher Education Institutions (HEI’s), including various programmes by the SU FMHS, which can support the development of health leadership and management within the NHI.

It is also not clear how the proposed District Health Management Offices (DHMOs) differs from current district management structures, or how the proposed NHI will strengthen the functioning of these offices.

The DHMO’s responsibility for non-personal health services is supported. However, much of this is currently being managed by Municipal Health Services, and the White Paper needs to elaborate on whether local government will continue to deliver these services or if it is proposing a change in responsibilities. As local government is the locus of delivery for basic infrastructure related to the environment, it would be a regressive step to remove non-personal health services from this sphere of government. **The White Paper should therefore elaborate on how the NHI can support structures and systems for intergovernmental collaboration in addressing the social determinants of health.**

As an entity that straddles the academic sector and the provincial department of health, the faculty also requires clarity in terms of roles, powers and functions of the provincial departments of health vis-à-vis the National Department and the envisaged NHI Fund and NHI structures.

Section 6.3 Hospitals and Specialised Services under NHI
The definition of **district hospitals provided is inaccurate in the way it portrays family medicine.** District hospitals in South Africa generally speaking are generalist environments with male medical/surgical wards, female medical/surgical wards, maternity services, paediatric wards, emergency centre, outpatients and outreach services. These services generally speaking are not organised into disciplines as described and specialists in these disciplines are not employed to run separate departments. Family physicians as expert generalists are trained to work across all these components of the district hospital and are not a separate discipline alongside the others. The whole district hospital is therefore a family medicine environment. In large urban district hospitals the above may not hold true as these district hospitals tend to be larger, offer services at a higher level and are sometimes organised into specialist departments. For the vast majority of district hospitals in SA (usually in more rural settings) the description provided is inaccurate and does not
understand the role of the family physician at the district hospital. Please see the national position paper on family medicine for further clarification of this point (Mash, 2015).

On the other end of the spectrum, the White Paper appears to be silent on high-cost, highly specialized care, which one would assume, based on the reference to Centers of Excellence, would still form part of the NHI to some extent. The question is, under the NHI, what would the extent of reforms be: more care (e.g. more patients will be assisted and receive heart transplants), or better levels of care (e.g. reduced waiting times for heart transplants)?

There is also no clarity as to the details around governance and management models of central- and tertiary hospitals. Although mentioned in the White Paper, the details around the management of district hospitals and primary healthcare facilities require more detail. The centralization of central hospitals, which has already been initiated, also raises concern vis-a-vis financial management and grants, responsibility and accountability, the centralisation of procurement and purchasing decisions, and the impact it could have on service delivery. Clinical coordination of service delivery should not be centralized; facilities should be able to address regional needs and have specific referral pathways that relate to local circumstances and geography, localized outreach programmes and care coordination.

Care should be taken that centralization does not lead to further fragmentation and removal of healthcare to be further away and disconnected from local communities. The question is whether SA has the requisite numbers of personnel to place at the centre of the system. Centralisation can also lead to a decreased focus on and thus potential decreased competency in specialization and sub-specialist skills (e.g. in rare or specialist conditions or situations).

The most recent policy developments in the field that affects entities such as the FMHS, is the 2004 Modernisation of Tertiary Services (MTS) Plan. This project is now more than 12 years old, and many aspects thereof, such as designation of certain previously designated tertiary hospitals as central hospitals, have now been overtaken by more recent developments. The aspects of the plan, however, such as the costing model, patient transport and human resource planning, remain important elements of facilities that the FMHS and is associated with.

An area requiring more consideration and emphasis in NHI is that of mental health services. The place of mental healthcare, previously limited to specialized and tertiary hospitals, should be integrated in all levels. Shortages of key staff categories should also be addressed, e.g. Psychologists and Advanced Psychiatric Nurses, must be included at all levels of care.

Certain specialist services must also be delivered in regional and district areas. Outreach should be a requirement in the job descriptions/work agreements of all specialists (across professions), so that, for instance, tertiary hospital specialists support regional hospitals and regional hospital specialists support districts hospitals. The system should function in terms of accountability being taken by referral centres (at any level) for all the facilities that refer to them. Outreach is an important element of specialist services. Rehabilitation should also be delivered in region and district areas, ensuring that such services are supported.
with suitable infrastructure and appropriate human resources.

The move towards an NHI necessitates a review and renewal of the MTS Plan to position, prepare and integrate the central, tertiary and district services sector, as well as academic complexes, into the NHI. The FMHS is concerned about the understanding of an academic health complex, which according to the National Health Act can and should include all levels of the health service. This also raises concern about the implication that SU FMHS is only associated with a central hospital.

