



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

# **NHI Implementation: Institutions, bodies and commissions that must be established**

---

Friday, 08<sup>th</sup> September 2017.

## Table of Contents

<b>NATIONAL TERTIARY HEALTH SERVICES COMMITTEE.....</b>	<b>3</b>
TERMS OF REFERENCE .....	3
COMPOSITION .....	4
REPORTING LINES .....	5
OPERATING PROCEDURES.....	5
<b>NATIONAL GOVERNING BODY ON HUMAN RESOURCES FOR HEALTH (INCORPORATING TRAINING AND DEVELOPMENT).....</b>	<b>6</b>
TERMS OF REFERENCE .....	6
COMPOSITION OF THE NATIONAL GOVERNING BODY ON HUMAN RESOURCES FOR HEALTH .....	8
OPERATING PROCEDURES.....	8
NATIONAL GOVERNING BODY ON TRAINING AND DEVELOPMENT REPORTING .....	9
<b>NATIONAL HEALTH PRICING ADVISORY COMMITTEE .....</b>	<b>10</b>
PRIMARY OBJECTIVES: .....	10
TERMS OF REFERENCE .....	10
COMPOSITION .....	11
REPORTING LINES .....	12
OPERATING PROCEDURES.....	12
<b>MINISTERIAL ADVISORY COMMITTEE ON HEALTH CARE BENEFITS FOR NATIONAL HEALTH INSURANCE .....</b>	<b>13</b>
BACKGROUND .....	13
PRIMARY OBJECTIVES AND PURPOSE .....	13
TERMS OF REFERENCE .....	14
COMPOSITION .....	16
REPORTING LINES .....	16
OPERATING PROCEDURES.....	16
<b>NATIONAL ADVISORY COMMITTEE ON CONSOLIDATION OF FINANCING ARRANGEMENTS.....</b>	<b>18</b>
PRIMARY OBJECTIVES: .....	18
TERMS OF REFERENCE .....	18
COMPOSITION .....	20
REPORTING LINES .....	21
OPERATING PROCEDURES.....	21
<b>MINISTERIAL ADVISORY COMMITTEE ON HEALTH TECHNOLOGY ASSESSMENT FOR NATIONAL HEALTH INSURANCE .....</b>	<b>22</b>
PRIMARY OBJECTIVES AND PURPOSE .....	22
TERMS OF REFERENCE .....	22
COMPOSITION .....	24
REPORTING LINES .....	24
OPERATING PROCEDURES.....	24
<b>SOUTH AFRICAN NATIONAL HEALTH COMMISSION .....</b>	<b>26</b>
PRIMARY OBJECTIVES AND PURPOSE .....	26
TERMS OF REFERENCE.....	26
COMPOSITION:.....	27
REPORTING LINES.....	28
OPERATING PROCEDURES.....	28



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## NATIONAL TERTIARY HEALTH SERVICES COMMITTEE

This committee relates to the proposed governance arrangements regarding tertiary health services in South Africa.

### Terms of Reference

- a) **Prepare and maintain a national tertiary services plan** in coherence with the entire health system, especially the secondary/regional services (not with the aim of governance but to ensure an integrated approach between national tertiary health services plan and regional services, including referral system), burden of disease, economies of scale and capacity factors, including, but not limited to:
  - i. Equity of access
  - ii. Corporate governance (financial, structural, human resources, and risk management requirements),
  - iii. Clinical governance (service delivery, quality assurance, and clinical risk management),
  - iv. Monitoring and evaluation (review of strategic outcomes, service delivery outputs, applicable research related to tertiary services and knowledge translation, human resources, financial parameters, risk management)
  - v. Auditing and internal controls.
- b) **Develop the tools** required for reporting on tertiary service provision, resources and outcomes.
- c) Monitor the commissioning of tertiary services as the planned expansion is rolled out to new sites and any planned consolidation of services.
- d) **Evaluate and report on the outcomes** of monitoring and evaluation, as well as relevant research, to the NHC, via the NHC Technical Advisory Committee.
- e) **Facilitate peer reviewed clinical governance audits.**
- f) Recommend to the NHC, via the NHC Technical Advisory Committee **actions to be taken to address the evaluation and audit findings.**
- g) Develop and present to the NHC, via the NHC Technical Advisory Committee explicit **definitions, norms and standards** to be used for tertiary services:
  - i. health care interventions and clinical services to be provided as regional and tertiary services, (including clinical governance, clinical support services and other support services)
  - ii. provision and maintenance of facilities in which tertiary health services are provided,
  - iii. appropriate medical equipment and associated technologies to support tertiary health services, and
  - iv. determining staffing levels for tertiary health services,

- v. with due cognisance and collaboration with national policies on health services, technology, infrastructure and human resources for health and with consideration of the link between service norms and standards and academic activities of teaching and learning and research. (This includes service, infrastructure and staffing norms.)
- h) **Consult** with clinicians, academics and professional groups (councils and associations) to develop a draft, and /or set in place, comprehensive set of clinical guidelines and rationing criteria for all tertiary disciplines and for tertiary care in general.
- i) **Consult** with private sector specialist health service providers, Higher Education Institutions (HEIs) and other higher education forums, international donors, and any other interested parties regarding the roles and responsibilities of tertiary health services in a NHI system.
- j) **Develop the terms of reference and commission applicable research** related to tertiary services and knowledge translation.
- k) **Develop a costing and funding model** for financing tertiary services and for equitable allocation of the budgeted funds.
- l) **Draft clear guidelines** for an accreditation process for the rendering of tertiary services.
- m) Make recommendations to the NHC, via the NHC Technical Advisory Committee regarding the **health institutions to be accredited to deliver specific tertiary services** (whether funded through a central grant allocation or otherwise).
- n) **Facilitate guidance and support** for provinces in the governance of tertiary services delivered in their health institutions.

