MEMORANDUM ON THE OBJECTS OF THE NATIONAL HEALTH INSURANCE BILL, 2019

1. BACKGROUND

1. General

1.1 Cabinet approved the policy for the transformation of the South African health care system to achieve universal coverage for health services, which includes the creation of a National Health Insurance Fund as a strategy for moving towards Universal Health Coverage (UHC).

1.2 The aim of universal health coverage is to provide South Africans with—
(a) access to needed health care that is of sufficient quality to be effective; and
(b) financial protection from the costs of health care.

1.3 The National Health Insurance Bill, 2019 (''Bill''), seeks to provide for the universal access to health care services in the Republic in accordance with the National Health Insurance White Paper and the Constitution of South Africa, 1996 (''Constitution''). The Bill envisages the establishment of a National Health Insurance Fund (''Fund'') and sets out its powers, functions and governance structures. The Fund will purchase health care services for all users who are registered with the Fund. The Bill will also create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of users and preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users.

1.4 The Preamble recognises the socio-economic imbalances and inequities of the past, the need to heal the divisions of the past, the need to establish a society based on democratic values, social justice and fundamental human rights and the need to improve the quality of life of all citizens. The Preamble also takes cognisance of Article 12 of the United Nations Covenant on Economic, Social and Cultural Rights, 1966, which provides for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and of Article 16 of the African Charter on Human and People's Rights, 1981, which provides for the right to enjoy the best attainable state of physical and mental health. The Preamble also recognises the right to have access to health care services, including reproductive health care as provided in section 27(1)(*a*) of the Constitution as well as the obligation on the State to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to health care services as provided in section 27(2) of the Constitution.

2. ADDRESSING BARRIERS TO ACCESS

2.1 Structural challenges in the health system

2.1.1 There is a need for reform of both the health care financing and service delivery systems so that all South Africans have access to affordable, quality personal health care services regardless of their socio-economic status within the context of the burden of disease in South Africa.

2.1.2 The main problem relates to the fragmentation of health care fund pools in the South African health system and the aim is to create an integrated pool in order to achieve universal health coverage for health

care services by establishing a purchaser-provider split with the Fund being the single-payer for comprehensive health care services purchased on behalf of users.

2.1.3 The barriers to access that need to be addressed are—

(a) an onerous burden of out-of-pocket payments on some individuals due to the uneven implementation of user fee exemptions at public hospitals and the high cost of care in the private sector;
(b) distance to health facilities remains a major barrier to access, including in terms of the availability and costs of public and emergency transport;
(c) lack of sufficient, qualified staff within the public health sector relative to the size of the population served by this sector;
(d) misdistribution of health care providers between geographic areas, with a concentration in large urban areas;
(e) weak purchasing and incentive mechanisms;
(f) fragmented funding and risk pools, which limit the potential for income and risk cross-subsidies; and
(g) inefficient provider payment mechanisms in both the public and the private health sectors.

2.1.4 In order to achieve the objectives listed below, there must be a reconfiguration of the institutions and organisations involved in the funding, pooling, purchasing and provision of health care services in the South African health system.

2.2. The implementation of reforms in the 2017/18 to 2021/2022 period will take place in six phases:

2.2.1 The intermediate preparatory phase involve improving the quality of the health system by first certifying the health facilities to ensure they meet the requirements of the Office of Health Standards Compliance.

2.2.2 Initiate the establishment of the Fund whilst simultaneously introducing a national quality improvement plan that helps facilities to be certified and accredited to provide health care services to be funded under National Health Insurance (''NHI''). During this phase health facilities that are certified and accredited will start to provide health care services for users of the Fund (September 2019—March 2021)

2.2.3 Fund and its Executive Authority will bid for funds through the main budget as part of the budget process to expand coverage using certified and accredited public and private sector health facilities. This phase will focus on fully establishing the purchaser-provider split and associated reforms, such as changing provider payment mechanisms and the implementation of the Fund's institutional arrangements (May 2020-March 2021).

