

Establishing the NHI Service Benefits Framework: lessons learnt and stakeholder engagement

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The NHI Service Benefits Framework documents the conditions, services, and care pathways reflected in existing national clinical policy, and the minimum or average required resources.

The South African Government has committed to accelerated progress towards universal health coverage, ensuring equitable access to quality and affordable healthcare services for all South Africans, based on need. This goal is being pursued through the phased introduction of National Health Insurance and alignment of what have historically been two parallel health systems in South Africa – public and private. It is a critical step towards addressing one of the most enduring structural legacies of apartheid, which is a key factor underlying South Africa’s status as the country with the highest level of inequality in the world. In August 2019, the NHI Bill was presented to Parliament, marking the latest step in the process of legislative reform.

This chapter provides an overview of ongoing work by the National Department of Health to develop what is internationally referred to as a ‘health benefits package’ but what in South Africa is referred to as the ‘Service Benefits’ to be provided under NHI. This is an explicit definition or list

of conditions and the associated healthcare services that will be purchased by the NHI Fund on behalf of all South Africans, and provided by public and private providers across the country.

An overview is given of the process of designing and developing the Service Benefits Framework, and the role of the Framework as a tool supporting good governance in benefit design. The chapter outlines lessons learnt by the National Department of Health including the critical role of stakeholder engagement; the need for the adoption of standardised nomenclature and classification systems to support definition of the service benefits; the need to strengthen and align the process of policy development across all areas of health; and the establishment of health-management information systems that are aligned with the service benefits and that can thereby support planning for and delivery of these services, as well as monitoring and evaluation of results.

Introduction

South Africa is grappling with the immense task of transforming what have historically been two parallel health systems – public and private – into a unified health system that serves the needs of all South Africans and accelerates progress towards universal health coverage (UHC).¹ The policy driving this transformation is National Health Insurance (NHI).

From the start it was intended that NHI implementation would be phased; however, the rate of progress has been slower than anticipated.² Arguably, one of the reasons has been the absence of an explicit definition or list of conditions and associated healthcare services to be covered under NHI and provided by public and private sector providers in South Africa. If positioned at the centre of NHI reform, an explicit list of benefits would have enabled a wide range of national health sector stakeholders to engage actively in a discourse on what NHI will offer and what their respective roles could and should be in this new paradigm.

In recognition of this gap and building on the work of NHI Workstream 2 (2015 - 2017),³ the National Department of Health (NDoH) developed the NHI Service Benefits Framework (SBF), which documents the conditions, services, and care pathways reflected in existing national clinical policy, and the minimum or average required resources associated with their delivery, also as per existing national health policy. This is considered a key starting point given the commitment by the NDoH that the range of services funded under NHI will be no less than currently available in the public sector.⁴ The SBF will also provide a definitive baseline from which to revise these services over time.

The initial intended audience of the SBF is policymakers and planners in the NDoH who will use the Framework to drive alignment across policy, and operational and financial planning, both under the current health system and through the transition to full implementation of NHI. The content of the SBF will also be used together with data on burden of disease and demography to inform needs-based scenario analysis/forecasting (e.g. human resources, commodities, etc.) for units of analysis ranging from contracting units for primary health care (CUPs), to district, provincial, and national level. In this way, the SBF will enable ongoing costing of scenarios for NHI delivery in South Africa.

However, the intention is ultimately for this information to be made available to all health sector stakeholders, including the general public (to look up what services are available and where); public and private providers (to provide transparency on cost assumptions and inform resource planning); clinicians (to utilise clinical protocols and care pathways and support adherence to referral policies); medical schemes (to provide market certainty on what are ‘complementary’ services);¹ and regulators

(to support governance, including clinical governance), etc. Having access to this information will ensure that these stakeholders have a common understanding of current policy and guidelines, and in this way support them to participate actively in discussion and debate on where and how these should be revised over time.

This chapter provides an overview of the development of the NHI SBF since its inception in 2016. It describes the origin and the resulting design or ‘shape’ of the service benefits; and lists three lessons learnt by the NDoH, with particular focus on the critical role of stakeholder engagement across NDoH directorates. The review provides a recommendation linked to this lesson, namely to similarly implement engagement with all national health sector stakeholders as the structure and content of the SBF is further refined and expanded. This process will make provision for incremental reduction in fragmentation of service benefit definition across the public and private sector, but also help to build trust, establish buy-in, leverage complementary expertise held in the private sector, and build a common understanding that will enable a smoother transition to NHI. This engagement should focus on the development of a single set of service benefits funded under NHI and delivered by public and private sector providers to all South Africans, and discussion on how existing roles and responsibilities must evolve to allow for the establishment of a single unified health system.