**Important:**

- a) *“The National Tertiary Health Services Committee will not replace or duplicate the functions and responsibilities of the Expert Review Committee established to develop the Essential Medicines List and/or other clinical committees established to recommend policy and treatment guidelines.*
- b) *The National Tertiary Health Services Committee will not replace or duplicate the functions and responsibilities of the Committee on Health Technology Assessment for National Health Insurance.*
- c) *The National Tertiary Health Services Committee will collaborate with such structures and consider the inputs of such structures in their recommendations.”*

**Composition**

- a) Core membership of the Committee appointed by the Minister of Health:
  - i. Relevant Senior Official (at a DDG level) of National Department of Health
  - ii. Four Relevant Senior Official (at a DDG level) of Provincial Departments of Health without Central Hospitals, nominated by the National Health Council.
  - iii. All Central Hospital Chief Executive Officers
- b) One Relevant Senior Official (at a DDG level) from the National Treasury nominated by the Minister of Finance
  - i. One Relevant Senior Official (at a DDG level) from the Department of Higher Education and Training nominated by the Minister of Higher Education and Training
- c) Representative from the Council of Deans of Health Science Faculties, Dental and Medical Faculties;
  - i. Representative from the Professional Councils (HPCSA, SANC, PCSA)

- d) In addition, the Minister will appoint one (1) representative of each group because of their special knowledge of matters following a call for nominations:
  - i. Colleges of Medicine;
  - ii. Operational experience of Private Hospital management and service delivery;
  - iii. Professional societies;
  - iv. NHLS and SANBS; and
  - v. Civil society

The Minister of Health will appoint a Chair and Deputy Chair from the above list of Members.

## **Reporting Lines**

- a) Report to the NHC, via the NHC Technical Advisory Committee.

## **Operating Procedures**

- a) Meetings:
  - i. The committee will meet every 6 weeks, plus
  - ii. one annual planning workshop.
- b) Minutes of meetings and key documents that have been approved should routinely be made available to all interested parties and published on the NDOH website for wider access.
- c) The NDOH will be responsible for secretariat functions.
- d) The Committee should be authorised to establish sub-committees and to appoint task teams or persons to conduct ad hoc work, provided that
  - i. clear TORs are signed off by the committee
  - ii. timeframes are stipulated



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## **NATIONAL GOVERNING BODY ON HUMAN RESOURCES FOR HEALTH (incorporating Training and Development)**

The National Governing Body on Human Resources for Health will be the main body responsible for establishing a clear vision and for recommending policy related to health sciences student education and training to the two departments and Ministers. It will also oversee and monitor implementation of the policy and evaluate its impact. The National Governing Body on Human Resources for Health will coordinate and align strategy, policy and financing of health sciences education with co-responsibility between the Department of Higher Education and Training (DHET) and the National Department of Health (NDOH). The National Governing Body on Human Resources for Health, as a DHET and NDOH approved structure, will therefore carry the authority of both departments.

The main functions relate to the governance of education and training of health professionals in matters such as joint staff responsibilities, access to service platform (facilities, equipment, services, etc.), relationships across provincial boundaries, uniform engagement with the services and new teaching programmes.

### **Terms of Reference**

- a) Develop and present to the NHC explicit definitions, norms and standards to be used for health science student training:
  - i. clinical teaching to be provided on the health service platform,
  - ii. clinical training to be provided on the health service platform,
  - iii. research to be undertaken by health science students,
  - iv. provision and maintenance of facilities in which health science learning can take place,
  - v. appropriate medical equipment and associated technologies to support health science learning, and
  - vi. determining teaching staffing levels (numbers, qualifications, ratios to students, etc.) for health science learning, with due cognisance and collaboration with national education and training policies and with consideration of the link between academic activities of teaching and learning and research and service norms and standards. (This includes service, infrastructure and staffing norms.)
- b) Develop, co-ordinate and align strategic initiatives, planning imperatives, policy developments, and financing of health sciences education and training.
- c) Identify strategic planning imperatives in health science education that will support a human resource for health plan.
- d) Determine a shared vision for health sciences student education and training to produce human resources for health (HRH) for the country per the national plan and prepare and maintain a

national plan for health sciences student education and training to produce human resources for health (HRH) for the country per the national HRH strategy

- i. Making recommendations on the realistic expansion of the health science education for health-related professions and allied professions
  - ii. Corporate governance (financial, structural, human resources, and risk management requirements)
  - iii. Governance of education and training (delivery of courses and quality of output),
  - iv. Monitoring and evaluation (review of strategic outcomes, education outputs, applicable research related to health science student training, human resources for teaching and training, financial parameters, risk management), and
  - v. Auditing and internal controls.
- e) Develop the terms of reference and commission applicable health science training research and knowledge translation.
  - f) Maintain and periodically review a costing and funding model for financing health sciences student education and for equitable allocation of the budgeted funds.
  - g) Draft clear guidelines for an accreditation process.
  - h) Manage the relationship between the Department of Health, the Department of Higher Education and Training and other relevant stakeholders involved in health sciences student education and training.
  - i) Engage with the higher education institutions generally and with the Deans responsible for faculties that train health professionals specifically, as well as provincial health departments, the professional bodies and other relevant stakeholders as required to promote the policy for health sciences student education and training.
  - j) Provide a national framework (and template agreement) that will govern the relationship between higher education and health at national, provincial and local levels and fulfil the national governance function in relation to these.
  - k) Engage with the health professional councils (HPCSA, SANC, SAPC) and other relative bodies regarding accreditation and registration of health professionals.
  - l) Investigate the funding implications and make recommendations on the funding for improved and expanded health sciences student education and training.
  - m) Conduct the technical work required to prepare and maintain a national health science student training plan.
  - n) Conduct technical consultations with professional groups (councils and associations) to develop and /or set in place a comprehensive set of training outcome skills required of all health professionals.
  - o) Conduct technical consultations with private sector specialist health service providers, Higher Education Institutions (HEIs) and other higher education forums, international donors, and any other interested parties regarding the skills mix and clinical competencies required from health science graduates to provide health services in a NHI system.
  - p) Prepare terms of reference for applicable research related to health science student training as decided by the National Governing Body on Training and Development and manage the commissioning, oversight and payment of the work.
  - q) Develop recommendations on the requirements and establishment of a human resource information system,