2.2.4 Shift some of the conditional grants such as the National Tertiary Services grant and the HIV/AIDS and TB grant from the Department of Health into the Fund and continue with step 2.5.3. (April 2021-March 2022).

2.2.5 Shifting some or all of the funds currently in the provincial equitable share formula for personal health care services (currently the main public health funding stream to the Fund to gradually extend these delivery and management reforms to all districts and public hospitals (April 2022).

2.2.6 The final phase will largely relate to expanding coverage in terms of being able to accommodate the maximum projected utilisation rates and gradually increasing the range of services to which there is a benefit entitlement. In a favourable economic environment there will

be an initiation of the evaluation of new taxation options for the Fund including evaluating a surcharge on income tax, a small payroll tax or as financing sources for NHI.

2.3 This phased approach will be described in more detail in a series of implementation plans by the Department of Health, and will be updated regularly on the basis of insights gained from piloting some of the activities and careful monitoring of each phase.

2.4 The purpose of the introduction of the reforms mentioned in paragraph 2.2 above is to ensure consistency with the global vision that health care should be seen as a social investment and not be subject to trading as a commodity. The universal health coverage system is a reflection of the kind of society we wish to live in: one based on the values of social solidarity, equity, justice and fairness.

3. AFFORDABILITY AND SUSTAINABILITY

3.1 A legitimate concern is the affordability and sustainability of National Health Insurance in South Africa. This can best be considered with reference to the nature of the proposed system and the checks and balances that will be put in place to limit unnecessary expenditure increases for supply-side as well as demand-side management.

3.2 Affordability and sustainability can be addressed as follows:

3.2.1 Placing increased emphasis on health promotion and preventive services and outlining how this will be achieved (e.g. through the activities of ward health agents);

3.2.2 establishing high quality primary health care services as the foundation of the health system, to ensure that the majority of health problems can be diagnosed and treated at this level;

3.2.3 introducing a mechanism for 'gatekeeping' through a primary health care approach and referral system, where patients access higher level services on the basis of referral networks;

3.2.4 a system of priority setting that emphasises health promotion and disease prevention and in which medically necessary interventions are used; and

3.2.5 improving public health facility infrastructure and to strengthen district health management.

4. STRENGTHENING PRIMARY HEALTH CARE ("PHC") SERVICES

4.1 Building a high quality and effective PHC service delivery platform is the foundation upon which the health system will be based.

4.2 The PHC service delivery platform will be located within the District Health Management Offices and services will be delivered in a comprehensive and integrated way.

4.3 There will be an increased emphasis on health promotion and preventive services, in addition to improving curative and rehabilitative services.

4.4 The delivery of primary health care services will be population-orientated with extensive use of community and home-based services in addition to PHC facilities, follows:

4.4.1 PHC outreach teams will be deployed in each municipal ward, supported by a nurse and linked to a PHC facility such as a clinic;

4.4.2 PHC outreach teams will be allocated households that they will visit on a regular basis. They will provide health promotion education, identify those in need of preventive (e.g. immunisations), or rehabilitative services and refer them to the relevant PHC facility;

4.4.3 outreach teams will also facilitate community involvement and participation in identifying health problems and behaviours that place individuals at risk of disease or injury and implement appropriate interventions to address these problems at a community level; and

4.4.4 school health services will be provided to improve the physical and mental health and general well-being of school going children, including pre-Grade R, and Grade R up to Grade 12.

4.5 Private primary health care providers will be drawn on to increase service delivery capacity and to improve access to needed health services, especially in under-served rural and informal urban areas.

4.6 Contracting arrangements will be explored, including improved sessional appointments; contracts to deliver comprehensive PHC services from government health facilities or mobile health posts; and contracts with multi-disciplinary group or network practices operating from private premises.

