

# National Health Insurance:

## vision, challenges, and potential solutions

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NHI has the potential to fundamentally transform the South African health sector to a more integrated, equitable and cost-effective system. While the end goals of NHI are laid out in the White Paper, the immediate practical steps to move in this direction need to be articulated more clearly.

National Health Insurance (NHI) is a reform aimed to move South Africa towards universal health coverage, and to bridge the current two-tiered health system in which the public and private sectors operate largely in silos. While some progress has been made over the past decade, with the NHI Green Paper and White Paper envisaging a phased implementation approach, progress has arguably been considerably slower than anticipated. This chapter provides a technical review of the NHI vision, progress and key challenges, and proposes solutions to overcome these challenges in the hope of assisting the South African Government to unblock bottlenecks impeding NHI implementation.

The chapter identifies several important challenges and potential solutions in the areas of revenue raising, pooling,

purchasing and provision, which are critical to a health financing system. Key identified challenges include but are not limited to: difficulties in centralising funding in a national NHI Fund given the existing provincialised health financing system; insufficient progress in building capacity to manage NHI; distrust of the private health sector and slow progress in building a mixed delivery platform, such as capitation arrangements with independent general practitioners; and weaknesses in public sector provision and quality.

The chapter recommends potential solutions to these challenges, including practical steps that can be taken in the medium term to accelerate progress towards the long-term vision of NHI.

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# Introduction

National Health Insurance (NHI) is a highly anticipated reform and is likely to be the most significant reorganisation of the South African health system ever undertaken. The reform as outlined in the NHI White Paper of 2017<sup>1</sup> aims to move South Africa towards Universal Health Coverage (UHC), meaning that all people and communities have equitable access to the quality health services they need, without exposing users to financial hardship.<sup>2</sup> At its core, the reform aims to bridge the current two-tiered health system, in which the vast majority of citizens rely on a public health system plagued by lack of access and quality of care, and a predominantly affluent minority access health care in a better-resourced private sector. The Government seeks to achieve this reform by introducing a purchaser-provider split and establishing an NHI Fund as a single public purchaser, which will purchase health services on behalf of the Government for the entire population from a mixed provision platform that will include both public and private providers.

The NHI Green Paper<sup>3</sup> and subsequent White Paper envisage a phased implementation of NHI over a 15-year period. The first phase, from 2012 to 2016, mostly entailed piloting and health-system-strengthening initiatives, while the second and current phase from 2017 to 2022 will lay the legal and institutional foundation for NHI, including establishing the NHI Fund, contracting units for primary care (CUPs), and several ministerial advisory committees. The

NHI Bill<sup>4</sup> was published in July 2019, a key step towards creating the legal framework of NHI. However, while some advances have been made, the reform has arguably been slow to progress after almost a decade of policy making and more than six years of piloting. Few of the activities envisaged in the White Paper for implementation in phase two have taken off substantially.

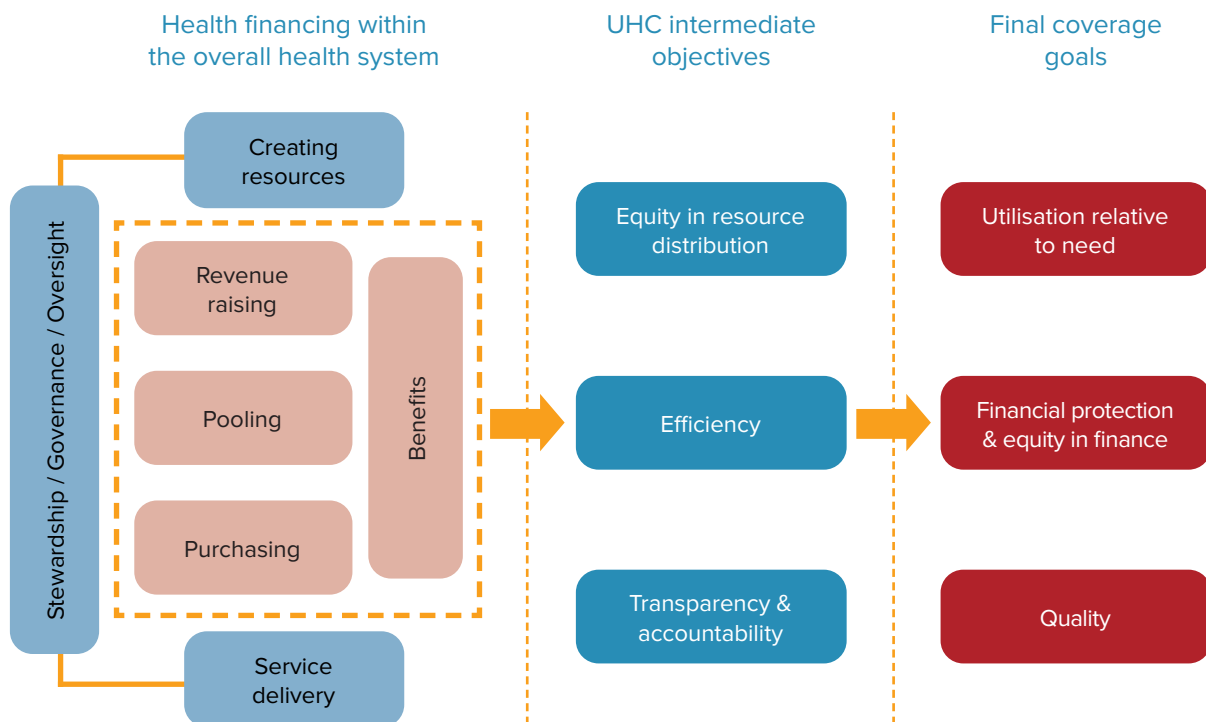
This chapter aims to provide a technical review of the NHI vision and key challenges to achieving this vision, and proposes solutions to overcome these. The review covers key dimensions of health financing, including revenue raising, pooling, purchasing and provision, and includes challenges and potential solutions for financial, policy, legislative and political issues. The hope is that this analysis will assist the South African Government to unblock bottlenecks and take practical steps to make progress with the phased implementation of NHI.