Development of the NHI Service Benefits Framework

Origin: NHI Workstream 2

Technical work to define the NHI service benefits started in the Ministerial Committee on NHI.⁴ Thereafter, the NHI SBF was conceived by one of the six NHI workstreams (2015 - 2017) established by the Minister of Health.³ The terms of reference for Workstream 2 included directives to develop an approach to health benefits policy drawing on best practice; to cost these services; and to establish health technology assessment (HTA) capacity for clinical interventions, pharmaceuticals and technologies. Emphasis was placed on the need to build on the extensive work already done by the NDoH on “packages of services in Primary Health Care (PHC) and priority programmes”.³

The Workstream drew guidance from the 2017 NHI White Paper,⁵ which indicated that the service benefits should be defined by level of care and with particular emphasis on driving efficiency through establishment of gate-keeping at the PHC level; the White Paper also stated the need to ensure equitable access and patient-centred care through the articulation of patient care pathways aligned with clinical practice guidelines, thereby highlighting the relationship between the service benefits and referral policy. Members of

the Workstream agreed that the Framework should provide the baseline against which to identify and begin application of priority setting for resource allocation, including through use of HTA.

The 18-month timeframe of Workstream 2 was sufficient to deliver a first iteration of the NHI SBF as well as costed scenarios for development of an HTA body to support national HTA capacity development and ongoing review of these services through a defined and transparent priority-setting process. Thereafter, further resources were dedicated to expanding and refining the SBF in preparation for the establishment of the gazetted national advisory committees on healthcare benefits intended to advance the work of Workstream 2, as well as the advisory committees for pricing and HTA.⁶ This work was done in consultation with the medical scheme regulator, the Council for Medical Schemes (CMS) and the prescribed minimum benefits (PMB) Advisory Committee formed in 2017.⁷ Publishing of the NHI Bill in August 2019 and establishment of the NHI Fund Office have reaffirmed commitment to the establishment of an HTA agency, benefits advisory and pricing committees as well as interim ministerial committees for healthcare benefits and HTA.¹

Benefits structure: services and care pathways

Development of the Framework started with the definition of facility-based PHC services; to this end a review was done of the available national clinical guidelines to assess which, if any, could provide the foundation for the Framework. The 2014 edition of the national Standard Treatment Guidelines for PHC (STG-PHC) (later updated to reflect the 2018 edition) was chosen as the primary clinical data source.⁸ The STG-PHC is one of the implementation tools for the Essential Medicines List (EML)⁹, together with Standard Treatment Guidelines for Hospitals (Adult⁹ and Paediatric¹⁰ versions), and the EML for Tertiary and Quaternary Level.¹¹

The STG-PHC was chosen based on three characteristics. Firstly, in terms of the burden of disease addressed at PHC level, this one document reflects the widest scope of clinical guidelines applicable in South Africa. Secondly, as a foundational element of the EML development process, the medicine-related content has been driven by a selection process that incorporates priority-setting. Thirdly, the extent of detail provided over and above treatment directives supports efforts to align clinical guidance with resource input-related policy and thereby generate evidence-linked costing specific to the South African public sector setting. Although not uniformly available or explicit, this detail in the STG-PHC includes data on the condition and/or service for which care is available including International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), the body system to which this applies, the average number of visits, key clinical steps per visit, and referral criteria. The primary limitation of using the STG-PHC is that as an implementation tool for the EML, the conditions listed are facility-based and treatment oriented. Therefore, it was acknowledged that to complete a full list

of PHC services, subsequent supplementation with other community-based and prevention-service guidelines would be required.