4.7 Contracted private providers will be integrated into the PHC service delivery platform in line with the vision of making comprehensive promotive, preventive, curative and rehabilitative services accessible to all and will be coordinated through the Contracting Units for Primary Health Care (CUPs). They will be an integral part of district health services, contribute not only to clinical service delivery but, where appropriate, also clinical governance activities, and have strong working relationships with other elements of the district health care delivery platform.

4.8 District Health Management Offices (DHMOs) will be established as government-components reporting to the national sphere to which responsibilities are delegated. Appropriate governance structures will be established at district level to ensure that these institutions serve the public interest.

4.9 To ensure that the Fund purchases quality health services, the management of hospitals will be decentralised to ensure their effective functioning and sustainability. The delegation of management authority to public hospital facilities will be piloted.

4.10 Central hospitals will have semi-autonomous boards and administration, management, budgeting and governance functions. The central hospitals will become government components and the competence of the national sphere of government. They will contract directly with the Fund.

4.11 Provincial tertiary and regional hospitals or groups of hospitals and specialised hospitals will become semi-autonomous entities accountable to the Minister through regulation and whose functions can be delegated to different sphere of government.

5. OBJECTIVES OF THE BILL

5.1 Principles

National Health Insurance will be based on the following overarching principles:

(a) **Universality —** all will be able to access the same essential health care benefits regardless of their financial means; and

(b) **Social solidarity —** all regardless of their socio-economic status will benefit from a national system of health care, which is based on income

cross-subsidies between the affluent and the impoverished and risk cross-subsidies between the healthy and the sick.

5.2 Goal

The goal of the National Health Insurance is to move towards universal coverage by serving as a strategic and active purchaser of personal health care services and by—
(a) ensuring that the entire population, and not just particular groups, are entitled to benefit from needed, high quality health care;
(b) extending over time the range of services to which the population is entitled; and
(c) reducing the extent to which the population has to make direct, out-of-pocket payments for health services.

5.3 Objectives

The Fund will strive to achieve the following specific objectives:
(a) universal protection against financial risk;
(b) equitable distribution of the burden of funding the universal health system:
(c) equitable and fair provision and use of health services;
(d) efficiency in service provision and administration;
(e) quality in service delivery; and
(f) good governance and stewardship.

5.4 Applicable Legislation

National legislation (as amended) and applicable or related to the contents and mandate of the Bill, and any other legislation that may or may not require amendment at a later stage, include:

Act No. 63 of 1982	Allied Health Professions Act, 1982
Act No. 130 of 1993	Compensation for Occupational Injuries and Diseases Act, 1993
Act No. 89 of 1998	Competition Act, 1998
Act No. 111 of 1998	Correctional Services Act, 1998
Act No 19 of 1979	Dental Technicians Act, 1979
Act No. 56 of 1974	Health Professions Act 56 of 1974 as amended
Act No. 101 of 1997	Higher Education Act, 1997
Act No. 58 of 1962	Income Tax, 1962
Act No. 40 of 2002	Institution of Legal Proceedings Against Certain Organs of State Act, 2002
Act No. 97 of 1997	Intergovernmental Fiscal Relations Act, 1997
Act No. 28 of 1974	International Health Regulations Act, 1974
Act No. 117 of 1998	Local Government Municipal Systems Act, 1998 as amended
Act No. 131 of 1998	Medical Schemes Act, 1998
Act No. 101 of 1965	Medicines and Related Substances Act, 1965
Act No. 17 of 2002	Mental Health Care, 2002
Act No. 9 of 2009	Money Bills Amendment Procedure and Related Matters Act, 2009
Act No. 61 of 2003	National Health Act, 2003
Act No. 32 of 2000	Municipal Systems Act, 2000
Act No. 37 of 2000	National Health Laboratory Services Act, 2000
Act No. 33 of 2005	Nursing Act, 2005
Act No. 78 of 1973	Occupational Diseases in Mines and Works Act, 1973
Act No. 85 of 1993	Occupational Health and Safety Act, 1993