## Analytical framework

The World Health Organization (WHO) identifies three key dimensions of health financing within health systems, namely revenue raising, pooling, and purchasing, which are intrinsically linked to the other three core health-system functions, namely provision/service delivery, stewardship/governance, and creating resources<sup>5</sup> (Figure 1).

In this chapter, the three health-financing functions and provision were used to form the analytical framework. These are generally defined as follows:

Figure 1 : Health financing systems and UHC objectives and goals, WHO, 2017



Source: Kutzin et al, 2017<sup>5</sup>  
 UHC = universal health coverage; WHO = World Health Organization.

- **Revenue raising** means the process of raising funds for the health system; this includes sourcing of funds and the mechanisms by which revenue may be raised. Reliability and sustainability of the revenue sources are critical.
- **Pooling** refers to the accumulation and management of revenue so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures. Bigger and diverse pools provide better risk adjustment.
- **Purchasing** refers to processes by which funds are transferred from the purchasing authority to healthcare providers, including the management and contractual arrangements that guide these processes. Purchasing can be either active or passive and has implications for efficiency and targeting of health expenditure. Strategic purchasing is essential to ensure value for money.
- **Provision** refers to the arrangements for delivering health services through a platform that can include various types of healthcare providers, both public and private, who are reimbursed by the purchasing authority or authorities. Quality of services and responsiveness towards people's expectations are vital.

Vision, challenges and potential solutions are presented and discussed for each of the dimensions. The vision for each dimension draws primarily on the NHI White Paper, and where relevant, other publicly available policy documents and guidelines. Challenges to realising the vision were identified by the authors drawing on their knowledge and experience as senior managers and experts from government and international organisations. Finally, potential solutions to these challenges were identified to assist the country in progressing towards the vision of NHI. This approach may include a degree of subjectivity and other authors will undoubtedly have prioritised other aspects, such as the political economy of these reforms. The chapter was largely written and submitted before the publication of the NHI Bill in July 2019 and may therefore not fully reflect some of the latest developments.

## Key findings

### Revenue raising



#### Vision

The NHI White Paper envisages a significant increase in public financing of health care, both in absolute terms and as a percentage of total healthcare financing. It was projected that public health financing would increase from around 4% of gross domestic product (GDP) to 6.2% of GDP by 2025/26. Although this will require additional funding, total health expenditure may not grow to the same extent as a result of beneficiaries voluntarily leaving medical schemes and instead using publicly funded services as the NHI matures.

It is, however, difficult to predict how much healthcare spending will decrease in the private sector over the same period if the medical aids are losing members. The increased obligation on the public sector must be financed through general taxation. At some point tax revenue for health services must rise. Specific tax mechanisms could be introduced in later stages to finance the impact of this transition to NHI, most likely some combination of payroll tax, surcharge on taxable income, and/or value-added tax (VAT). It is also envisaged that user fees will be abolished under NHI.<sup>1</sup>



### Challenge: constrained fiscal climate and competing budget priorities

South Africa is in a period of low economic growth, exceeding 1% in only one of the past four years. In the first few years following the global financial crisis of 2008, Government ran large deficits and accumulated large debts, which led to the decision in 2012 to close the fiscal gap (Figure 2). Government expenditure growth has since been contained, and tax increases (both VAT and personal income tax) have already been necessary to address the fiscal deficit.<sup>6-8</sup> Nevertheless, national debt (R2.7 trillion in 2019/20) is still rising, with interest payments (R202 billion in 2019/20) being one of the fastest-growing expenditure areas, approaching the level of the entire public health budget. The fiscal deficit is 4.7% of GDP in 2019/20 and exceeds 4% throughout the medium-term expenditure framework (MTEF).

Health's share of the national budget in 2019/20 is 14% of consolidated public spending excluding interest payments.<sup>6</sup> South Africa's level of public health spending, per capita and as a percentage of government's overall spending, is comparable to that of other upper middle-income countries<sup>9</sup> but the system is inefficient and better outcomes can be achieved even within these levels. At the same time, several major spending pressures have arisen, such as increasing public sector salaries, fee-free higher education and, more recently, financial support to the national power utility Eskom.<sup>6</sup> This has limited the possibility of increased funding to the health sector, and given the current economic outlook, these factors are likely to influence health budgets for the foreseeable future.

The White Paper estimates a funding shortfall of R72 billion for NHI by 2025/26, based on an assumption of 3.5% annual economic growth.<sup>1</sup> This model was based on significant increases in utilisation and unit costs of public sector services and a significant degree of private sector provider contracting at discounted private sector prices. Noting that government budgets until 2021/22 are already published and that national growth is significantly below 3.5%, it seems unlikely that the gap identified in the White Paper can be achieved by 2025/26.