South Africa experiences what is often referred to as a 'quadruple burden of disease'.¹² This includes HIV and TB; maternal and communicable diseases; non-communicable diseases; and injury and trauma. Development of the Framework began by linking each condition with associated at-risk populations defined in terms of the quadruple burden categories, and the relevant age groups or life stages. Thereafter, the care pathway associated with each condition and at-risk population was translated from clinical terminology into lay-person terms. The intention was to ensure that any person working in the health sector without a clinical background, could understand the content, and thereby engage with the Framework and use the data it provided. For example, a non-clinical manager working in a district office or a CUP would be able track PHC gate-keeping by understanding which patients could be seen at PHC level, and which required referral to a higher level. Similarly, a public health professional could analyse the conditions for which care was available for a particular at-risk population, e.g. neonate, infants, pregnant women. The result was a data structure that supports an explicitly defined and easy-to-communicate set of service benefits, reflected in Figure 1. The SBF includes the total number of visits expected for a condition or service as it applies to an age group or life stage and for each visit; the lowest level of the health system at which the care can be provided; and the associated clinical steps and referral criteria.

Costing structure: per-patient clinical resource inputs

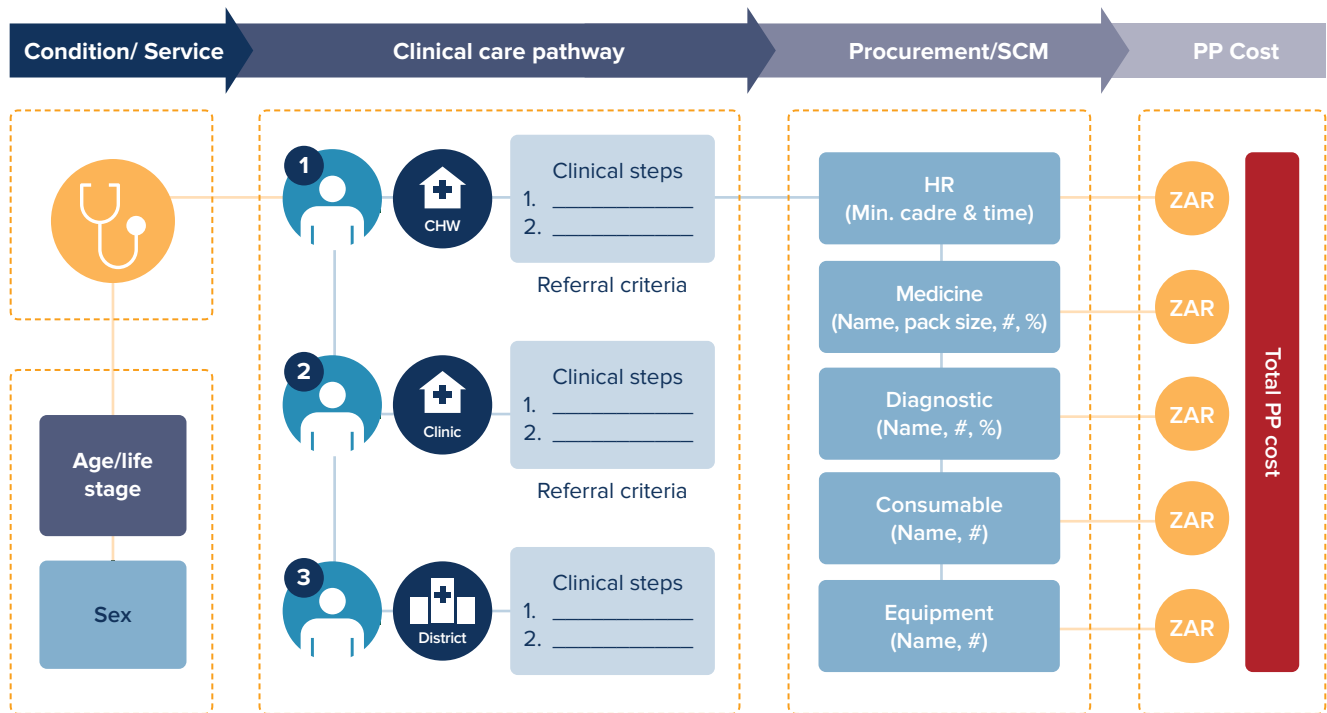
Having an explicitly defined set of PHC benefits provided the first opportunity to build a costings database for NHI in South Africa. The proposed approach was to focus initially on the direct clinical resources required per patient visit (i.e. medicines, consumables, and diagnostics) to which unit costs could be linked so as to calculate per-patient direct costs. The intention was to then add further inputs reflecting shared clinical resources (i.e. equipment and human resources), which together with population and burden-of-disease data, could be used to estimate the additional per-patient cost for a defined population. It was acknowledged that the per-patient costing methodology would ultimately also have to account for a range of co-morbidities. The approach excluded fixed capital and left calculation of overhead/administration costs to the final step, suggesting that this be dependent on the final management structure supporting NHI rollout and that it be capped at a percentage of service-delivery cost.