Section 6.4 Establishment of the Office of Health Standards compliance (OHSC)
The work of the Office of Health Standards Compliance (OHSC) is vital in maintaining standards. If standards are not met by a facility rendering services within the NHI, in terms of amendments to the Health Act specific corrective and punitive actions are initiated which have serious consequences for that facility, its staff and the patients they serve. The implications of this punitive system which include closure of facilities, in the absence of support for improving clinical governance and quality of care, on access for underserved communities need serious consideration. It is understood that the OHSC would be able to levy fines for non-compliance; by implication, these fines would have to come from the DRG-based allocations made by the NHI Fund. This could ultimately further comprise the quality of care to be rendered by facilities.

The focus of the OHSC is purely on quality assurance processes i.e. standard setting and inspecting compliance with standards, and does not provide support or a clear process to improve quality of care. Stronger policy and leadership around quality improvement within the health services is needed beyond standard setting and audits. Clinical governance and clinical leadership, and the need for training in and support of these areas for health professionals and health managers should form part of the NHI programme, as well as bedside evidence-based practice.

Section 6.6 Enhancing human resources for health
As an institution with a mandate to develop human resources, and the responsibility to train health professionals in the health service to meet the needs of the future health system, it is of great concern to us that so little attention is given to human resources in this document. Without health care professionals there can be no heath care and thus no NHI. The very short section on human resources gives no detail on how the needs of the NHI will be met; changing the funding mechanisms will not change the availability of human resources for health. There need to be clear targets, in terms of optimum numbers and skills mix, for the range of health care professionals needed for the NHI. Based on that, there needs to be a focused strategy in terms of how those numbers will be achieved, which in turn will impact on the numbers that need to be trained, as well as the skills that are likely to be needed. It will be incumbent on faculties of health sciences including the FMHS at Stellenbosch University then to ensure that adequate numbers of students are being trained and that curricula are relevant. In addition, human resource development (including undergraduate, postgraduate and in-service education) needs to be embedded in the NHI so that the health service as a whole needs to be viewed as a learning and training organization; it is only if the health and education sectors work together that the needs of the country will be addressed. The NHI provides the opportunity to remove some of the unnecessary distinctions and divisions between service provision and training, so that
the future needs of the health service can be provided for. **In order to achieve this, a NHI work stream on human resources for health, that includes HEI’s as crucial stakeholders, is critically needed.**

**Chapter 7: Financing of NHI**

As noted by many other commentators, the financing of the NHI is of concern to the Faculty and the FMHS looks forward to the publication of the NHI Financing Paper. The FMHS note the strides already made in the centralization of certain procurement decisions, in conjunction with the Chief Procurement Officer. It is of vital importance that the progression towards an NHI does not detract from current service delivery objectives, and that **adequate provision is made for the necessary funding increases for teaching and training, as well as research in view of positioning the sector for the NHI.**

The shift towards centralized pooling of resources (as opposed to centrally set care protocols and implementation programmes), and the coordination of service delivery objectives and national assurances of quality and standards are supported.

**This chapter however provides no information on the financing of academic medicine.** The MTS Plan is associated with the National Tertiary Services Grant (NTSG), and its future under the NHI, and the transitional phase to the NHI, should be clarified. The objective of the NTSG is “to ensure provision of tertiary health services for all South African citizens” and “to compensate tertiary facilities for the additional costs associated with provision of these services including cross border patients”. In addition, provinces receive Health Professions Training and Development Grants (HPTDG). The ability to train all healthcare professionals’ undergraduate students, as well as postgraduate students, directly depends on this grant. The future of these and other conditional grants is uncertain under the envisaged NHI.

**Clarity is needed vis-a-vis transitional plans relating to the NTSG and the HPTDG are important for the academic health sector and its key services** (as outlined in 3.1 to 3.3. below). For example, if phased out, how will these income streams be replaced? Will new grants or allocations be developed, or will central and tertiary hospitals rely on a budgetary allocation based on DRG’s? Will income be linked to the NHI Fund, or be outside of the NHI Fund?