Act No. 63 of 1982	Allied Health Professions Act, 1982
Act No 13 of 2006	Older Persons Act, 2006
Act No. 53 of 1974	Pharmacy Act 1974
Act No 70 of 2008	Prevention of and Treatment for Substance Abuse Act, 2008
Act No. 56 of 1996	Road Accident Fund Act, 1996
Act No. 35 of 2007	Traditional Health Practitioners Act, 2007

6. CLAUSE BY CLAUSE ANALYSIS

6.1 Clause 1

Clause 1 provides for the definitions of the Bill.

6.2 Clause 2

Clause 2 provides for purpose of the Bill.

6.3 Clause 3

Clause 3 provides for the scope and application of the Bill.

6.4 Clause 4

6.4.1 Clause 4 deals with the eligibility to become a beneficiary of the Fund. Clause 4 provides that the Fund must, in consultation with the Minister, purchase comprehensive health service benefits as determined by the Benefits Advisory Committee of the Fund on behalf of—

(a) South African citizens;
(b) persons who are permanently resident in the Republic;
(c) the dependants of persons referred to in paragraphs *(a)* and *(b)*;
(d) all children, including children of asylum seekers or illegal immigrants are entitled as provided for in section 28 of the Constitution; and
(e) all inmates as provided for in section 12 of the Correctional Services Act.

6.4.2 This clause also provides that an asylum seeker or illegal foreigner is only entitled to emergency medical services and service for notifiable candidates of public health concern.

6.5 Clause 5

Clause 5 of the Bill deals with the registration as users with the Fund and for, amongst others, the presentation of an identity document, smart card, valid permit or visa in terms of the provisions of the Refugees Act, 1998 (Act No. 130 of 1998), or the Immigration Act, 2002 (Act No. 13 of 2002), as the case may be, for persons intending to register with the Fund.

6.6 Clause 6

Clause 6 deals with the rights of the users of the Fund. These include, amongst others, the right to receive quality health care services free of charge from certified and accredited health care service providers and health establishments upon presentation of proof of registration.

6.7 Clause 7

Clause 7 provides that the Fund will purchase health care service as determined by the Benefits Advisory Committee in consultation with the Minister for the benefit of users who are registered with the Fund.

6.8 Clause 8

Clause 8 deals with the cost coverage in relation to the Fund. This clause provides that a person who is registered as a beneficiary will receive the required services as purchased on his or her behalf by the Fund from certified and accredited health care service providers at no cost.

6.9 Clause 9

Clause 9 provides for the establishment of the Fund as a national public entity as contemplated in the Public Finance Management Act, 1999 (Act No. 1 of 1999) (''PFMA'').

6.10 Clause 10

Clause 10 contains a list of functions of the Fund.

6.11 Clause 11

Clause 11 contains a list of the powers of the Fund.

6.12 Clause 12

Clause 12 makes provision for the establishment of an independent Board that is accountable to Parliament in accordance with the provisions of the PFMA.

6.13 Clause 13

Clause 13 makes provision for the constitution and composition of the Board. It sets out the process for the nomination of candidates to serve on the Board and the role of the *ad-hoc* panel tasked with interviews of the shortlisted candidates and making recommendations to the Minister of Health (''Minister'') for his appeal. Clause 13 also outlines the conditions in terms of which the Minister may dissolve the Board after consultation with the Portfolio Committee.

6.14 Clause 14

Clause 14 deals with the appointment of the Chairperson and Deputy Chairperson of the Board.

6.15 Clause 15

Clause 15 makes provision for the functions and powers of the Board. In terms of this clause, the Board must fulfil the functions of an accounting authority in terms of the provisions of the PFMA and is accountable to Parliament. The Board shall advise the Minister on any matter concerning—

(a) the management and administration of the Fund;
(b) the improvement of efficiency and performance of the Fund in terms of universal purchasing and provision of health care services;
(c) terms and conditions of employment of Fund employees;
(d) collective bargaining; and
(e) the budget of the Fund.