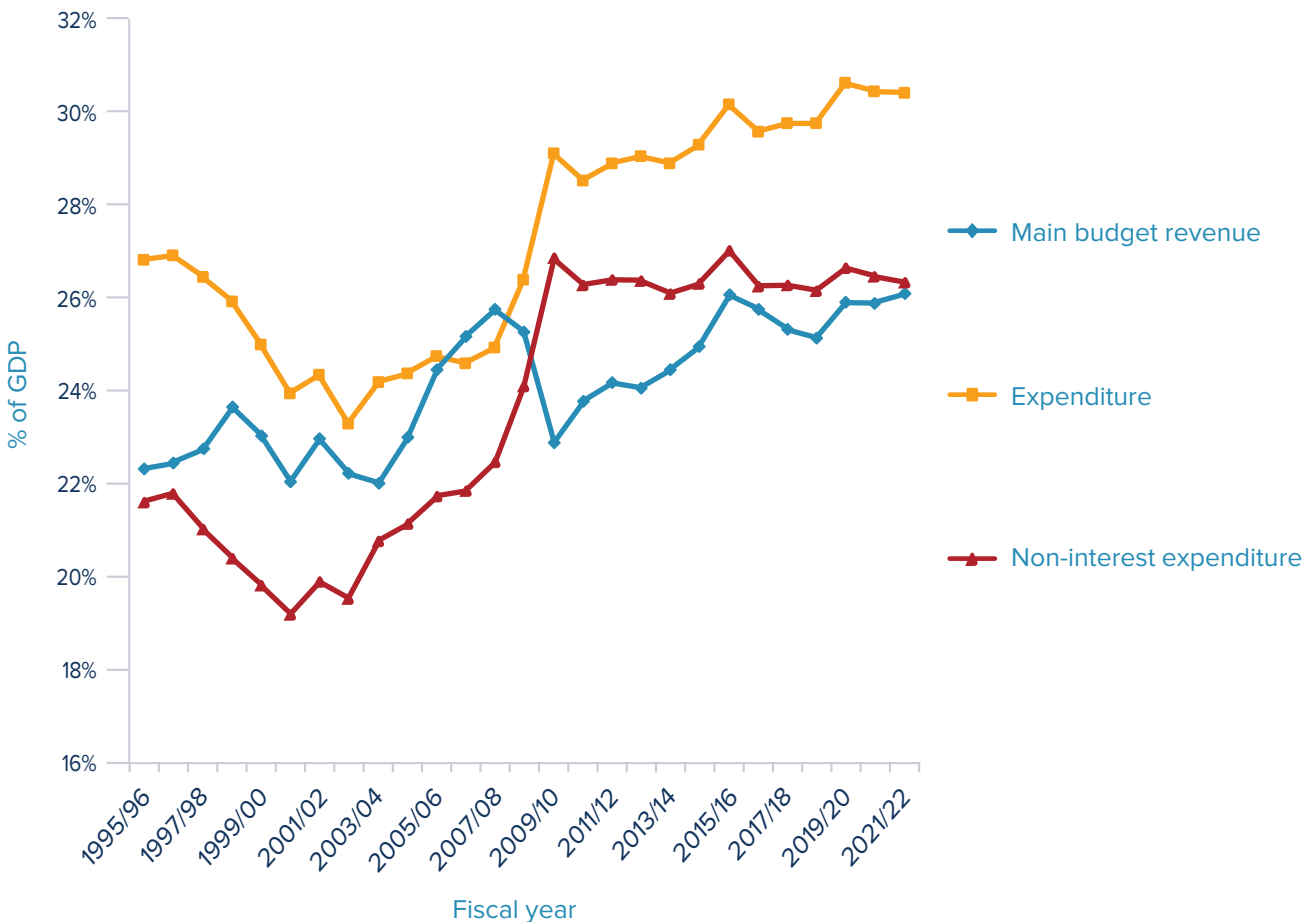


### Potential solutions

The authors commissioned and reviewed several updated cost models on NHI. Several tentative conclusions were drawn:

- We see the direction of travel as more important than the duration, and we do not view economic challenges as the main binding constraint in making progress on NHI because full rollout of NHI can be done over a longer timeframe than initially envisaged. The timetable for the funding increases up to 2025 presented in the White Paper are likely not affordable and may therefore need to be extended.
- Some existing costing models for NHI may overestimate the required financial resources because they assume that a high proportion of NHI beneficiaries will use private providers at existing high prices. NHI should rather be conceptualised as gradually and progressively extending patient choices, with attention to building economies of scale, quality and competition. A revised cost model for NHI shows that substantial reforms, including expansion of some services are possible within an additional cost of around R33 billion per annum by 2025/26, with potential further progress over time as more funds become available.<sup>4</sup> The revised model includes 10 - 15 high-priority interventions that could initially be prioritised in the rollout of NHI, such as progressive involvement of general practitioners (GPs) through a capitation-based model, and further rollout of the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) model.
- NHI holds the potential to bring down costs of expensive private services and make them more accessible by leveraging purchasing power and economies of scale. However, for this to happen Government needs to begin contracting with the private sector and prove these efficiency gains, for example through capitation-based arrangements with independent GPs.
- Government must regulate the private sector more effectively, for example, as laid out recently, by the Competition Commission’s market inquiry and by rejecting unjustified new hospital licenses putting in place stricter policies for public servants working for the private sector, and tightening a range of provisions relating to medical aids.
- Linked to this, progress must be made with development of a mixed public-private delivery platform, also to build greater acceptance for new taxes linked to NHI.

Figure 2 : Government revenue and expenditure as a percentage of GDP, South Africa, 1995/96 - 2021/22



Source: Based on National Treasury data, 2019.<sup>10</sup> GDP = gross domestic product.