A further concern relates to the approach to state-owned entities and issues of governance and efficiency. It is vital that the NHI Fund and the various structures created in terms of it are able to act in a manner that is beyond reproach, and that appointments, governance and other decisions made avoid the pitfalls documented in relation to independent entities. Public, but independent entities such as the Council for Medical Schemes have fared quite well, whilst in contrast the NHLS has experienced challenges. **The place of the NHI Fund, and its various structures, within the context of the Public Finance Management Act (i.e. the level of autonomy and statutory powers), should be clear.**
Chapter 8: Purchasing of health services

Purchasing, service delivery and management (including accountability and direct oversight) should remain the domain of provinces, which are best placed to fulfill these functions in an NHI, and are currently afforded these competencies in the Constitution. **Centralization at a national level is likely to lead to further fragmentation, as it would necessitate central management of not nine provincial authorities, but rather of 52 district authorities**, tens of thousands of providers and hundreds, if not thousands, of procurement line items. The exclusion or limitation of the current role of provincial departments of health, and the constitutional- and labour relations impacts of such changes merit careful scrutiny and risk assessment.

It is clear that not all provinces are performing equally well in implementing healthcare services. This will require such deficiencies to be addressed, as the NHI and centralization will not solve such challenges. Skilled staff, for example on purchasing and procurement, will still be needed throughout the country. Provincial Health Services are closer to the population to be serviced, have experience in implementation of healthcare interventions, and have been responsible for implementing the NHI pilots.

In this regard academic institutions, such as the **FMHS of Stellenbosch University** can play an important role not only in assisting provinces in implementing the NHI, but also in **addressing specific health training needs (in clinical areas, as well as in health policy and management)**, as well as supporting procurement decisions through health technology assessments (HTA).

The need for HTA to inform the prioritisation and resource allocation for effective and affordable health technology is not adequately addressed in the White Paper. Pharmaceuticals and technology are major cost drivers in the health system, and the **White Paper should indicate how capacity and infrastructure for HTA will be developed to address this in the public and private health sectors**. Academic institutions such as the SU FMHS which have capacity in evidence based health care and economic evaluations, can contribute to developing HTA to support the NHI.

It should also be borne in mind that cost containment measures such as a strict adherence to specific protocols (‘gate keeping’) in terms of referrals could have unintended consequences. Adherence to referral systems has led to a successful law suit against the provincial Department of Health, which case ultimately went to the Constitutional Court, where it was ruled that the right of access to healthcare should have been applied to override the rigidity of the referral system. The **NHI should provide for the necessary flexibility in service delivery so as to ensure appropriateness of care**, although protocolised approaches will be the norm.

The impact of administration costs, a major cost driver in the private sector is not discussed, or measures identified to ensure efficient management and to contain administration costs of the NHI. Important support systems and processes such as reliable Information systems, contracting, quality audits, and regulatory capacity are not adequately discussed and need to be elaborated on further as critical components of a functioning NHI, in which South Africa has very limited capacity and poorly functioning systems currently.
Health information systems in particular will be essential to inform the planning, monitoring and evaluation of the effects of the NHI. To date the national health information system remains fragmented, with multiple data collection systems, and produces poor quality data, which is not used adequately for planning and management of the health system. It is not clear whether the proposed NHI information systems will be an additional system or whether it will attempt to integrate and improve existing information systems. The patient registration system is supported, but again it’s not clear whether this is complementary to or will replace existing information systems. Given the huge costs and timeframes required to develop and implement new systems, and the existing poor performance of health information systems in South Africa, this component needs more elaboration. It is important to note that many of the weaknesses of the current health information system in the public sector relates to human factors. New technology may facilitate some processes, but unless the HRH are sufficiently competent and motivated to use the health information, the current problems may persist in any new NHI information system.

Lastly, although risk management and fraud mitigation is discussed, little is described on how malpractice lawsuits will be handled under the NHI system. As there will be a purchaser-provider split, and as the provider would be the central hospital where training takes place, but the funder and purchaser would no longer be the province, but the NHI Fund, patients would sue the central hospital in its own name, which would necessitate specific and separate indemnity cover. Due to the increase incidences of such lawsuits, as well as the quantum claimed by patients, this matter could have a severe impact on the ability of the hospital to render services in the face of a large claim. Furthermore, harm that results from centrally determined protocols, guidelines or formularies could render the NHI Fund, or its administration entities, liable as well. Furthermore, if any entity rendering services under the NHI is sued, the question is who would carry those costs? Will the NHI provide NHI-funded liability insurance or cover?

4. Comments on selected areas of the NHI

Training and teaching

Skilled and adequately trained HRH will be the backbone of the NHI and will ultimately determine its success. The NHI outlines that ‘the health workforce is a key pillar of the health system and the planning, development, provisioning, distribution and management of human resources will be further improved to meet the needs of the population’, but does not indicate how this will be done.

There is a well-documented shortage of healthcare workers (HCW) in South Africa; this shortage is compounded and discrepancies in the distribution of the HCW’s, in terms of the public – private sector, urban-rural and between provinces.