- r) Develop Strategies on the recruitment of health professionals, retention, performance of the health workforce.
- s) Develop guidelines for the optimal leadership, governance and management of the health workforce.
- t) Conduct technical work to develop and improve a costing and funding model for financing health science student training and for equitable allocation of the budgeted funds.
- u) Prepare documentation to the NHC regarding the expansion of health science student training that the Committee recommends.
- v) Provide appropriate logistical support for guidance and support to provincial health departments and HEIs in the governance of their multi-lateral agreements.

## **Composition of the National Governing Body on Human Resources for Health**

The National Governing Body on Human Resources for Health involves two major parties, the Department of Health, and the Department of Higher Education and Training.

The composition of the Committee comprises of representatives of those stakeholders who are directly responsible for education and training of health professionals.

- a) Core membership of the Committee appointed by the Minister of Health:
  - i. Deputy Director-General of the Department of Higher Education and Training
  - ii. Deputy Director-General of the National Department of Health
  - iii. Four Relevant Senior Official (at a DDG level) of Provincial Departments of Health, nominated by the National Health Council
  - iv. One representative from the National Health Laboratory Service
  - v. One representative from the South African Military Health Services nominated by the Surgeon General
  - vi. Representative from the Council of Deans of Health Science Faculties, Dental and Medical Faculties;
- b) In addition, the Minister will appoint one (1) representative because of their special knowledge of matters following a call for nominations:
  - i. Representative from the Professional Councils (HPCSA, SANC, PCSA)
  - ii. Colleges of Medicine;
  - iii. Operational experience of Private Hospital management and service delivery;
  - iv. Health Professional societies (including specific knowledge of matters relating to Junior Doctors, Rural Doctors, Registrars and Specialists); and
  - v. Civil society.

The Minister of Health will appoint a Chair and Deputy Chair from the above list of Members.

## **Operating Procedures**

- a) Meetings - There should be:
  - i. meetings every 6 weeks, plus



- ii. one annual planning workshop,
- b) The NDOH will be responsible for secretariat functions.
- c) The procedures for notice of meetings, discussion, decision-taking and reporting should be decided by the National Governing Body on Training and Development.
- d) Resolutions and recommendations made by the National Governing Body on Training and Development should be by consensus and where that is not possible the minority view must be presented to both Ministers.
- e) Minutes of National Governing Body on Training and Development meetings must be provided to all members.
- f) Minutes of meetings (and key documents that have been approved by the Ministers) should routinely be made available to all interested parties and published on the NDOH and DHET websites for wider access.
- g) The National Governing Body on Training and Development may establish standing or ad hoc technical subcommittees and appoint task teams or persons to provide advice on relevant issues or to conduct ad hoc work, if
  - i. clear TORs are signed off by the committee, and
  - ii. timeframes are stipulated
- h) Any sub-committee must include at least one member of the National Governing Body on Training and Development, who should preferably chair the sub-committee.

### **National Governing Body on Training and Development Reporting**

- a) Report to the NHC, via the NHC Technical Advisory Committee.



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## NATIONAL HEALTH PRICING ADVISORY COMMITTEE

### Primary Objectives:

To develop:

- a) **Risk Adjusted Capitation** – At the PHC level, the main mechanism that will be used to pay contracted providers will be a risk-adjusted capitation system with an element of performance-based payment.
- b) **A case-mix system for the reimbursement of hospitals' and medical specialists' services at hospital level** - Payment related to services delivered would be determined through a system of case-mix activity adjusted payments (such as Diagnosis-Related Groups or DRGs).
  - i. Defined as the whole set of activities and interventions of the hospital and medical specialist resulting from the first consultation and diagnosis of the medical specialist in the hospital
  - ii. These tariffs apply to all hospitals and include two separate components: a reimbursement of hospital costs and an honorarium for medical specialists.

### Terms of Reference

- a) Develop a uniform product costing model to calculate unit costs, including examples of the cost template of:
  - i. Primary Health Care;
  - ii. Provider payment at hospital level;
  - iii. Laboratory and diagnostic imaging tests;
  - iv. Patient transport including EMS; and
  - v. Ancillary services to health care
- b) Develop a uniform Pricing Strategy, based on the following principles
  - i. Enabling equitable economic development
  - ii. Financial sustainability
  - iii. Economic efficiency
  - iv. Equity and affordability
- c) Develop a set of performance-based indicators of outcomes - Providers, both the public and private, will be assessed against indicators of clinical care, health outcomes and clinical governance rather than simply on perceived quality of services.
- d) Providing objective analysis on the appropriate pay levels for identifiable groups within the public sector;