6.16 Clause 16

Clause 16 deals with the conduct and disclosure of interests by members of the Board.

6.17 Clause 17

Clause 17 makes provision for the Board to determine its own procedures.

6.18 Clause 18

This clause deals with the remuneration and reimbursement of members of the Board.

6.19 Clause 19

Clause 19 makes provision for the appointment of the Chief Executive Officer ("CEO") of the Fund. The CEO shall be appointed on the basis of his or her experience and technical competence as the administrative head of the Fund in accordance with a transparent and competitive process.

6.20 Clause 20

Clause 20 provides that the CEO is directly accountable to the Board and his or her responsibilities include, amongst others—
(a) the formation and development of an efficient Fund administration;
(b) the organisation and control of the staff of the Fund;
(c) the maintenance of discipline within the Fund;
(d) the effective deployment and utilisation of staff; and
(e) the establishment of an Investigating Unit within the national office of the Fund.

6.21 Clause 21

Clause 21 provides for the relationship of CEO with the Minister, Director-General and Office of Health Standards Compliance.

6.22 Clause 22

Clause 22 deals with the power of the CEO in relation to the appointment and dismissal of the executive management officials of the Fund.

6.23 Clause 23

Clause 23 empowers the Minister to appoint technical committees.

6.24 Clause 24

Clause 24 empowers the Board to establish technical committees.

6.25 Clause 25

Clause 25 makes provision for the appointment of a Benefits Advisory Committee by the Minister, after consultation with the Board.

6.26 Clause 26

Clause 26 provides that the Minister must, after consultation with the Board, establish a Health Care Benefits Pricing Committee.

6.27 Clause 27

Clause 27 makes provision for the appointment of a Stakeholder Advisory Committee by the Minister, after consultation with the Board.

6.28 Clause 28

Clause 28 provides for the disclosure of interests by members of a committee.

6.29 Clause 29

Clause 29 provides for the remuneration and procedures of a committee that is established by the Minister in terms of clause 23 of the Bill and empowers the Minister to determine the remuneration and procedures in respect of such a committee.

6.30 Clause 30

Clause 30 provides for vacation of office by members of the committee.

6.31 Clause 31

Clause 31 provides for the legislative role of the Minister in relation to the governance and stewardship of the national health system and the governance and stewardship of the Fund.

6.32 Clause 32

Clause 32 provides for the legislative role of the Department as contemplated in the National Health Act, 2003 (Act No. 61 of 2003) (''National Health Act'').

6.33 Clause 33

Clause 33 deals with the role of medical schemes. In terms of this clause, medical schemes registered in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998), or any other voluntary private health insurance scheme, shall be restricted to providing complementary cover for health care service benefits that are not purchased by the Fund on behalf of users.

6.34 Clause 34

Clause 34 provides for the National Health Information System.

6.35 Clause 35

Clause 35 provides for the purchasing of health services by the Fund. The Fund shall actively and strategically purchase health care services on behalf of users in accordance with need and the provisions of this Act.

6.36 Clause 36

Clause 36 provides for the role of District Health Management Offices. The District Health Management Office established by section 31A of the National Health Act must facilitate, coordinate and manage the provision of non-personal public health care programmes at district level in compliance with national policy guidelines and applicable law.

6.37 Clause 37

Clause 37 makes provision for the establishment of the Contracting Unit for Primary Health Care. The Contracting Unit is the organisational unit with which the Fund contracts for the provision of primary health care services within a specified geographical sub-district area.

6.38 Clause 38

Clause 38 provides for the establishment by the Minister of the Office of Health Products Procurement that is accountable to the Board of the Fund.

6.39 Clause 39

Clause 39 provides for accreditation of public and private health establishments by the Fund.