In the longer term, economic growth is important, as internationally there is a very strong correlation between GDP and health expenditure.<sup>11-14</sup> Efforts to improve growth should be encouraged but have a longer time perspective. In the medium- to long-term, it may be more feasible for Government to increase health financing by increasing prioritisation of health in budget allocations to bring South Africa closer to the Abuja target, namely allocating 15% of government's budget to health.<sup>15</sup> Reference to potential new taxes were made above under the vision for revenue raising. Given that chronic diseases have become the largest national burden of disease, consideration may also be given to increasing excise taxes on unhealthy goods ('sin-taxes'), such as alcohol, tobacco and the recently introduced sugary beverage tax. Although a hard earmarking of this revenue is unlikely to be implemented, some international experience shows that public support for such taxes is stronger when a portion of the revenue is allocated to health interventions.<sup>16,17</sup> For example, in the Philippines, increases in alcohol taxes helped to fund recent reforms in their health system.<sup>18,19</sup> The pros of sin-taxes include reduced consumption of harmful substances, whereas cons include that they often do not raise large enough sums of revenue. Other longer-term options might include ultimately raising the tax-to-GDP ratio above 26% of GDP on main budget or introducing new mandatory social security contributions.<sup>20</sup> Although the tax-to-GDP ratio in South Africa is already slightly above the average for upper-middle income countries, it falls below that of high-income countries,<sup>21</sup> and South Africa has a relatively poorly developed mandatory contributory social security system.<sup>20</sup>

Gradual introduction of a pay-roll tax may be palatable if it accompanies improved quality and benefits, while the private sector fails to contain costs and therefore loses members. Such a tax can be a part of total revenue and need not be ring-fenced for health.



### Challenge: low utilisation and performance of existing NHI allocations

Dedicated funding for NHI was first introduced in Budget 2012,<sup>22</sup> through a direct conditional grant to provinces, which the following year was largely centralised to a new indirect conditional grant managed by the national Department.<sup>23</sup> The grant initially focused on contracting of GPs to work in public clinics and on infrastructure improvements in the 11 NHI pilot districts. The scope of the grant has, however, broadened over time, and in Budget 2018<sup>8</sup> it received additional allocations of R4.2 billion and was restructured to have three components (Health Facility Revitalisation, Non-Personal Services, and Personal Services). Some of the funding (R12 million in 2019/20) was also earmarked in the NDoH's core budget to establish interim NHI management structures. As shown in Table 1, there has been considerable underspending of the NHI Grant.

Spending was to some degree increased by introducing new priorities in-year, such as the creation of three new components (HR Capacitation, Beds and Laundry Services, and HPV Vaccine) and shifting budgets away from underspending areas for this purpose.<sup>24</sup> Part of the reason why existing allocations are underspent is that the NHI Fund has not been established and capacity to contract services has not been sufficiently strengthened. In addition, there have been concerns about additional funding being dedicated to contracting private sector services when the public health sector is under significant financial strain (leading to some funding in the NHI grant being reallocated to human resource capacitation in the provinces).<sup>25</sup>



### Potential solutions

Given that underspending is largely a result of capacity limitations, addressing these limitations should be prioritised. Adequate financial and institutional

Table 1: South African health expenditure against NHI indirect grant allocations in 2018/19

Components	Original budget (R'000)	Adjusted budget (R'000)	Expenditure (R'000)	% spent (v. adjusted budget)
Health Facility Revitalisation Component	891 359	836 359	648 051	77%
Non-Personal Services Component	700 000	700 000	499 889	71%
Personal Services Component	712 500	391 500	247 234	63%
HR Capacitation Component	0	350 000	339 744	97%
Beds and Laundry Services Component	0	150 000	515	0.3%
HPV Vaccines Component	0	30 000	29 809	99%
<b>Grand Total</b>	<b>2 303 859</b>	<b>2 457 859</b>	<b>1 765 241</b>	<b>77%</b>

Source: National Treasury, 2019.<sup>26</sup>  
NHI = National Health Insurance.

capacities of the agencies managing NHI are essential, as seen in experience from other countries.<sup>27</sup> In order to improve spending and performance, existing and potentially additional allocations should be used to scale up capacity in the Department and build contracting and purchasing expertise, which can later be transitioned into the NHI Fund once it has been established as a public entity.

## Pooling



### Vision

The vision of NHI is to establish an NHI Fund as a single purchaser, where the majority of public funding for personal health services is pooled into the Fund to strategically (actively) purchase health services on behalf of the entire population. Revenue pooling is intended to maximise risk and income cross-subsidisation, increase purchasing power, reduce inefficiencies, and simplify funding flows.<sup>1</sup>

Achievement of this vision will likely entail consolidation of a large portion of public revenue currently directed to health care, including through the equitable share paid to provincial and local governments, conditional grants, health service components of compensation funds such as the Road Accident Fund, medical scheme subsidies of public sector employees, and medical tax credits.

This vision also encompasses a degree of migration of medical scheme beneficiaries to NHI; once NHI is fully developed, it is envisaged that medical schemes will play a limited role.



### Challenge: intergovernmental financing arrangements and legal provisions

While provincial-level pooling exists in countries such as Canada and Australia, South Africa has decided to create a national NHI Fund (along the lines of Thailand and South Korea). The pooling of health funding into a single NHI Fund will require changes to the current intergovernmental distribution of functions given that functional assignments and funding are integrally linked, i.e. 'funds' follow 'function'.

Section 227 of the Constitution<sup>28</sup> specifically entitles provinces (and local government) to an equitable share of revenue raised nationally to enable them to provide basic services and perform the functions allocated to them. Section 213 further stipulates that a province's equitable share must be a direct charge against the National Revenue Fund, meaning that it cannot be paid to the province via a national department or public entity. Substantial public funding for health can be pooled into a single NHI Fund through centralisation of those health functions that need to be centralised for NHI to work, including some functions currently assigned to provinces. This can be done through amendments to relevant health legislation. Schedule 4 of the Constitution only lists the broad areas of concurrent legislative competence ('health' for provinces and 'municipal health services' for local government), and the details

thereof are defined in the National Health Act of 2003.<sup>29</sup> It is therefore likely that no constitutional amendments are required for this shift and that amendments to health legislation would suffice. Ambulance services can, however, only be shifted from the provincial sphere through constitutional amendment, as this is listed as a functional area of exclusive provincial legislative competence in Schedule 5 of the Constitution.