- i. Comparing appropriate rates for identifiable groups with prevailing private sector/market rates. This should have regard to evidence on recruitment and retention trends in respect of each group;
- e) Implement interim measures and processes to stabilise price determination mechanisms in the private health system with the cooperation of private sector health stakeholders, until the full implementation of NHI in 2026.
- f) Undertaking a consultative process with the view to maximizing consensus on the implementation of a new pricing framework, which stakeholders and role-players must as far as possible include:
  - i. Medical schemes;
  - ii. Medical schemes intermediaries;
  - iii. Health professionals;
  - iv. Private and public hospitals;
  - v. Provincial health departments;
  - vi. Consumer representatives;
  - vii. Manufacturers of medicines and medical products;
  - viii. Pharmacists;
  - ix. The Health Professions Council;
  - x. The Pharmacy Council;
  - xi. The South African Health Products Regulatory Authority;
  - xii. The Nursing Council;
  - xiii. The Competition Commission;
  - xiv. The Pricing Committee; and
  - xv. National Treasury.
- g) Determine appropriate rates for administrative and overhead expenditure related to health care provision and the management of the NHI Fund.
- h) Define information requirements and establish processes to institutionalise routine collection of data appropriate (fair and efficient) pricing requires information on
  - i. the ***marginal value***;
  - ii. the ***price elasticity of demand***
- i) Develop recommendations on the establishment of a Health Care Pricing Authority, which will include amongst others the following functions:
  - i. Coordinates and manages multi-lateral price negotiations;
  - ii. Enforces or supports the enforcement of compliance with all legislation relating to price determination in the health system;
  - iii. Determines benchmarks; and
  - iv. Manages disputes arising from published final prices

## Composition

The Pricing Advisory Committee

- a) Core membership of the Committee appointed by the Minister of Health:
  - i. Relevant Senior Official (at a DDG level) of National Department of Health

- ii. One Relevant Senior Official (at a DDG level) from the National Treasury nominated by the Minister of Finance
- b) In addition, the Minister of Health will appoint representatives (maximum of 11) based on their special knowledge of health economics and financing and benefit design in the following areas through a call for nominations:
  - i. Operational experience of Medical Schemes and/or administration of medical schemes
  - ii. Professional Councils (HPCSA, SANC, PCSA, Dental)
  - iii. Operational experience of Private Hospital management and service delivery;
  - iv. Health Professional societies;
  - v. NHLS and SANBS;
  - vi. Actuarial Expert with health care benefit design experience
  - vi. Academic and research organizations; and
  - vii. Civil society.

The Minister of Health will appoint a Chair and Deputy Chair from the above list of Members.

## **Reporting Lines**

- a) Report to the NHC, via the NHC Technical Advisory Committee.

## **Operating Procedures**

- a) Meetings - There should be:
  - i. meetings every 6 weeks, plus
  - ii. one annual planning workshop,
- b) The NDOH will be responsible for secretariat functions.
- c) The procedures for notice of meetings, discussion, decision-taking and reporting should be decided by the Committee.
- d) Resolutions and recommendations made by the Committee should be by consensus and where that is not possible the minority view must be presented to both Ministers.
- e) Minutes of Committee meetings must be provided to all members.
- f) Minutes of meetings (and key documents that have been approved by the Ministers) should routinely be made available to all interested parties and published on the NDOH websites for wider access.
- g) The Committee may establish standing or ad hoc technical subcommittees and appoint task teams or persons to provide advice on relevant issues or to conduct ad hoc work, provided that
  - i. clear TORs are signed off by the committee, and
  - ii. timeframes are stipulated
- h) Any sub-committee must include at least one member of the Committee , who should preferably chair the sub-committee.



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## MINISTERIAL ADVISORY COMMITTEE ON HEALTH CARE BENEFITS FOR NATIONAL HEALTH INSURANCE

### Background

As part of the phased implementation, in December 2015, the National Department of Health has established six work streams to provide technical support in the finalization of the implementation plan for NHI. The six work streams identified to support the phased implementation of NHI are:

- (a) Prepare for the establishment of the NHI Fund;
- (b) Design and Implementation of NHI Health Care Service Benefits;
- (c) Prepare for the purchaser-provider split and accreditation of providers;
- (d) The role of medical schemes in an NHI environment;
- (e) Complete NHI Policy paper for public release; and
- (f) Strengthening the District Health System.

The work streams are not implementing entities but will make recommendations to the Department. At the end of April 2017, the work streams had finalized their recommendations on respective mandates.

### Primary Objectives and Purpose

Work Stream 2 has developed a Service Benefits Framework (SBF). The SBF comprises of two components:

a) **Database of current health services**

- A complete list of services provided at the community level, fixed Primary Health Care (PHC) facilities and hospitals in the Public Health Sector as per existing national guidelines, with a list all the inputs per health intervention

b) **Costing Model**

- Estimate the cost to provide health services at fixed PHC facilities in the public sector, at a standardised quality of care, and to the entire in-need population, to achieve UHC.

SBF can be considered to:

- Model the resource implications of different services scenarios under NHI at various levels of the health system
- Assess actual service delivery against stated policy
- Development of reimbursement mechanisms under NHI

- Alignment of services available under NHI versus private schemes
- Review and revision or full rollout of existing coding/classification systems

The Ministerial Advisory Committee on Health Care Benefits is being established to implement the recommendations of Work Stream 2.

**Important:**

- a) The Ministerial Advisory Committee on Health Care Benefits will not replace or duplicate the functions and responsibilities of the Expert Review Committee established to develop the Essential Medicines List and/or other clinical committees established to recommend policy and treatment guidelines.
- b) The Ministerial Advisory Committee on Health Care Benefits will not replace or duplicate the functions and responsibilities of the Committee on Health Technology Assessment.
- c) The Ministerial Advisory Committee on Health Care Benefits will collaborate with such structures and consider the inputs of such structures in their recommendations.
- d) In undertaking their activities, should the Ministerial Advisory Committee on Health Care Benefits identify gaps and/or duplication of effort, this should be brought to the attention of the Director-General: Health with suitable recommendations on how they can be addressed.

**Terms of Reference**

Ministerial Advisory Committee on Health Care Benefits will be a panel of medical and other experts to recommend covered benefits covered under NHI and to advise the Minister of Health on the social, financial and health impact of benefits covered under NHI.