6.40 Clause 40

Clause 40 deals with the payment of service providers of the Fund. In terms of the clause, the Fund, in consultation with the Minister, will determine the nature of service provider payment mechanisms and adopt mechanisms to establish that health care service providers, health establishments and suppliers are properly accredited in terms of clause 39, before they receive payment.

6.41 Clause 41

Clause 41 provides that an affected natural or juristic person, namely a user, health care service provider, health establishment or supplier, may lodge a complaint with the Fund in consultation with the Minister and the Fund must deal with such complaints in a timeous manner and in terms of applicable law.

6.42 Clause 42

Clause 42 deals with the lodging of complaints with a Fund.

6.43 Clause 43

Clause 43 deals with the lodging of appeals to the Appeal Tribunal against a decision as contemplated in clause 42.

6.44 Clause 44

Clause 44 deals with the establishment of the Appeal Tribunal, its composition and the term of office of its members.

6.45 Clause 45

Clause 45 makes provision for the powers of the Appeal Tribunal.

6.46 Clause 46

Clause 46 provides for the designation of the secretariat of the Appeal Tribunal.

6.47 Clause 47

Clause 47 provides for the remuneration and procedures of the Appeal Tribunal.

6.48 Clause 48

Clause 48 makes provision for the sources of income of the Fund. In terms of clause 48, the South African Revenue Service will undertake all revenue collection related to the Fund, including the collection of any supplementary health tax levies if applicable. The Treasury will, in consultation with the Minister of Finance, the Minister and the Fund, determine the budget and allocation of revenue to the Fund on an annual basis.

6.49 Clause 49

Clause 49 provides for the chief source of income of the Fund.

6.50 Clause 50

Clause 50 deals with the auditing of the books of the Fund.

6.51 Clause 51

Clause 51 provides that the Board, as the accounting authority of the Fund, must submit to the Minister an annual report on the activities of the Fund during each financial year. Furthermore, the clause makes provision for the requirements of the annual report in terms of its content and the obligation on the Minister to table the annual report in the National Assembly and the National Council of Provinces without delay.

6.52 Clause 52

Clause 52 deals with the assignment of duties and delegation of powers of the Fund.

6.53 Clause 53

Clause 53 makes provision for the protection of confidential information.

6.54 Clause 54

Clause 54 creates a list of offences in instances where a natural or juristic person contravenes specific provisions in the Bill.

6.55 Clause 55

Clause 55 makes provision for the powers of the Minister to make regulations.

6.56 Clause 56

Clause 56 makes provision for the powers of the Fund to issue directives.

6.57 Clause 57

Clause 57 deals with transitional arrangements in respect of the Bill.

6.58 Clause 58

Clause 58 deals with the repeal and amendment of laws as provided in the Schedule to the Bill.

6.59 Clause 59

Clause 59 provides for the short title and commencement.

7. DEPARTMENTS/BODIES CONSULTED

- National Health Council
- National Treasury
- Forum of South African Directors General
- Public Consultations through 197 received and evaluated written comments
- Civil Society
- Traditional Leaders
- Health Professional Groups
- Finding intermediaries

8. FINANCIAL IMPLICATIONS FOR THE STATE

The Fund will be financed in various interrelated phases as determined in consultation with the National Treasury:

8.1 The costing/budgeting focuses on practical issues, rather than general models (three of which were previously contracted). The latest focuses on three issues:

(a) Quality of care improvement programme: The War-room is of the view that a new funding component is required to accelerate quality initiatives, to support a stronger response post OHSC audit and also to support progressive accreditation of facilities for Fund. Amounts of R75 million, R125 million and R175 million will be considered for potential reprioritisation as part of the budget process.

(b) Establishment of Fund: The preliminary costing is R57 million, R145 million and R287 million. These should be seen as ideal and will probably be less given practical delays e.g. in passing Bill. Again in the short term these funds can largely be found through reprioritisation within the grant.