In ensuring access, the White Paper also needs to address the distribution of health professionals to rural and other underserved areas. The lack of human resources for health (HRH) in rural areas limits access to quality health care and is a challenge to achieving universal coverage (Department of Health 2011 & World Health Organisation 2007). By supporting decentralised training of health professionals on a broader
platform, evidence suggests that such initiatives contribute to strengthening the health system and that more of these health professionals return to work in rural and underserved areas after qualifying (Doherty 2016).

An improvement of services is an opportunity to improve teaching and training, and vice versa. Under NHI with its intended phased approach, the health system should operate as a Learning Organisation, viz. one that acquires knowledge and innovates fast enough to survive and thrive in a rapidly changing environment. As such, the health system should create a culture that encourages and supports continuous staff learning, critical thinking, and risk taking with new ideas; that allows mistakes, and values employee contributions; that learns from experience and experiment; and that disseminates the new knowledge throughout the organisation for embedding into day-to-day activities. Training should therefore be a part of the core functioning of NHI. Human Resource development needs to be integral to the health service function (part of the system) and not simply the task of educational institutions (an add-on to the system) i.e. it is a shared responsibility, so that every health professional should be a trainer.

It is recommended that an NHI Work Stream be created to deal with the training and teaching issues within the NHI. The White Paper lacks detail regarding integration of teaching and training in relation to the NHI. Due to the mutual inter-relatedness of training and service provision in all the healthcare sectors, policy changes in the one impact the other. Vacancies in training positions not only affect the ability to achieve the necessary human resource for health targets, but also impact on service delivery.

The FMHS advocates for the compulsory decentralisation of training specialists at district hospitals for a period of at least one year of the 4 years registrar training, on a rotation basis to ensure adequate representation of specialist services at district hospitals. International models such as these have shown improved clinical governance, health outcomes and decreased patient volumes at tertiary and regional hospitals with a decrease in overall health expenditure per patient. This will also assist with the model of DCSTs that may fail to gain momentum due to the large vacancies per district.

Updating and actual implementation of the Human Resource for Health Strategy, 2012 – 2017 should be a key component of the steps towards the NHI for the academic complexes and central hospital sectors. The Strategy was comprehensive in intending to close human resource gaps such as increasing production, contextual training, research, monitoring and evaluation, etc. but has not been implemented as planned. It envisaged addressing shortfalls in human resources measured in 2010 by defining targets for increased outputs by 2017 and further on to 2025. The baseline and targets require updating and alignment ensured between the two key policies. There should be clear goals, and planning with stakeholders as to how to achieve these goals.

The need for a stronger emphasis and plan to train managers in leadership and management is re-iterated, and the role that HEI’s can play in this regard.
The interaction between higher education (as represented by the Department of Higher Education and Training (DHET) as a national function, coupled with university autonomy in governance and management) and health (as represented by the Provincial Departments of Health) is not well-defined in the White Paper, and unless comprehensively addressed, could lead to severe negative implications for both academic facilities and central hospitals. In addition the lack of clarity of academic health complexes and the funding thereof needs to be defined to ensure adequate capacity of the health system to respond to the HRH. It is recommended that the dedicated academic complexes NHI Work Stream, referred to above, include stakeholders such as the HPCSA and the DHET. It is also recommended that the FMHS contribute to regional and district hospital level of care that should be included in the NHI. The focus should be on how best to meet the existing and future training needs of the country and the NHI.

It is proposed that the following matters, amongst others, should be on the agenda of the proposed special Work-stream:

- **Specialists should be trained for regional hospitals and district support, where general medical specialists are needed,** rather than focusing only on sub-specialists found in central (tertiary and quaternary) hospitals, which will require specific focus in terms of where and how specialist training occurs. The role of generalist specialist and the contribution of other specialists relevant to improving clinical governance at district level such as paediatrics, obstetrics and gynecology, anesthetics and general surgery should be clearly outlined with DHET. A major shift in focus from concentrating services to tertiary level should be devolved to lower levels with outreach to PHC thereby decreasing bottlenecks and improving the quality of care at lower levels. The National Facilities audit 2012 conducted by the Health Systems Trust (HST) indicates that PHC facilities scored lower than hospitals in all priority areas of quality of care. Innovative strategies to address the ‘heart-beat’ of the NHI will therefore be required if PHC is to be improved. Sustainable long-term solutions such as broadening training platforms are advocated rather than attempting to recruit tertiary hospice-centric trained specialists to districts especially rural districts that have the highest vacancy rates.