Work to date has culminated in the determination of all direct and shared per-patient resource inputs required to provide services at each visit, as shown in Figure 1. These resource inputs were initially deduced from the STG-PHC and then mapped to explicit items as reflected in the available resource-related policy documents.

The intention was to ensure that the content is recognisable to procurement, supply chain and finance managers, and enables them to understand how the resources they oversee link to delivery of care for specific patient conditions seen at specific levels of the health system. All data sources are listed in Table 1.

The next step in development of the SBF is to assign unit costs to each input. These will be the national cost as per current awarded tenders and the Department of Public Service and Administration personnel rates. The intention is to establish a baseline of current or 'actual' per-patient costs and an estimate of total cost against which to conduct a

Figure 1: South African NHI Service Benefits Framework structure, 2019



HR = human resources; PP = per patient; SCM = supply chain management.

Table 1: South African NHI Service Benefits Framework data sources, 2019

Data	National policy or guideline data source	Unit cost data source
Health condition/service	Essential Medicines List and Standard Treatment Guidelines, 2018 ⁸	N/A (Calculated)
Human resources	<p>Profession: Subset based on Department of Public Service and Administration cadres and Clinical Scopes of Practise</p> <p>Time: Clinical expertise (No existing policy)</p>	Department of Public Service and Administration Salary Scale
Medicine	Name and dosage: Essential Medicines List and Standard Treatment Guidelines, 2018 ⁸	Master Procurement Catalogue
Laboratory	Essential Laboratory List for PHC	National Health Laboratory Tariff List
Consumables	National Health Commodities Catalogue for PHC ¹³	Master Procurement Catalogue
Equipment	National Health Commodities Catalogue for PHC ¹³	National Tenders

range of comparative analyses within the public sector. One of the analyses would be to compare the total estimated cost of full coverage with the current size and distribution of the health budget to estimate the discrepancies in funded priorities (allocative efficiency). Another analysis would be to identify where/how savings could be achieved through improved pricing and procurement negotiations (technical efficiency). A further analysis would assess the equity implications of subnational procurement by comparing national commodity price lists with provincial ones to assess the current range in costs of particular services across provinces. The process of linking these costs to resource inputs is currently underway.

Expanding beyond PHC

Beginning the development of the SBF with a focus on PHC was an explicit decision taken for three reasons. The first reason was the explicit directive in the Workstream 2 terms of reference to build on existing work already done by the NDoH on PHC programmes.³ A second was the recognition of PHC as the foundation and ‘heart-beat’ of NHI and that a focus on this would help address equity considerations.⁵ A third reason was that in defining the service benefits to align with national clinical guidelines and care pathways, this necessarily required beginning with the entry point to the health system for each condition, which outside of emergency, would be PHC. Beginning with PHC also had the benefit of providing a clear picture of how and where gate-keeping should apply which, when compared with current practices, would highlight the extent of efficiencies that could be realised by seeing patients at the appropriate level of care.

That said, it is envisaged that the SBF will extend beyond PHC to hospital services. This will introduce a greater level of complexity to the structure and costing methodology employed. At the same time, it will ensure that the full set of service benefits are articulated including priority programmes that involve specialised care. This means that, compared with the typically high volume but low cost services provided at PHC level, low volume and high cost services would also be explicitly defined and are likely to be the content to which HTA is applied as a priority. The latter is the content to which full HTA included in the Bill is likely to be applied.

Early lessons learnt

Development of the SBF is ongoing and iterative, but three early lessons can and should inform how this work is taken forward. The first lesson relates to the critical role of stakeholder engagement in benefit design and review. The second and third lessons relate to the structure of the SBF and the need for national alignment across policy, strategy, guidelines, and associated health-management information systems (HMIS).

Firstly, as the initial terms of reference for Workstream 2 indicated, there was indeed extensive groundwork on which to build; however, it has quickly become apparent that the current national guidelines and policy documents do not always speak to one another. This has, in turn, highlighted the extent of broad stakeholder engagement and participation required across directorates within the NDoH to develop the SBF, i.e. before turning to wider stakeholders at provincial level or in the private sector and civil society.