(c) Actuarial costing model: Treasury commissioned a simplified intervention-based costing tool for 2019/20 which provides simple estimates of costs of a set of 15 or so interventions. These include for example removing user fees, extending chronic medicine distribution programme (CCMDD), extending ARV rollout, increasing antenatal visits, rolling out capitation model for General Practitioners (GPs), cataract surgery programme, establishing Fund. The full set of interventions costs in the longer term around R30 billion per annum. The Department will adapt the tool to find a set of priority interventions. Most of these interventions can be scaled up progressively as funding becomes available and does not need significant new funds in Budget 2020.

8.2 The Human Resources Capacitation Grant will be used to appoint staff to ensure implementation of the Fund already increases from R330 million spending in 2018/19 to R600 million in 2019/20 to R1 billion in 2020/21 and R1.1 billion in outer years. This should be focussed in the first instance on statutory posts such as interns and community service, given problems in provinces funding these key posts and national interest in making sure these are fully funded.

8.3 The above is preliminary work and to be taken forward will need to be further developed around Budget 2020.

8.4 The rising Fund budget baseline (R4.2 billion was reprioritised from tax subsidy; NHI grant rises from R2.5 billion in 2019/20 to R3.1 billion in 2020/21) and under-spending in 2018/19 (around R600 million), requires that most of the short term funding for the above is derived from reprioritisation and rising baseline. The 2020/21 budget of R3.1 billion is already substantially above 2018/19 spending of R 1.7 billion.

8.5 In the next phase the Fund and its Executive Authority will be able to bid for funds through the main budget as part of the budget process.

8.6 Thereafter consideration will be given to shifting some of the conditional grants such as the National Tertiary Services grant and the HIV/AIDS and TB grant from the Department to the Fund. Preliminary analysis suggests this will require legal amendments.

8.7 The table below outlines the 2019 MTEF Fund Conditional Grant allocations:

Table 1: National Health Insurance Conditional Grant 2019 MTEF Allocations

Non-Personal Services Component	**758,000**	**832,000**	**858,860**
CCMDD	420,000	476,000	483,280
Ideal Clinic Component	23,000	26,000	27,430
Information Systems	315,000	330,000	348,150
Medicine Stock Surveillance System	*143,000*	*150,000*	*158,250*
Health Patient Registration System	*172,000*	*180,000*	*189,900*
Personal Services Component	**639,288**	**783,000**	**915,068**
HP Contracting Current Model (contr - In)	289,288	305,198	321,053
GP Contracting - Capitation	150,000	200,000	211,000
Mental Health Services	100,000	125,000	150,000
Other priority services (Oncology)	100,000	152,802	233,015
Total NHI Indirect Grant	**2,533,699**	**3,210,816**	**3,336,016**

Total Conditional Grants Allocation (Direct & Indirect)	**47,522,518**	**52,435,758**	**57,424,345**

	2019 MTEF Allocations		
	2019/20	2020/21	2020/21
Direct Grants	R'000	R'000	R'000
Health Prof Training and Dev Grant	2,940,428	3,102,152	3,272,770
National Tertiary Services Grant	13,185,528	14,068,863	14,842,650
Comprehensive HIV and AIDS, TB & COS	**22,038,994**	**24,408,471**	**27,752,587**
HIV/AIDS Component	*19,963,269*	*22,195,284*	*24,518,748*
TB Component	*485,300*	*511,989*	*540,151*
Community Outreached Services Component	*1,500,000*	*1,584,000*	*2,582,500*
Malaria Component	*90,425*	*117,198*	*111,188*
Health Facility Revitalisation Grant	6,006,973	6,359,557	6,858,024
Human Papillomavirus (HPV)	211,200	222,816	235,071
Human Resources Capacitation Grant	605,696	1,063,083	1,127,227
TOTAL	**44,988,819**	**49,224,942**	**54,088,329**

8.8 In a later phase consideration will be given to shifting of funds currently in the provincial equitable share formula for personal health care services (currently the main public health funding stream consisting of around R150 billion per annum) to the Fund. This will require amendments to the National Health Act, 2003. This will also depend on how functions are shifted, for example if central hospitals are brought to the national level.