- **Consideration of equity: equity means that greater resources must be given to underserved areas, such as rural areas, in order to achieve equality of outcome,** and NHI needs to take this into account, particularly in terms of the way that the training, development, recruitment and retention of health care professionals (and thus also students) is managed.

- **How to effect increased intakes of students require increased funding, coupled with an adaptation of medical training:**

- **The impact of the NHI, its structures and benefits on faculty curricula:**

- **Ensuring that we not only train sufficient numbers of HCWs but also that quality of training is maintained at all levels.** This could be fulfilled through a monitoring and evaluation function by an entity such as a dedicated sub-committee of the Council for Higher Education, currently tasked as an education and training Quality Assurer for tertiary education. This included addressing the synchronized roles and processes of the regulatory bodies and Higher Education Authorities;

- **Related to curricula, the importance of building attitudes to lifelong learning through integrating learning of EBHC at undergraduate level for all healthcare workers are important.**
level this expands to not just being good users of evidence but also be good doers of research. Being able to conduct locally relevant research to inform healthcare policy and delivery.

- A specific focus on the enhancement of the nursing and midwifery workforce through quality educational programmes and the meaningful regulation thereof. Midwifery and Primary Health Care Nurse Specialists are acute concerns for example.

- A review of the training of nursing, specialists, and sub-specialists is required.

- Ensuring that persons are trained in the appropriate settings to minimize the cost of re-training and re-orientation required, as is the case with students trained in Cuba.

Planning should also consider the longer term needs of the country. For example, are 10 medical schools sufficient for its current and future needs? How are post graduate training planned? How will one select the right students and train them in the right place?

In terms of the need for more training and services in rural areas, incentives are one strategy mentioned in the White Paper. It should be appreciated that rural training requires supervision and support structures to be in place, and a good working environment for students and those teaching and providing services in such areas. Evidence is clear that selecting students from rural communities and training them there increases the likelihood that they will practice there, and this should be facilitated in the NHI.

The development of the NHI Benefit Package by one of the Work Streams will also impact on the human resources, and hence the training requirements for, and in the NHI. Who would be needed to deliver that package, how they should be trained, who will monitor progress in training outputs and quality of training, are key considerations. The White Paper’s proposed move into multi-disciplinary practices and units, should be considered as well – what skills are required for practitioners to work within such settings?

The role of South African academic health facilities in training students from other African countries should also be considered and clarified. Such students use the NHI-funded system as a training platform, and also render services to NHI patients.

It is proposed that the training platforms should include the private sector environment. This could ensure wider exposure of students to a greater diversity of clinical settings where healthcare deliver occurs. The private sector also has resources not available in the public sector that will enhance the student learning experience. It must be emphasized that the proposal is not for the private sector to become the institution responsible for offering the training, but rather that the facilities are used as training sites, where such facilities are included in the District Health Authority.

The FMHS also wishes to address a particular type of professional training, viz. the training of nursing professionals. It is suggested that the universities are responsible for the problems the nursing profession are currently experiencing. However, these problems could be attributed to the four year comprehensive nursing qualification introduced by SANC which led to the registration as a nurse (General, psychiatric, community) and midwife in accordance with R425 of February 1985 as amended. This qualification was a
combination of four qualifications which may have taken seven years of study condensed into four years. The diploma in nursing at the time was three years, midwifery one year, psychiatry one year and community health one year. This resulted in a limitation of depth of each of these specialties. The duration of the degree programme offered at universities prior to this change was four years with much more depth.

It is also important to note that nursing faculty at universities have consistently supported the goal of quality nursing and midwifery education (both theory and clinical) at colleges through collaboration, relevant agreements as enacted, research and continuing education. University undergraduate programmes in nursing also meet the professional body’s clinical practice requirements, but are most often in the fortunate position to work with other health care students and benefit from Inter-professional Education practices.

The Division of Nursing’s strong post graduate programmes are an important resource to contribute to the training of PHC Nurse Practitioners and Advanced midwives which will be required on PHC levels.

The question should not an “either or”, but rather what would be the best training platform for a specific purpose. In the view of the FHMS the issue is not whether a nurse is university, or college trained – the curricula should align with the needs of the country and developments in the profession and medicine in general. Furthermore, training in an inter-professional team context is extremely important, and should, in line with the recognition of multidisciplinary practices in the White Paper, be further supported and enhanced within the NHI context. Community engagement, evidence-based practice and continuing research efforts are important to strengthen health care in the country, and degree-prepared nurses from universities are critical role-players in this regard.