The National Health Act (2003) currently assigns substantial health functions to provinces, including hospital services and comprehensive primary health services, and following basic education, health is the second largest expenditure item on provincial budgets. On average, provinces spend around a third of their budgets on health.<sup>30</sup> Though local government is predominantly responsible for the environmental health function, larger municipalities (mainly metropolitan municipalities) continue to provide personal health services in terms of specific transitional measures in the National Health Act, where the supporting service-level agreements with provinces for rendering these services are often seen by municipalities as insufficient to pay for all the services they provide.<sup>31</sup> Appropriately assigning or re-assigning health functions between the three spheres of government is therefore critical for the successful implementation of NHI. Despite this, this topic has not been the focus of many discussions in recent years, largely because of its sensitive nature, i.e. this restructuring could substantially reconfigure the scope/mandate of provincial governments.



### Potential solutions

In order to centralise public funding for personal health services to a public entity in the national sphere of government, such as the envisaged NHI Fund, the focus should first be on sorting out the functional assignments between the three spheres of government rather than on the funding mechanism, which is presently the case. This will require extensive legislative change around the functions of the spheres.

When a function is shifted, all funding attached to the identified function will shift, including equitable share and health conditional grants, and the relinquishing sphere is generally required to transfer all concomitant resources to the receiving sphere of government. When social grants and Further Education and Training (FET) colleges were centralised, provinces had no more responsibilities, nor received any funding for such functions. A more complex system could be envisaged for health under NHI, where the intention is to centralise certain functions in full (e.g. central hospitals), and with others (e.g. primary health care (PHC) and other hospitals) to appoint provincial administrations to perform the functions on behalf of the national sphere through delegation. Under a delegation arrangement, it may be possible to shift the funding to the NHI Fund without transferring personnel, infrastructure and other assets to the national sphere of government.

The complexity of re-assigning functions (with or without re-delegation) between spheres should, however, not be underestimated, but will vary in complexity. Shifting of the 10 central hospitals from provinces to the national sphere would be less complex legally than the reconfiguration of PHC, but one of the challenges to be resolved with the central hospital shift is that these hospitals generally also provide regional and district hospital services. The PHC platform currently includes approximately 3 500 clinics,<sup>32</sup> a massive number of staff, and a budget exceeding R60 billion per annum (including HIV and AIDS),<sup>25</sup> which will need to be shifted to 52 new government components (District Health Management Offices), or potentially even 350 CUPs, while at the same time ensuring continued service delivery.

The transition towards centralised health functions required for central pooling holds major risk, given the decentralised nature of healthcare provision. Considerable attention will need to be given to establish decentralised structures such as districts, CUPs and semi-autonomous hospitals, as well as an improved system of delegations.



#### Challenge: potential reluctance of some medical scheme members to shift to NHI

A potential obstacle to NHI implementation may be reluctance of medical scheme members to give up their medical schemes and shift to NHI. While previous research has found that there is broad acceptance of NHI among the general population, medical scheme members have been found to be less supportive of NHI than public sector users.<sup>33,34</sup> Such resistance may emanate from a number of factors, including perceptions among medical scheme beneficiaries that the shift may result in interruption of benefits or decreased access to private health care and the presumed lower quality of health services offered by the public sector. It may also emanate from a lack of trust in the integrity or sustainability of a publicly administered NHI Fund in the context of revelations of corruption, state capture and failing public entities within Government more broadly. The diagnostic report of the National Planning Commission and NHI White Paper identified leadership and governance challenges at various levels of Government.<sup>35</sup> Involuntarily compelling movement *en masse* to NHI by statutorily limiting benefit coverage of medical schemes is likely to risk widespread opposition among the 8.8 million beneficiaries<sup>36</sup> of medical schemes, potentially impeding or delaying NHI implementation through protracted litigation or tax avoidance.



#### Potential solutions

Universal health care reforms are complex, long-term policy engagements, and international experience shows step-by-step approaches are often preferable in order to gain political support from key interest groups.<sup>37</sup> Acceptance of NHI by healthcare users is likely to evolve over time and will depend on the benefits and quality of services offered. It is advisable to introduce NHI incrementally, starting with consolidation of public funding sources and demonstrating the capacity of the Fund to

manage funds effectively and ensure access to health services for beneficiaries, focusing also on services that are likely to be attractive (e.g. access to their own GPs through the capitation model). It has previously been argued that the acceptability of NHI depends on its ability to demonstrate significant advantages over existing services offered in the public sector.<sup>38</sup> In this way, beneficiaries of medical schemes will progressively gain confidence in NHI. In addition, many people are finding it progressively difficult to afford private medical aids and membership is now stagnating.<sup>36</sup> Once NHI is fully rolled out and widely trusted, statutory restriction of the role of medical schemes could be considered.

The virtual absence of strategic purchasing (discussed further below) from private providers makes it difficult to proceed rapidly with mandatory pooling of resources currently paid by members to private medical schemes.

## Purchasing



### Vision

The idea of a purchaser/provider split is central to the NHI reform. Purchasing/budgeting and provision are currently institutionally integrated in the public sector, and the idea is to split these functions in order to contractually tie funding to specific outputs and services. The NHI Fund will act as a purchaser of health services for and on behalf of the population, while provinces/institutions and private entities will act as providers. CUPs are to be the contracting party on the provider side for PHC services, which will simplify contracting compared with individual contracts between the NHI Fund and each of the 3 500 PHC facilities in the public sector.<sup>1</sup> In the event that the CUP system proves impracticable or where specific CUPs do not have sufficient capacity, the district health management office will contract with the NHI Fund. The way in which health services are purchased will be reformed and become more strategic and active, by contractually linking this to performance, efficiency, workloads and case-mix. More specifically:

- PHC services will be purchased using risk-based capitation.
- Hospital services will be purchased through Diagnosis-Related Groups (DRGs).