- a) **The specification of a comprehensive set of benefits** - The committee will advise the Minister of Health on which interventions should be included in the health service benefits.
  - i. In doing so, the Ministerial Advisory Committee on Health Care Benefits, will review scientific evidence generated from studies to identify the disease burden in South Africa, assess the cost-effectiveness of interventions and the feasibility of scaling up. In this way, the health benefits selected will be evidenced-based.
  - ii. It will specify services to be provided to the population in each district and communicate this to potential service providers.
  - iii. It will also identify the consequences for service providers who fail to offer the expected benefits to the patients they serve.
  - iv. It will regularly assess whether health service benefits are in line with the needs of the district, updating it as the epidemiological profile changes.
- b) **Develop norms and standards for effective health care service delivery**, including
  - i. The Scope of care;
  - ii. The Care Setting – or the most appropriate point of delivering care
  - iii. Exclusions – determine under which circumstances certain services will be excluded
  - iv. Waiting times

- v. The Ministerial Advisory Committee on Health Care Benefits will ensure the core services provided are uniform across the district and are provided with the requisite quality.
- c) **Review and recommend development of treatment guidelines and protocols** - The Ministerial Advisory Committee on Health Care Benefits will jointly with clinical committees and expert groups, who advise on clinical treatment guidelines, treatment protocols and the essential medicines list review existing guidelines and treatment protocols, with a view to identifying any gaps or inconsistencies in the current set and undertake appropriate measures to address them.
- i. Where, necessary will recommend
    - The development of additional guidelines for interventions as the need arises, including with the advent of new knowledge and technology
    - Recommend to the Director-General: Health the establishing ad hoc committees to fill necessary gaps that might fall outside of the scope and TOR of existing clinical committees.
  - ii. Specify patient management requirements and care path networks - Considering transitions in levels of care the benefit design must specify care pathways and referral networks, within and between facilities
- d) **Develop and operationalize an implementation framework** - The Ministerial Advisory Committee on Health Care Benefits will develop and operationalize an implementation framework.
- i. Identify current constraints associated with the implementation;
  - ii. Identify and mitigate any measures required to ensure the sustainability of the package of benefits
  - iii. A transition process to determine which services are to be provided and for whom, has to be designed, implemented and regularly reviewed
  - iv. Oversee the implementation of the **comprehensive set of benefits** within the voluntary insurance sector.
- e) **Periodically review the health care benefit specification** - The Ministerial Advisory Committee on Health Care Benefits will undertake an assessment of whether the essential health benefits need to be modified or updated to account for changes in medical evidence or scientific advancement, or to address any gaps in access, coverage or changes in the evidence base
- f) **Determine and adopt an appropriate process for resource estimate** –
- i. The Ministerial Advisory Committee on Health Care Benefits will specify resource requirements that are necessary to provide health service benefits to the population.
  - ii. In collaboration with the National Health Pricing Advisory Committee develop an approach to on-going revisions to the costing of health care service benefits to be covered under NHI using the public service benefits as a point of departure;
  - iii. Develop the purchasing strategies necessary to maximize the use and affordability of health services
- g) **The Ministerial Advisory Committee on Health Care Benefits following consultation** with key stakeholders with expertise in the public and private health sectors must recommend a final benefit structure for implementation from 1<sup>st</sup> January 2018.
- h) **Development of standardized materials** communicating what services will be covered and how will they be accessed - While the purchaser(s) and providers will be able to work from one set of

health service benefit specifications, a different set of specifications that are less technical and detailed, needs to be provided to the general public

- i) **Information and data requirements** - The Ministerial Advisory Committee on Health Care Benefits will stipulate the different requirements, including but not limited to
  - i. Improved data needed on current utilization patterns at different levels of facility
  - ii. patient outcomes for morbidity and mortality
  - iii. budget and spending indicators
  - iv. relationship between money spent and quality/utilization/outcomes
- j) **Review and advise on contracting of health providers** - The Ministerial Advisory Committee on Health Care Benefits has a key role in advising the on possible reforms to contracting of health care providers in both the public and private sectors.

## Composition

- a) Core membership of the Committee appointed by the Minister of Health:
  - i. Relevant Senior Official (at a DDG level) of National Department of Health
  - ii. Two Relevant Senior Official (at a DDG level) of Provincial Departments of Health, nominated by the National Health Council.
- b) One Relevant Senior Official (at a DDG level) from the National Treasury nominated by the Minister of Finance
- c) In addition, the Minister will appoint representatives because of their special knowledge of matters following a call for nominations published in the Government Gazette:
  - i. Representative from the Council of Deans of Health Science Faculties, Dental and Medical Faculties;
  - ii. Representative from the Professional Councils (HPCSA, SANC, PCSA)
  - iii. Colleges of Medicine;
  - iv. Operational experience of Private Hospital management and service delivery;
  - v. Health Professional societies;
  - vi. Council for Medical Schemes
  - vii. Operational experience of medical schemes and/or administration of medical schemes
  - viii. Actuarial Expert with health care benefit design experience
  - ix. Academic and research organizations; and
  - x. Civil society.

## Reporting Lines

- a) Report to the NHC, via the NHC Technical Advisory Committee.

## Operating Procedures

- a) Meetings - There should be:
  - i. meetings every 6 weeks, plus
  - ii. one annual planning workshop,



- b) The NDOH will be responsible for secretariat functions.
- c) The procedures for notice of meetings, discussion, decision-taking and reporting should be decided by the Committee.
- d) Resolutions and recommendations made by the Committee should be by consensus and where that is not possible the minority view must be presented to both Ministers.
- e) Minutes of Committee meetings must be provided to all members.
- f) Minutes of meetings (and key documents that have been approved by the Ministers) should routinely be made available to all interested parties and published on the NDOH websites for wider access.
- g) The Committee may establish standing or ad hoc technical subcommittees and appoint task teams or persons to provide advice on relevant issues or to conduct ad hoc work, if
  - i. clear TORs are signed off by the committee, and
  - ii. timeframes are stipulated
- h) Any sub-committee must include at least one member of the Committee, who should preferably chair the sub-committee.