8.9 Chapter 7 of the Fund White Paper details several new taxation options for the Fund, including evaluating a surcharge on income tax, a small payroll-based taxes as financing sources for the Fund. Due to the current fiscal condition, tax increases may come at a later stage of NHI implementation.

9. PARLIAMENTARY PROCEDURE

9.1 The Constitution regulates the manner in which legislation may be enacted by Parliament and prescribes the different procedures to be followed for such enactment. Section 76 of the Constitution provides for the parliamentary procedure for ordinary Bills affecting the provinces. In terms of section 76(3) a Bill must be dealt with in accordance with the procedure established by either section 76(1) or section 76(2) if that Bill provides for legislation envisaged in section 76(3)*(a)* to *(f)* or if it falls within a functional area listed in Schedule 4.

9.2 In ***Tongoane and Others v National Minister for Agriculture and Land Affairs and Others***[i] ("***Tongoane*** judgment"), the CC confirmed and upheld the test for tagging that was formulated in ***Ex Parte President of the Republic of South Africa: In re Constitutionality of the Liquor Bill***[ii], where the CC held that—

> *"the heading of section 76, namely, 'Ordinary Bills affecting provinces' provides a strong textual indication that section 76(3) must be understood as requiring that any Bill whose provisions in substantial measure fall within a functional area listed in Schedule 4, be dealt with under section 76.".*

9.3 At paragraph 50 of the Tongoane judgment the CC held that the tagging test focuses on all the provisions of the Bill in order to determine the extent to which they substantially affect the functional areas listed in Schedule 4 and not on whether any of its provisions are incidental to its substance.

9.4 The CC stated the following at paragraph 58 of the Tongoane judgment:

> "*What matters for the purposes of tagging is not the substance or the true purpose and effect of the Bill, rather, what matters is whether the provisions of the Bill 'in substantial measure fall within a functional area listed in Schedule 4'*.".

9.5 The CC further held that the test for tagging must be informed by its purpose. Tagging is not concerned with determining the sphere of government that has the competence to legislate on a matter. Nor is the purpose concerned with preventing interference in the legislative competence of another sphere of government. The process is concerned with the question of how the Bill should be considered by the provinces and in the National Council of Provinces, and how a Bill must be considered by the provincial legislatures depends on whether it affects the provinces. The more it affects the interest, concerns and capacities of the provinces, the more say the provinces should have on its content.[iii]

9.6 To determine whether the provisions of the Bill in substantial measure fall within a functional area listed in Schedule 4, the Bill ought to be considered against the provisions of the Constitution relating to the tagging of Bills as well as against the functional areas listed in Schedule 4 and Schedule 5 to the Constitution.

9.7 The test compels the consideration of the substance, purpose and effect of the subject matter of the Bill. In view of the discussion above and after careful scrutiny of all the provisions in the Bill, we are of the opinion that the Bill in substantial measure falls within the ambit of "health services" which is an area listed in Part A of Schedule 4, which makes provision for functional areas of concurrent national and provincial legislative competence. As such, the

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[i] CCT 100/09 [2010] 10.
[ii] [1999] ZACC 15; 2000 (1) SA 732 (CC); 2000 (1) BCLR 1(CC).
[iii] Paragraph 60 of the Tongoane judgment.

State Law Advisers and the Department of Health are of the opinion that the Bill must be tagged as a section 76 Bill.

9.8 The State Law Advisers are of the opinion that there is no need for a referral of the Bill to the National House of Traditional Leaders as it contains no provisions pertaining to customary law or the customs of traditional communities as envisaged in section 18(1)(*a*) of the Traditional Leadership and Governance Framework Act, 2003 (Act No. 41 of 2003.)

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