The White Paper envisages that the NHI Fund will purchase services from both public and private providers, and by virtue of its size take advantage of its bargaining power to improve efficiencies and value for money. As a single purchaser, one of the main objectives of its purchasing functions will be to improve geographical and socio-economic equity in access to healthcare services.



#### Challenge: lack of technical skills and information systems for strategic purchasing

International experience shows that movement towards UHC requires significant technical know-how.<sup>37</sup> Weak technical skills and understanding of strategic purchasing and its relevance at all levels of government

remains a key challenge in the roll-out of NHI. Currently, purchasing and provision function in an integrated manner, with no purchaser/provider split introduced, little strategic purchasing, and DRGs and capitation payment methods have not yet been implemented.

While some efforts have been made to develop both capitation models for PHC purchasing and a DRG model for hospital purchasing, piloting or implementation of these models has not taken off and there is still little practical know-how of strategic purchasing in government.

Strategic purchasing is data-driven<sup>39</sup> and requires intensified collection and use of data and improved information systems. There has been some notable progress with the roll-out of a health patient registration system in over 3 000 public health facilities, with approximately 40 million patients registered and assigned a unique identifier.<sup>40</sup> However, there are still issues related to information and communications technology (ICT) infrastructure, connectivity, basic ICT literacy, and centralised registries with unique identifiers for providers and facilities. Previous research also found International Classification of Disease (ICD) coding, generally a requirement for implementing DRGs at central hospitals, to be both incomplete and inaccurate.<sup>41</sup> The introduction of strategic purchasing within the public sector entails a substantial set of reforms, and the way these are designed and implemented will determine the degree to which these reforms will end up generating greater efficiency.



#### Potential solutions

There is an urgent need to build purchasing capacity within government, which will transition to the NHI Fund once this is set up. In the short term, this will improve management and implementation of existing NHI allocations and activities. The new Minister of Health's plan to rapidly establish an NHI implementation unit could be a game changer in this regard.<sup>42</sup> Over the long term, it will provide the expertise required during the transition from the current delivery model to NHI. Contracting out services to independent GPs has not yet taken place and needs to be fast-tracked, as the model needs constant refinement through a number of iterations. In the public sector, increased use of needs-adjusted population-based allocation of resources across districts should be encouraged. Under the current arrangement, this can be done by provincial departments of health with national technical support, and more formally later by the NHI Fund. In addition to improving readiness for NHI, this has the potential to improve equity in resource distribution, also in the short to medium term.<sup>43,44</sup>

Establishment and further development and linkage of patient, provider and facility registries and agreement on adoption of coding systems for diagnosis (e.g. ICD) and interventions (e.g. International Classification of Health Interventions (ICHI)) are fundamental for enrolment,

electronic health records and provider contacting/payments. Plans to upgrade ICT infrastructure and digital health skills across the levels of care need to be further developed and rolled out urgently. An all-encompassing national data system is not necessarily needed or preferable, but certain components of it, such as patient and provider registries, should be centrally developed. Most other systems do not have to be the same for the whole country, so long as they are interoperable and provide minimum data needed such as diagnostic and therapeutic coding required for strategic purchasing.



#### Challenge: lack of progress with purchasing from private providers

Despite funds being allocated for this purpose, very little strategic purchasing from private providers has taken place as part of NHI piloting and implementation to date. This may partly be the result of a preference towards public sector strengthening, but may also be due to the private sector often being significantly more expensive than the public sector. Direct comparisons of cost across the private and public sectors are confounded by a number of factors, but gross health per capita expenditure in South Africa is approximately four to five times higher in the private sector than the public sector.<sup>a</sup> Reasons for the higher costs vary, but some of the key ones include higher doctor-to-patient ratio, lack of cost-effectiveness considerations (e.g. the caesarean section rate of >60% in 2017,<sup>36</sup> compared with 26% in the public sector<sup>45</sup> and 21% globally,<sup>46</sup> and an intensive care unit (ICU) bed hospitalisation rate that is much higher than that in most Organisation for Economic Co-operation and Development (OECD) countries<sup>47</sup>), and lower pharmaceutical prices in the public sector. Lack of price regulation and fee-for-service payment are also a problem in the private sector in South Africa, like in several other countries.<sup>48</sup> The Preliminary Health Market Inquiry Report<sup>47</sup> has been critical of Government's failure at 'multiple levels' to regulate the private sector effectively and safeguard the rights of health service users.



#### Potential solutions

Strategic purchasing has at its heart the objective of bringing down high prices and achieving greater value for money. The ability of NHI to substitute some of the existing 4% of GDP for private health financing with a common NHI pool, is substantially dependent on its ability to offer services, such as GPs, medicine and specialist services that existing medical scheme members want to use, but at prices that allow for wider population access. Strategic purchasing under NHI could be an effective instrument for influencing provider behaviours, requiring them to share data and information to foster transparency and accountability. In return, private sector providers get access to a larger market of users under NHI. The design of purchasing mechanisms and geographical selection of providers will need to take socio-economic and geographical equity implications into account.

a Authors' calculations based on National Treasury data.



Implementation of capitation-based contracts with private PHC providers, such as GPs, either through CUPs or through other arrangements, is a priority. Research has shown that GPs in solo and group practices can contract with NHI at competitive rates.<sup>49</sup> A risk-adjusted capitation-based model would incentivise providers to ration service provision with more affordable criteria, standards and protocols and nudge providers towards the most cost-effective services, such as preventive care and PHC services. In designing and implementing GP capitation arrangements, consideration needs to be given to avoiding some of the problems of episodic and largely curative-based care that existed under the old district surgeon system.

Attempts to develop a DRG reimbursement system for hospitals have been slow to progress and need to be put back on track urgently. The data needs for DRG implementation require accurate diagnosis and procedural coding and it is therefore important that such systems are put in place urgently.