In the case of clinical guidance, the documentation review highlighted the existence of more than a hundred national clinical practice guidelines variously developed, adopted or endorsed by the NDoH but with little or no documented guidance on the role or development process of these guidelines compared with the STG-PHC. There was concern that in the absence of such guidance there may be ambiguities at best or misalignment at worst.

In the case of resource input policies and guidelines, the document review showed an essential laboratory list for PHC and the Workload Indicator of Staffing Norms (WISN) for particular levels of care, but there was no documentation on how or whether these were aligned with the clinical guidelines. The National Health Commodities Catalogue for PHC Facilities¹³ developed in 2019, which details the equipment and consumables to be available in PHC facilities, is similarly not aligned with clinical guidelines. Furthermore, these lists do not appear to be systematically linked to HMIS supporting procurement or supply chain management of the listed items, resulting in further ambiguity.

A second lesson drawn from stakeholder consultations with NDoH directorates was that the structure of the SBF, based directly on the STG-PHC, will not be fit for purpose as a national data structure for service benefits in the long term. One reason is that the current structure is not consistent or hierarchical, as the STG-PHC was not designed with this objective. However, stakeholder engagement has provided valuable knowledge on the extent of data required by different directorates. This will need to be consolidated using standardised nomenclature, and in time adoption of national coding and classification schema, to create a single national data architecture that supports national coordination of healthcare services. It will be critical that the schema together provide a level of detail that supports clinical governance to address quality of care; however, the schema should also provide sufficient scope and thereby incentives for providers to pursue and realise efficiency gains in the public sector and drive down prices in the private sector. This work will be led by the NHI Fund Office and Advisory Committees, with preparatory work on an alignment process for the public and private sector benefits underway through collaboration between the NDoH and CMS. This is in recognition that the structure of the private sector PMBs are also not fit for purpose to pursue UHC.

A third lesson was the need to standardise and align processes proactively for the development of national policy, strategy and guidelines, and to ensure that the content of these documents is used to inform the design of all associated HMIS. This is to ensure a linkage between policy decisions on adoption and roll-out of services on the one hand (e.g. feasibility or scenario analyses), and subsequent monitoring and evaluation of service delivery on the other. Work is already underway with the development by the NDoH of a Policy Information Management System that will serve two purposes, namely to store and manage all health-related policy, strategy and guidelines and ultimately feed directly into the SBF, and to provide a standardised protocol for development of each of these types of documents.

Finally, while not a lesson in itself, what has become increasingly apparent is the role that the SBF can play in supporting good governance as it applies to benefit design. Following a multi-stakeholder engagement process involving researchers and policymakers from a range of countries including South Africa, all committed to UHC, the Center for Global Development (CGD) defines good governance as an environment that upholds three principles: transparency, consistency or coherence, and participation.¹⁴

- **Transparency** means that people are not only able to access information and understand the service entitlements, but also the implications of these entitlements for themselves and the wider population. In this way, transparency becomes a prerequisite for social solidarity and legitimacy of decisions as well as a necessary condition for holding those who make the decisions accountable against the national commitment to UHC and equity. Ensuring transparency must therefore extend beyond ensuring that information is available to ensuring that it is relevant, timely, up-to-date and understandable to the range of national health sector audiences. The CGD notes that this has been shown to not only build awareness and offer an opportunity for health education, but also to strengthen public trust in the health system and reduce any margin for bias. This was the initial thinking behind translating the clinical content of the STG-PHC into a format that could be understood by non-clinicians.
- **Consistency** relates to ensuring that where information is provided, there are no contradictions or ambiguity. This means ensuring that all stakeholders have a clear and common understanding of the services, which in turn supports coordination and allows for improved decision-making. This was exactly the challenge identified in the wide range of national clinical guidelines and policy, and addressed through stakeholder engagement across the NDoH directorates. Finally, transparency and consistency ultimately enable participation.

- **Participation** ensures that the service benefits are defensible in a democratic society. Participation also increases the chance of successful implementation of legitimate and defensible, albeit difficult, allocation decisions.

Recommendation: national stakeholder engagement and participation

The need for stakeholder engagement in benefit design across the different directorates within the NDoH is equally, if not more, relevant than bringing alignment across the spheres of government and across the public and private sector as NHI is implemented. However, each of these stakeholder engagements will be that much more complex than the NDoH directorate engagements, for different reasons.