Service delivery

As stated above, excellent training is dependent on excellent service delivery at the site or platform of the training. The White Paper should clarify what the role of the NHI Benefit Package will be within training institutions, as not all services will be rendered as part of the NHI. This is evident from the various references to the NHI benefit determination Unit in the NHI Fund, and the Work Stream dealing with this issue. It would be necessary nonetheless to ensure students are trained on all relevant aspects of their profession, irrespective of whether those professional acts are part of NHI benefits or not. This also raises the matter of funding and pricing of such services, and the mechanisms that would be in place to deal with the delivery of care outside of the NHI package, whether for training purposes, or purely as the patient might not have responded, or might need care different to what is generally offered as part of the NHI package.

Research

The FMHS has a reputation for research built over decades of diligent and persistent effort. The Faculty continues to perform as a leading research-rich environment with extensive international collaborations, in addition to national and local partnerships. A research agenda shaped by strategic research focus areas ensures that the Faculty’s research activities address the major health challenges facing the African continent.
The FMHS Research Themes, which aligns with the priorities of the National Department of Health, are:

- Infectious Diseases (especially tuberculosis and HIV/AIDS)
- Maternal and Child Health
- Mental Health (psychiatric disorders) and Neurosciences
- Non-communicable diseases (specifically Cancer, Diabetes, and CVD)
- Health Systems Strengthening
- Violence, Injuries, Trauma and Rehabilitation

The NHI White Paper contains virtually no references to the role of research. Yet research is one of the core functions of institutions of higher learning. It informs and transforms both teaching and training, as well as service delivery.

Research should be a key component of the NHI. Not only in terms of clinical, health systems and public health research, but also in terms of monitoring and evaluation of the NHI and/or components thereof. HEI’s such as the SU FMHS can make a valuable contribution to evidence to inform the planning, monitoring and evaluation of the implementation of the NHI and should be more actively engaged in these roles in supporting the NHI.

Detailed reviews of the NHI pilot sites should be undertaken, not only in terms of the process and management indicators, but in terms of service delivery and health outcomes and the impact of the WBCOT’s and District Clinical Specialist Teams. This will be good indicator of service delivery under an NHI, and whether the ultimate goal namely, improved access to quality healthcare, is indeed achievable.

The FHMS requires clarification and discussion (e.g. as part of one of the NHI Work Streams) on the following questions:

- The White Paper refers to Centres of Excellence and Research Hubs. How will these work within the context of the National Health Act’s provisions on research and research priorities, clinical trials (as governed by the Medicines Control Council and in future the South African Health Products Regulatory Authority), product evaluations in the medical device field, etc.? What exactly would constitute a “research hub” and what would constitute a “Centre of Excellence”?
- How will the governance of these Centres and Hubs work? What will their relationship be with universities, or could they be independent or based in private institution?
- Will the NHI Fund cover research activities, and will it allow research staff to also act as service delivery providers under the NHI? How will the mandate of so-called “joint staff” (working for the university and the province), change?
- What is the relationship of NHI with Medical Research Council (MRC), the Council for Scientific and Industrial Research (CSIR) and other research funding systems, such as the National Research Foundation (NRF)?
- What will the role of external funding, such as the US National Institutes of Health (NIH) be in the NHI and in the clinical setting?
- **How will research be funded and financed?** How will the healthcare of an NHI patient who participates in health research be covered? Will there be any health research funds ear-marked within the NHI Fund?
- **Who will set research agendas?**
- **What will happen to existing structures involved in research, such as Provincial Health Research Ethics Committees, etc.?** Will research agendas and permissions also be centrally determined?
- **How will the NHI affect research conducted in public and private settings, as well as public- and privately funded research?**

Areas where the University of Stellenbosch can contribute through its research activities, are in the fields of evidence based health care, health systems research and health technology assessment. The outcomes of this research should not only inform procurement and purchasing decisions, but also the setting of national treatment guidelines. The work of the Office of Health Standards Compliance (OHSC), a key protagonist in the lead-up to the NHI should also be underpinned by research.

The FMHS recommends that the NHI constitute fertile ground for research, and should develop its own operational projects. The White Paper does not include a process of monitoring and evaluation for the NHI. Given the limited evidence of what works and how the particular components of a NHI result in changes in access to health care and health outcomes it is important to have a clear monitoring and evaluation (M&E) and research plan for the NHI. Important research questions identified from the international literature, and which are critical to understand as part of a monitoring and evaluation of the NHI include:-

- Governance & Institutional capacity;
- Quality of care;
- Target groups benefitting; and
- Causal pathways.