A positive example of contracting with the private sector where progress has been made is the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) model; this has allowed stable patients on antiretroviral therapy (ART) and chronic treatment to collect their medicine from private pharmacies and other selected pick-up-points instead of visiting public sector clinics every month. This model has significantly decreased the need to queue and reduced waiting times for patients to collect medicines, which is of obvious benefit to patients, public facilities and private service providers.



#### Challenge: lack of progress with purchasing from public providers

There has also been little progress in implementing strategic purchasing mechanisms within the public sector. Healthcare services are funded through annual budget allocations and on an input basis rather than via mechanisms that reimburse providers based on services provided. There are no case-based payments for hospital services or risk-adjusted capitation-based payments for PHC. Insufficient attention has been given to the future institutional form of public hospitals to enable them to contract directly with the future NHI Fund. The NHI Bill<sup>4</sup> outlines the legal framework, powers and functions for CUPs in broad terms, but more detailed plans for their configuration are still to be developed.



#### Potential solutions

The vision of NHI is for provider-payment mechanisms such as DRGs and capitation to be applied also to public providers, and steps in this direction do not need to wait for the NHI Fund to be established. Greater use of contracting at all levels of the public health system would improve accountability, and link financing to performance more successfully. Cleverly designed purchasing arrangements within the public sector have

the potential to improve efficiency and could make the public sector more responsive to user demands. These arrangements must have safeguards to ensure improved equity and that the needs of the poor and rural public are addressed. Although there are practical implementation difficulties in implementing strategic purchasing within the public sector environment, there are good international examples of such models in middle-income countries, for example the DRG and capitation systems in Thailand.<sup>50</sup> One area where DRGs could potentially be implemented in the medium term is the National Tertiary Services Grant, which subsidises public tertiary and central hospitals. Provinces could also introduce some form of capitation-like system for district budgeting for PHC services, by using needs-based formulae based on the size and risk profile of the district population in resource allocations. Capitation payments can be complemented with performance-based payments, e.g. for reducing unnecessary referrals and meeting targets for prevention services. Consideration needs to be given to the structure and resourcing required to enable functioning CUPs and to the legislative changes mentioned above.

## Provision



#### Vision

The NHI White Paper devotes significant attention to the provision and reorganisation of healthcare service delivery to achieve coverage of the population for comprehensive healthcare services. It envisages an integrated provision platform where the NHI Fund contracts directly with accredited providers in both the public and private sectors.

The vision of NHI is to place PHC providers at the core of healthcare services and ensure that individuals access care as close as possible to where they reside. In addition to PHC, NHI will contract with accredited hospitals in both the public and private sectors and ensure that access to hospital services will be through referral by PHC providers.



#### Challenge: inadequate quality of care in the public sector

While supportive of NHI, some stakeholders are of the view that NHI will not function optimally until quality in the public sector is first drastically improved.<sup>51,52</sup> Similar points have been made by international scholars, who have argued that expanding coverage must go hand in hand with improving health system performance, often including strengthening of the public sector.<sup>53</sup> Several assessments, including those performed by the Office of Health Standards Compliance (OHSC), have exposed severe challenges in the public sector that include fragmentation, non-responsiveness, poor performance, and wasteful allocation and use of resources. Of the facilities inspected, 62.5% were found to be either non-compliant or critically non-compliant with norms and standards, and an additional 23% were conditionally compliant with serious concerns. Figure 3 shows that in 2016/17, the average score across 851 facility inspections was only 52%.<sup>54</sup>



### Potential solutions

The Government has launched several programmes to strengthen PHC services, the most recent being the Ideal Clinic programme. While an important step in recent years was the establishment of the OHSC, Government needs a stronger system for addressing the shortfalls identified during OHSC inspections, through complaints and elsewhere. This will be important to enable public facilities to meet prescribed standards for certification by the OHSC and contracting by the NHI. The OHSC is a new institution in South Africa and there is a need to develop a culture of learning in the public sector.

In 2018, stewardship of the NHI reform was partly moved to the Presidency,<sup>55,56</sup> and since then both the Presidency and the NDoH have increasingly focused on improving quality of public health facilities.<sup>57</sup> This will require additional resources to address problems identified during OHSC audits and improve quality of care. Among other things, funds have already been reprioritised from the NHI Grant towards frontline service provision through filling critical posts at various levels of care and procuring beds and linen for hospitals.<sup>24</sup> A greatly strengthened system of

delegations is required to enable public sector managers to better manage and take accountability for their institutions, and legal reforms are required to create new statutory forms for public hospitals to enable them to contract formally with the NHI Fund.