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## NATIONAL ADVISORY COMMITTEE ON CONSOLIDATION OF FINANCING ARRANGEMENTS

### Primary Objectives:

Making progress towards universal health coverage requires transformation and reconfiguration of institutions for pooling of funds and purchasing of services to achieve income and risk cross-subsidisation whilst improving the efficiency in purchasing of personal health services. NHI requires the establishment of strong governance mechanisms and improved accountability for the use of allocated funds.

The establishment of a single financing pool with a single purchaser requires the clear identification of transitional arrangements and structures. The current financing structure is significantly fragmented

### Terms of Reference

- a) **The Committee will be responsible for implementing the consolidation of financing arrangements** - The consolidation of funding streams into 5 transitional funding arrangements will effectively reduce the current fragmentation and through a process of income cross-subsidisation allow for the transition towards the establishment of a single financing pool without having to wait for the raising of additional funding through the tax system.
  - i. The proposed 5 funding arrangements are:
    - a. The unemployed
    - b. The informal sector (such as taxi industry; hawkers, domestic workers)
    - c. Formal Sector employment (bigger business)
    - d. Formal Sector employment (small and medium size business)
    - e. Civil servants (including SOEs, Intelligence Agencies, Defence, Police Service)
- b) **Consolidation of Civil Servants Funding arrangements** – the Committee will be responsible in overseeing the following:
  - i. The consolidation of financing arrangements will start with the consolidation of all civil servants, including employees of State Owned Enterprises, Municipalities, Intelligence Agencies, Defence, and the Police Service into one financing arrangement.
  - ii. The consolidation of all civil servants, will be undertaken from the April 2017, in consultation with the Department of Public Service and Administration.
  - iii. Reform of GEMS structures to align to principles of NHI

- iv. The reform of the employer subsidy by Government
- c) Implementation within formal sector employment structures –**
- i. Replacement of PMBs with the comprehensive benefit structure
    - a) Those individuals accessing health care through medical scheme membership will see their current services expanded beyond PMBs to include the full range of services as outlined in the NHI package.
    - b) During 2017, the Council for Medical Schemes and the NDOH will consult with various stakeholders linked to the medical scheme industry (funding agents, administrators, managed care and providers) on the changes required to implement the package from the 1<sup>st</sup> of January 2018.
    - c) As legislative changes are made to the mandatory coverage and contributions of those in formal sector employment, the principles of a common, comprehensive set of services will be entrenched.
  - ii. Other phased initiatives include;
    - a) Standardisation of work place health services.
- d) Introduction of Mandatory Cover and Contributions related to Formal employment**
- i. Through a series of changes to existing legislation, mandatory cover and contributions will be introduced for all individuals in formal employment.
    - a) This applies specifically to circumstances where employers currently cover the employee but not dependants. The policy intent is to ensure that in line with White Paper on NHI, that employers contribute towards the cost of cover of employees and their dependants.
    - b) In the interim period, prior to full NHI implementation:
      - i. employers who do not subsidise employees with medical scheme cover, must start contributing towards the NHI Fund which will be buying the services for those individuals;
      - ii. employers who only subsidise employees and not their dependents must start contributing towards the costs of dependents.
  - ii. The Committee will make recommendations on whether the costs of cover will include subsidization by Government, Employers and the employees.
  - iii. Essential features including will be implemented from 2017:
  - iv. Amendment to the medical schemes act to consolidate existing restricted and open medical schemes
- e) Pricing Reform and Uniform benefits –**
- i. In 2017, an advisory pricing commission will be established by the Minister with the purpose of making recommendations on an appropriate service remuneration structure for health care benefits delivered by public and private providers.
  - ii. During 2018 and 2019, a revised pricing and remuneration structure for health services funded through transitional funding structures will be phased in.
  - iii. The Committee will be responsible for the implementation of these reforms within the Voluntary Insurance Sector

- f) **Undertaking a consultative process** with the view to maximizing consensus on the implementation of a new financing arrangements framework, which stakeholders and role-players must as far as possible include:
- i. Medical schemes;
  - ii. Medical schemes intermediaries;
  - iii. Health professionals;
  - iv. Private and public hospitals;
  - v. Provincial health departments;
  - vi. Consumer representatives;
  - vii. Manufacturers of medicines and medical products;
  - viii. Pharmacists;
  - ix. The Health Professions Council;
  - x. The Pharmacy Council;
  - xi. The South African Health Products Regulatory Authority;
  - xii. The Nursing Council;
  - xiii. The Competition Commission;
  - xiv. The Pricing Committee; and
  - xv. National Treasury.

## **Composition**

The Pricing Advisory Committee

- a) Core membership of the Committee appointed by the Minister of Health:
  - i. Relevant Senior Official (at a DDG level) of National Department of Health
  - ii. One Relevant Senior Official (at a DDG level) from the National Treasury nominated by the Minister of Finance
  - iii. One Relevant Senior Official (at a DDG level) of Provincial Departments of Health, nominated by the National Health Council.
  - iv. The Competition Commissioner
- b) In addition, the Minister of Health will appoint representatives (maximum of 11) based on their special knowledge of health economics and financing following a call for nominations:
  - i. Council for Medical Schemes
  - ii. Actuarial Expert with health care pricing experience
  - iii. Operational experience of medical schemes and/or administration of medical schemes
  - iv. Operational experience of Private Hospital management and service delivery;
  - v. Professional societies;
  - vi. Academic and research organizations; and
  - vii. Civil society.

The Minister of Health will appoint a Chair and Deputy Chair from the above list of Members.