Additional topics for research could include:
- interaction with the private sector;
- centralised vs decentralised funding and variations thereof (e.g. as per the UK NHS’s local trusts);
- centralised vs decentralized management and governance structure;
- procurement and purchasing models;
- monitoring and evaluation of existing NHI programmes, such as school health, ward-based outreach teams, District Clinical Specialist Teams, the OHSC, etc.;
- health outcomes measurement;
- cost of healthcare in the NHI;
- universal coverage models;
- governance structures linking the DHET and NDOH in its pursuit for healthcare for all.

With reference to other systems, the UK NHS has a part of its budget ring-fenced for research. Some NHS staff have no research contracts, some only have research contracts, etc. It is important the central hospitals and academic complexes are involved in research as one of their key functions. A health balance between own-sponsored, and outside-sponsored research is critical.
Lastly, the monitoring and evaluation of NHI activities should be clearly stipulated in the paper and include the electronic capture of not only patient records but of human resources for health that impact health outcomes from CHWs to regional specialists.

5. Conclusion

The current NHI White Paper proposals, although welcomed in principle and seen as a necessary reform in the health system, are quite static with little recognition of the complexity of the system, possible unintended consequences and the need for flexibility and adaptability.

With respect to the particular mandate of the Faculty, the FMHS recommends that central facilities and academic complexes have ring-fenced budgets, where, within a coherent whole, training, an appropriate service delivery system as a learning platform, with a strong research base, such institutions can flourish and respond to the healthcare and training needs of the country.

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

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APPENDIX A – Overview of Stellenbosch University and the Faculty of Medicine and Health Sciences

Stellenbosch University was founded in 1918, and is today ranked among the top 3 universities in Africa as a Research-intensive higher education institution, with a strong development agenda. Stellenbosch University with ca. 30,000 students reflects its Vision 2030 as being “inclusive, innovative and future focused: a place of discovery and excellence, where both staff and students are thought leaders in advancing knowledge, in the service of all stakeholders”.

The University of Stellenbosch’s Strategic Priorities show its commitment to South Africa and why it is committed to universal access to healthcare. Its strategic positioning for the 21st century is anchored in creating and sustaining an environment of inclusivity, transformation, innovation, diversity, and maintaining excellence with a focus on the future. This positioning supports our core activities of teaching and learning, research and community interaction, with student success, knowledge base, diversity and systemic sustainability as focus areas.

Three overarching strategic priorities, supported by strategic themes, have been identified, viz. to:

- Broaden access;
  - Theme 1: Increase access to new knowledge markets
  - Theme 2: Increase diversity profile of students and staff
- Sustain excellence; and
  - Theme 3: Positioning as the leading research institution in Africa
  - Theme 4: Maintain student success rate
- Enhance societal impact.
  - Theme 5: Establish committed, visionary leadership

The Faculty of Medicine and Health Sciences is one of 10 Faculties at the university, supporting and enabling the realisation of the university’s vision. The Faculty’s principal aims are to enrich the learning, research and community engagement experience and to develop future medical and health sciences professionals who through innovation and leadership will promote health, prevent disease and provide optimal healthcare and rehabilitation. In doing so we strive to ensure that our activities are informed by the best available evidence, and that our programmes remain relevant to and benefit local communities, our country and the African content. The Faculty remains committed to addressing the top 3 health challenges in South Africa, viz.
1) dealing with the quadruple burden of disease (HIV/TB, maternal and child death and illness, violence and injury and NCDs), 2) improving the performance of the health system (financing, workforce, infrastructure, IT and governance), and 3) addressing the social and ecological determinants of disease (including climate change)

The Faculty, with its 1850 staff and 4100 students, is contributing to key priorities of the Department of Health and the Minister, such as -

- Improving service delivery and Quality of Care through support of:
  - SUCCEED (Stellenbosch University Collaborative Capacity Enhancement through Engagement with Districts) for the priority districts with high disease burden of HIV/AIDS and TB in attainment of the 90:90:90 targets through the District Implementation Plan (DIP) process.
  - National Department of Health with an evaluation of the MomConnect programme, a mobile phone-based messaging service to provide South Africa's estimated 1.2-million pregnant women with free antenatal health care information.

- Decentralising Medical and Health Professional Education to District Level Care:
  - The UKWANDA Centre for Rural Health and the UKWANDA Rural Clinical School
  - Stellenbosch University Rural Medical Education Partnership Initiative (SURMEPI) project longitudinal evaluation indicates that decentralized medical education can contribute to the retention of medical graduates in rural areas

- Transforming the medical curriculum:
  - to ensure that graduates are equipped to manage patients in all contexts from PHC to regional/tertiary care
  - To ensure that graduates understand social accountability; the social determinants of ill health and that graduates are not only equipped as clinical experts but understand the public health aspects of medicine.