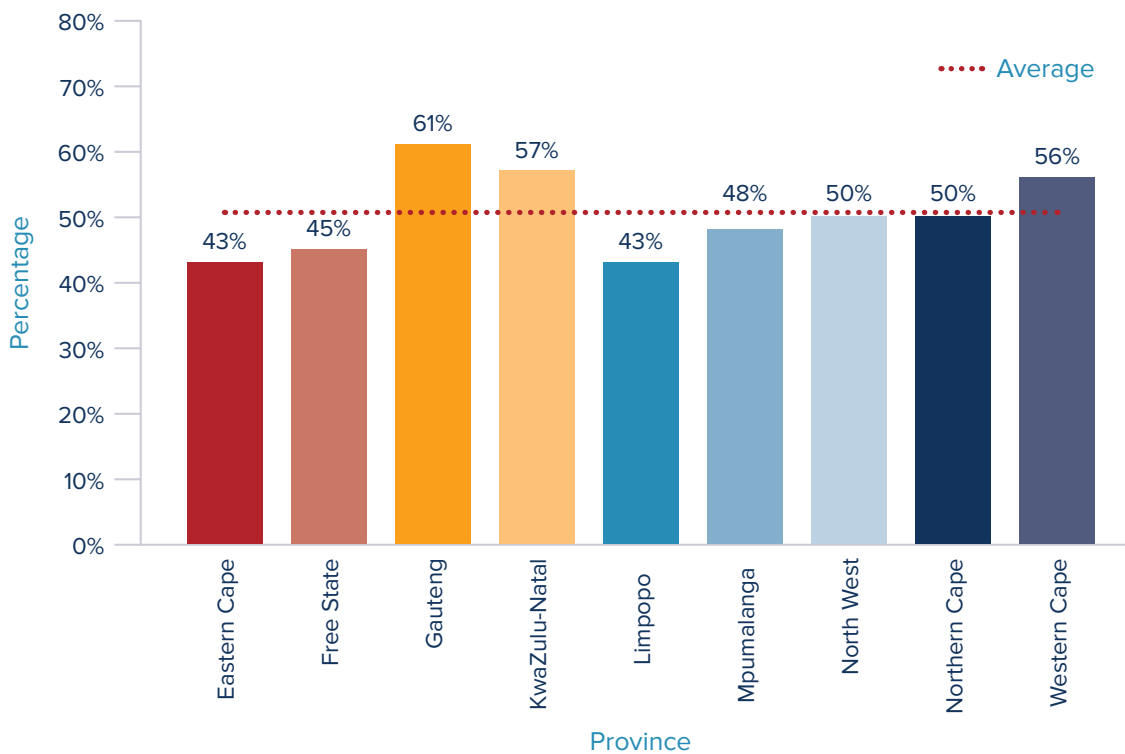


### Challenge: limited integration of private providers in the publicly funded provision platform

Although the White Paper envisages private providers as an integral part of the provision platform under NHI, in practice the private sector's involvement to date has been very limited, and ambiguous messages about the role of the private sector have been projected, as noted by both civil society and comments from industry stakeholders.<sup>58,59</sup> Contracting with private providers during the NHI pilots has largely been limited to contracting doctors to work sessions in public PHC facilities rather than strategic purchasing of services in private facilities.

Development of the NHI policy has been done almost in isolation of private providers, and consultation with private sector providers has largely been indirect, often through

Figure 3: Average OHSC inspection scores by province, South Africa, 2016/17



Source: OHSC, 2018.<sup>54</sup>  
OHSC = Office of Health Standards Compliance.

them submitting public comments in response to the release of policy papers. This has resulted in mistrust and confusion between private providers and Government when it comes to NHI.<sup>60-62</sup> There are also insufficient platforms, arrangements or clinical pathways in place for ensuring continuum of care across the service delivery levels (primary, secondary and tertiary) and across the public and private sectors.



### Potential solutions

Going forward, it could benefit the NHI process for Government to collaborate more closely with private providers and to recognise them as critical partners in rolling out NHI. The private sector should also be prepared to progressively take a bigger role in service provision beyond the medical scheme population by, for instance, showing a willingness to offer more favourable prices in exchange for higher patient volumes from the public sector and the poor, who are unable to afford medical scheme contributions.

If Government starts purchasing strategically from private providers, this can provide a lever to incentivise reform of the sector. For example, incentives for private solo GP practices to arrange themselves in multidisciplinary group practices or to utilise nurse practitioners, and for hospitals and doctors to work in a more integrated manner, should be explored. Purchasing services for the entire population will create a demand for private providers to establish in rural and less affluent areas of the country, perhaps also through specific incentives in reimbursement rates.

## Conclusions

NHI has the potential to fundamentally transform the South African health sector to a more integrated, equitable and cost-effective system than the two-tiered system currently in place. While the end goals of NHI are laid out in the White Paper, the immediate practical steps to move in this direction need to be articulated more clearly and few such steps have been taken substantially. Providers and users of health services are critical NHI partners and there is anxiety among stakeholders as the Government has not managed to effectively and coherently communicate what NHI means, what range of health services will be provided, what the financial contributions will be, how the quality of services will be ensured, and what the role of health providers and workers will be in public and private sectors.<sup>63</sup> An NHI implementation roadmap must be finalised urgently, outlining a time-bound framework of how NHI will be rolled out, namely what the key activities and tangible deliverables are, and how these activities will be completed and by whom.

The chapter has identified several important challenges impeding progress on NHI, including:

- Difficulties in centralising funding in a national NHI Fund given the existing provincialised health financing system.
- Insufficient progress in building capacity to manage NHI, especially in strategic purchasing, management and information systems.
- Mistrust between government and the private sector and slow progress in building a mixed delivery platform, such as capitation arrangements with independent GPs.
- Weaknesses in public sector provision and quality.

There are no definitive answers to several of the key questions related to the reform, such as the ideal balance between public and private provision and the pace at which to phase in the reform. However, the chapter has attempted to propose some practical solutions to the challenges identified, in the hope that these can help accelerate implementation of NHI.

## Recommendations

Key recommendations emanating from this analysis include the following:

- The legal aspects pertaining to the allocation of health functions under NHI need to be resolved urgently.
- The sector should scale up contracting and strategic purchasing from both public and private providers. This can be done incrementally under the current health system arrangements and does not have to wait until the NHI Fund is legally established.
- Capacity needs to be developed, primarily in the NDoH, to perform these purchasing functions. A strong NHI unit needs to be built within the NDoH, which can later be transferred to the NHI Fund once established.
- There is a need to accelerate the groundwork related to ICT-based integrated information systems, including further development or creation of registries as well as agreement on adoption of standardised coding systems for classification of diagnoses and interventions.
- NHI should be built incrementally and demonstrate benefits to the public. Priority should be given to gradually increasing access to a wider range of providers, such as private GPs contracted through capitation.
- The quality agenda driven jointly by the Presidency and the NDoH should be prioritised in order to strengthen the public sector in preparation for accreditation and contracting under NHI.

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