## Reporting Lines

- a) Report to the NHC, via the NHC Technical Advisory Committee.

## Operating Procedures

- a) Meetings - There should be:
  - i. meetings every 6 weeks, plus
  - ii. one annual planning workshop,
- b) The NDOH will be responsible for secretariat functions.
- c) The procedures for notice of meetings, discussion, decision-taking and reporting should be decided by the Committee.
- d) Resolutions and recommendations made by the Committee should be by consensus and where that is not possible the minority view must be presented to both Ministers.
- e) Minutes of Committee meetings must be provided to all members.
- f) Minutes of meetings (and key documents that have been approved by the Ministers) should routinely be made available to all interested parties and published on the NDOH websites for wider access.
- g) The Committee may establish standing or ad hoc technical subcommittees and appoint task teams or persons to provide advice on relevant issues or to conduct ad hoc work, provided that
  - i. clear TORs are signed off by the committee, and
  - ii. timeframes are stipulated
- h) Any sub-committee must include at least one member of the Committee, who should preferably chair the sub-committee.



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## MINISTERIAL ADVISORY COMMITTEE ON HEALTH TECHNOLOGY ASSESSMENT FOR NATIONAL HEALTH INSURANCE

The White Paper on NHI, states “a process of priority setting and health technology assessment (HTA) will be used to inform the decision-making processes of the NHI to determine the benefits to be covered. The range of services will be regularly reviewed using the best available evidence on cost-effectiveness, allocative, productive and technical efficiency and HTA.

### Primary Objectives and Purpose

Ministerial Advisory Committee on Health Technology Assessment (HTA Committee) will be a panel of multi-disciplinary experts to recommend prioritisation, selection, distribution, management and introduction of interventions for health promotion, disease prevention, diagnosis, treatment and rehabilitation.

### Terms of Reference

In settings where HTA is well-established, evidence supports coverage decisions, including the design of health service delivery. As such the HTA Committee will be required to undertake the following activities.

- a) A core characteristic of a successful HTA agency is **independence and financial sustainability**
  - i. Financial sustainability refers to the ability of an HTA agency to have a consistent financial flow. The HTA Committee will develop recommendations on funding requirements for on-going HTA in South Africa.
  - ii. The HTA Committee will develop recommendations on the organisational structure for HTA in South Africa that is deemed fair, independent and objective
- b) **Human resource development** - It is very important that sufficient human resource capacity is built into HTA research organizations as well as decision-making bodies
  - i. The HTA Committee will develop recommendations on the skills requirements for HTA in South Africa
  - ii. Following approval will oversee the implementation of the HTA structure.
  - iii. The HTA committee will identify and develop appropriate training programmes to ensure that a strong HTA agency is having full-time research staff working on and developing their skills on conducting HTA.
- c) **International collaboration** - International technical support is very useful, especially in the formative stages

- i. The HTA committee will identify and recommend to the Director-General: Health an international and national collaboration framework, in terms of but not limited to undertaking HTA and developing capacity for undertaking HTA.
- d) **Stakeholder consultation and management:**
  - i. The HTA process involves multiple stakeholders, as such, the HTA committee will develop and implement a comprehensive stakeholder engagement framework, which will include good management of potential conflict of interest.
- e) **Linking HTA to policy decision-making mechanisms**
  - i. The HTA committee will identify the appropriate mechanism for linking HTA to decision-making, including linkages to other structures and committees, such as the Pricing Advisory Committee, the SA Health Products Regulatory Agency and the Health Benefits Committee.
- f) **Undertake a resource mapping exercise:**
  - i. A mapping exercise of the current data gaps that exist on costs, effectiveness and other such data needed to conduct HTA in South Africa could be undertaken.
- g) **Adopt and Implement a prioritization framework** - to be as explicit as possible about what services are included and excluded and about what criteria guide service selection
  - i. Including the identification of specific measures required to ensure the cost-efficiency of mandatory benefits
  - ii. The HTA Committee will be required to map the impact of changes resulting from the provision of benefits expected in line with change in policies.
- h) **Initiate the process of conducting HTA:**
  - i. The HTA Committee, utilizing the prioritization framework will examine the latest cost-effectiveness research and value-based benefit design initiatives to see what lessons can be applied.
  - ii. The HTA Committee develop an operational HTA framework, including templates and guides on conducting HTA.
  - iii. The HTA Committee develop a process to fast-track the assessment of existing technology, including the development of the application form of expedited applications for confirmation of their expedited pathway.
  - iv. The HTA Committee develop a recommendation regarding guiding principles which apply to any future reviews of benefit changes
- i) **Linkages to Medicines Pricing**
  - i. The HTA Ministerial Advisory Committee should give consideration on how the existing structures such as the Pricing Committee and expert review committees for medicines will be incorporated into NHI structures
- j) **A good health information infrastructure** encourages appropriate HTA application
  - i. **The HTA Committee** will stipulate the different requirements, including but not limited to
    - Improved data needed on current utilization patterns at different levels of facility
    - patient outcomes for morbidity and mortality
    - budget and spending indicators
    - relationship between money spent and quality/utilization/outcomes

## Composition

- a) Core membership of the Committee appointed by the Minister of Health:
  - i. One Relevant Senior Officials (at a DDG level) of National Department of Health
  - ii. One Relevant Senior Official (at a DDG level) of Provincial Departments of Health, nominated by the National Health Council.
- b) One Relevant Senior Official (at a DDG level) from the National Treasury nominated by the Minister of Finance
- c) In addition, the Minister will appoint representatives because of their special knowledge of matters following a call for nominations:
  - i. Representative from the Council of Deans of Health Science Faculties, Dental and Medical Faculties;
  - ii. Representative from the Professional Councils (HPCSA, SANC, PCSA)
  - iii. Colleges of Medicine;
  - iv. Operational experience of Private Hospital management and service delivery;
  - v. Professional societies;
  - vi. Council for Medical Schemes
  - vii. Actuarial Expert with health care pricing experience
  - viii. Operational experience of medical schemes and/or administration of medical schemes
  - ix. Academic and research organizations; and
  - x. Civil society.