As a result the FMHS is ideally placed to provide comment and input into many aspects of the proposed NHI system, and indeed able to contribute to the design and implementation of a future ideal health system.

Two particular entities at the Faculty are particularly well positioned to assist with the optimal design of the proposed NHI, viz.:

The Centre for Health Systems and Services Research and Development (CHSSRD) is a multidisciplinary collaborative entity that provides a shared service and academic platform for health systems and services research and development and through its programs assists in building capacity, provides education and training and promotes national and international collaboration in the field of health systems and services research (HSSR) and health leadership and management development. The CHSSRD occupies a distinct niche, complementing work done elsewhere in this field in South Africa. Given that most of the challenges in health systems in South Africa are located more in the organisation and delivery of care, rather than in the policy area, the CHSSRD’s focus is on developing HSSR methods and training appropriate to improving the quality of research and on the organisation and delivery of health systems, leadership and management.
The Centre for Evidence-based health care (CEBHC) aims to develop, teach and promote evidence-based health care (EBHC) at undergraduate and postgraduate levels; to provide EBHC support and resources to healthcare professionals to help maintain the highest standards of healthcare practice; and to enhance the use of best evidence by government, non-governmental organizations and the private sector in healthcare policy and practice. Core activities of the CEBHC include research, teaching and knowledge translation.
APPENDIX B - Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>CEBHC</td>
<td>Centre for Evidence-Based Health Care</td>
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<tr>
<td>CHSSRD</td>
<td>Centre for Health Systems and Services Research and Development</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>CVD</td>
<td>Coronary Vascular Disease</td>
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<tr>
<td>CEBHC</td>
<td>Centre for Evidence-Based Health Care</td>
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<tr>
<td>DBE</td>
<td>Department of Basic Education</td>
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<tr>
<td>DCST</td>
<td>District Clinical Specialist Team</td>
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<tr>
<td>DHET</td>
<td>Department of Higher Education and Training</td>
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<tr>
<td>DHIS</td>
<td>District Health Information System</td>
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<tr>
<td>DHMO</td>
<td>District Health Management Office</td>
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<tr>
<td>DIP</td>
<td>District Implementation Plan</td>
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<tr>
<td>DRG</td>
<td>Diagnostic Related Group</td>
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<tr>
<td>EBHC</td>
<td>Evidence Based Health Care</td>
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<tr>
<td>EBM</td>
<td>Evidence Based Medicine</td>
</tr>
<tr>
<td>FMHS</td>
<td>Faculty of Medicine and Health Sciences, Stellenbosch University</td>
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<tr>
<td>HEI</td>
<td>Higher Education Institution</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>HSSR</td>
<td>Health Systems and Services Research</td>
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<tr>
<td>HST</td>
<td>Health Systems Trust</td>
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<td>HTA</td>
<td>Health Technology Assessment</td>
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<tr>
<td>IKS</td>
<td>Indigenous Knowledge Systems</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<tr>
<td>LMIC</td>
<td>Low- and Middle Income Countries</td>
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<tr>
<td>MRC</td>
<td>Medical Research Council</td>
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<tr>
<td>MTS</td>
<td>Modernisation of Tertiary Services</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NDP</td>
<td>National Development Plan</td>
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<td>NHC</td>
<td>National Health Council</td>
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<tr>
<td>NHI</td>
<td>National Health Insurance</td>
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<td>NHSTP</td>
<td>National Health Science Training Plan</td>
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<tr>
<td>NPTTHSS</td>
<td>National Plan for Teaching and Training Health Science Students</td>
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<tr>
<td>NRF</td>
<td>National Research Foundation</td>
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<tr>
<td>NTHSP</td>
<td>National Tertiary Health Services Plan</td>
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<tr>
<td>NTS</td>
<td>National Tertiary Services</td>
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<tr>
<td>NTSG</td>
<td>National Tertiary Services Grant</td>
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<tr>
<td>OHSC</td>
<td>Office for Health Standards Compliance</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>SANC</td>
<td>South African Nursing Council</td>
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<td>SU</td>
<td>Stellenbosch University</td>
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<tr>
<td>SUCCEED</td>
<td>SU Collaborative Capacity Enhancement through Engagement with Districts</td>
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<td>SURMEPI</td>
<td>Stellenbosch University Rural Medical Education Partnership Initiative</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>WBCOT</td>
<td>Ward Based Community Outreach Team</td>
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<tr>
<td>WBPHCOT</td>
<td>Ward Based Primary Health Care Outreach Team</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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