## Reporting Lines

- a) Report to the NHC, via the NHC Technical Advisory Committee.

## Operating Procedures

- a) Meetings - There should be:
  - i. meetings every 6 weeks, plus
  - ii. one annual planning workshop,
- b) The NDOH will be responsible for secretariat functions.
- c) The procedures for notice of meetings, discussion, decision-taking and reporting should be decided by the Committee.
- d) Resolutions and recommendations made by the Committee should be by consensus and where that is not possible the minority view must be presented to both Ministers.
- e) Minutes of Committee meetings must be provided to all members.
- f) Minutes of meetings (and key documents that have been approved by the Ministers) should routinely be made available to all interested parties and published on the NDOH websites for wider access.



- g) The Committee may establish standing or ad hoc technical subcommittees and appoint task teams or persons to provide advice on relevant issues or to conduct ad hoc work, provided that
  - i. clear TORs are signed off by the committee, and
  - ii. timeframes are stipulated
- h) Any sub-committee must include at least one member of the Committee, who should preferably chair the sub-committee.



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## **SOUTH AFRICAN NATIONAL HEALTH COMMISSION**

### **Primary Objectives and Purpose**

The South African National Health Commission will address the social determinants of health through a multi-sectoral and development approach involving key government departments and non-state actors.

This Commission will co-ordinate key sectors in implementing a health in all policies and an all-inclusive approach to the prevention and control of Non-Communicable Diseases, including mental health. Promoting health and preventing illness is central to National Health Insurance as well as to social and economic growth and development in South Africa.

### **Terms of reference**

- a) Identify the social and economic factors that drive premature illness and death from non-communicable diseases.
- b) Interrogate the means and mechanisms through which these determinants can be addressed, including the interventions required from different government departments and non-state actors.
- c) Utilise scientific evidence on the causes of non-communicable diseases and how to prevent these. Based on this information draw up feasible and implementable plans to promote health and prevent diseases through interventions by the relevant stakeholders.
- d) Research and utilise international best practice on health promotion and disease prevention interventions across sectors, analyse these for their feasibility and relevance to South Africa and make recommendations on implementation through SANHC to member government departments and non-state actors.
- e) Periodically analyse surveillance data on non-communicable diseases and adapt strategies to changing patterns.
- f) Analyse cost-effectiveness and cost benefit of interventions to reduce non-communicable diseases and ensure the most effective and efficient use of resources across sectors.
- g) Assist government departments and non-state actors to draw up strategic and operational plans that will positively impact on the social determinants of health.
- h) Consider and provide input into strategic and operational plans drawn up by government departments and other non-state actors vis-à-vis objectives and activities aimed at promoting health and preventing disease.

- i) Monitor the implementation of the plans and activities of all sectors with regards to the plans submitted to redress the social determinants of health.
- j) Evaluate existing interventions aimed at the promotion of health and the prevention of illness as well as programmes and projects that derive from the SANHC and make applicable recommendations to the relevant department or non-state actors.
- k) Ensure collaboration between and across government and non-state actors including non-government organizations, academia, representatives of labour and the private sector, to systematically improve the health status of South Africans and reduce the need for health care interventions.
- l) Ensure that all sectors that contribute to health and development outcomes of Non-Communicable Diseases are aware of their responsibilities and that they implement relevant policies and interventions as directed by the South African National Health Commission;
- m) Where circumstances permit the SANHC may act as a conduit for channelling funding to relevant sectors dealing with the social determinants of health.
- n) Co-ordinate sectors synergistically and eliminate wasteful duplication.

### **Composition:**

- a) Persons of high standing from National Government including, but not restricted to representatives from: -
  - i. Agriculture;
  - ii. Basic Education;
  - iii. Communications;
  - iv. Co-operative Governance and Traditional Affairs;
  - v. Economic Development;
  - vi. Energy;
  - vii. Environmental Affairs;
  - viii. Finance;
  - ix. Forestry and Fisheries;
  - x. Health;
  - xi. Higher Education and Training;
  - xii. Labour;
  - xiii. Presidency;
  - xiv. Public works;
  - xv. Rural Development and Land reform;
  - xvi. Science and Technology;
  - xvii. Small Business Development;
  - xviii. Social Development;
  - xix. Sport and Recreation;
  - xx. Trade and Industry;
  - xxi. Transport;
  - xxii. Water and Sanitation;

- b) In addition, the Minister of Health will appoint representatives because of their special knowledge of matters, following a call for nominations published in the Government Gazette:
- i. Civil society stakeholders (NGOs and NPOs);
  - ii. Academics/researchers/experts;
  - iii. Organised labour;
  - iv. CEOs of Water Boards;
  - v. Private sector; and
  - vi. Civil society.

Co-chairs, one from the government and one from the non-state sector will be appointed.

## **Reporting lines**

- a) Report to the NHC, via the NHC Technical Advisory Committee.

## **Operating Procedures**

- a) Meetings.
- i. The South African National Health Commission will meet every quarter, of which one meeting per annum will be a planning workshop.
- b) The SANHC may establish standing or ad hoc technical subcommittees and appoint task teams or persons to provide advice on relevant issues or conduct ad hoc work, provided that
- i. clear TORs are signed off by the Commission
  - ii. timeframes are stipulated.
- c) Any sub-committee must include at least one member of the Commission, who should preferably chair the sub-committee.
- d) The NDOH will be responsible for secretariat functions.
- e) Minutes of meetings and key documents that have been approved will be routinely available to all interested parties and published on the NOH website for wider access.