In the first case, engagement across NDoH directorates was intended to understand and drive alignment of existing policy related purely to service delivery. Therefore, the primary objective of the process was to gather and synthesise existing policy, guidelines and supporting documentation. In contrast, the objective of stakeholder consultation with the different spheres of Government will be to unpack inherently complex systems and concurrent functions between national and provincial government with a view to restructuring them. This will also be related not just to service delivery, but also to management of funds. This is particularly critical given the imperative to ensure that the funds available are sufficient to address population health needs, which will likely differ across the country based on factors such as population size and distribution, burden of disease, and unmet need. For this reason, introduction of the NHI Bill will itself require the repeal or amendment of multiple other laws.¹

In the second case, while there was fragmentation across NDoH directorates, the directorates were centralised around a single reporting authority and centrally located. In contrast, engagement with the private sector will involve an infinitely more fragmented group of stakeholders both geographically and in terms of allegiance. For example, the different types of private sector providers will need to come together to discuss how the combined benefits they currently provide, and/or their mode of delivery, will change to align with the NHI service benefits. This in turn will require balancing the need to ensure that existing medical scheme members are not disenfranchised, with recognition that the current mode of service delivery and supporting cost structures in the private sector are not sustainable.

A proactive approach to stakeholder engagement will also not be complete without establishment of a research agenda encompassing both methods and process-related research questions relating to the service benefits, but also a formative monitoring, evaluation and learning (MEL) framework that can help course-correct and demonstrate to all stakeholders the value of the approach to service benefits design and implementation. For example, specific research and capacity-building efforts can be assigned to a wide range of independent parties such as universities, the Medical Research Council, the Human Sciences Research Council, and civil society organisations, which are hardwired into the country's research and capacity-building infrastructure. The Department of Planning, Monitoring and Evaluation may also be able to make valuable contributions to the MEL framework by helping to review, evaluate and refine implementation in a constructive fashion.

As a result, the approach to stakeholder engagement on the NHI service benefits will necessarily depend on development and implementation of a clearly defined process for that engagement. In preparation for that time, the following section reflects on who the national health sector stakeholders are in South Africa and how they can be engaged most effectively to bring incremental alignment of service benefits under NHI.

Who are the stakeholder groups in South Africa?

Identification of stakeholder groups is crucial in any successful engagement process. A rule of thumb is to seek input from all those with a stake in the decisions of the policy in question. In South Africa, as in most countries introducing healthcare benefits reform, the first group must be citizens, who ought to know what healthcare services they can expect from providers under NHI. This issue of information asymmetry has been raised increasingly in public discourse in recent years and confirmed in the Competition Commission Health Market Inquiry (HMI) that found consumers to be “disempowered and uninformed”.¹⁵ Therefore, service users and their caregivers, and the broader citizenry who must navigate the health system, form a major stakeholder group.

Healthcare professionals across the public and private sector are another important constituency given their role in the implementation and scaling of the services benefits. They are represented by different national professional societies and the Health Professions and Nursing Councils of South Africa. Healthcare providers or establishments, both public and private, are similarly important constituencies. In the private sector, they are typically represented by hospital and general practitioner networks. Indeed, the private sector as a whole, including the healthcare products industry and the private medical scheme and insurance industry, currently account for over half of the total healthcare spending. These stakeholders are diverse, fragmented and often have controversial perspectives, but they are better understood

following completion of the Competition Commission HMI in 2019, and constitute an altogether crucial group of stakeholders with whom to engage.

In a country like South Africa where provinces have historically played a role in financing and overseeing the delivery of care, provincial authorities form another major group to be consulted. District health authorities, and the planned district health management offices, will also play an equally critical role as providers of the lowest level of service delivery coordination. The engagement of national regulators such as the Office of Health Standards Compliance, the Health Ombudsman and CMS are equally critical as are academia and the national research institutions listed earlier, which can support the creation of knowledge and provide evidence and thereby credibility to support implementation of particular initiatives. Several other groups situated further from the focus of the process but central to its success include a wide range of civil society organisations and the media, which are active and vocal in South Africa, as well as the Judiciary, Parliament and the leading political parties. Development partners will also be relevant from a local and global advocacy and market-shaping perspective.

Last, but not least, is the country's National Treasury. The National Treasury is a major commissioner and client of the ambitious effort to rationalise, make explicit, and cost the country's list of service benefits. Figure 2 shows some of the stakeholders crucial to the engagement process and tailoring of information in the NHI SBF.

What is the best way to engage with each of these stakeholders?

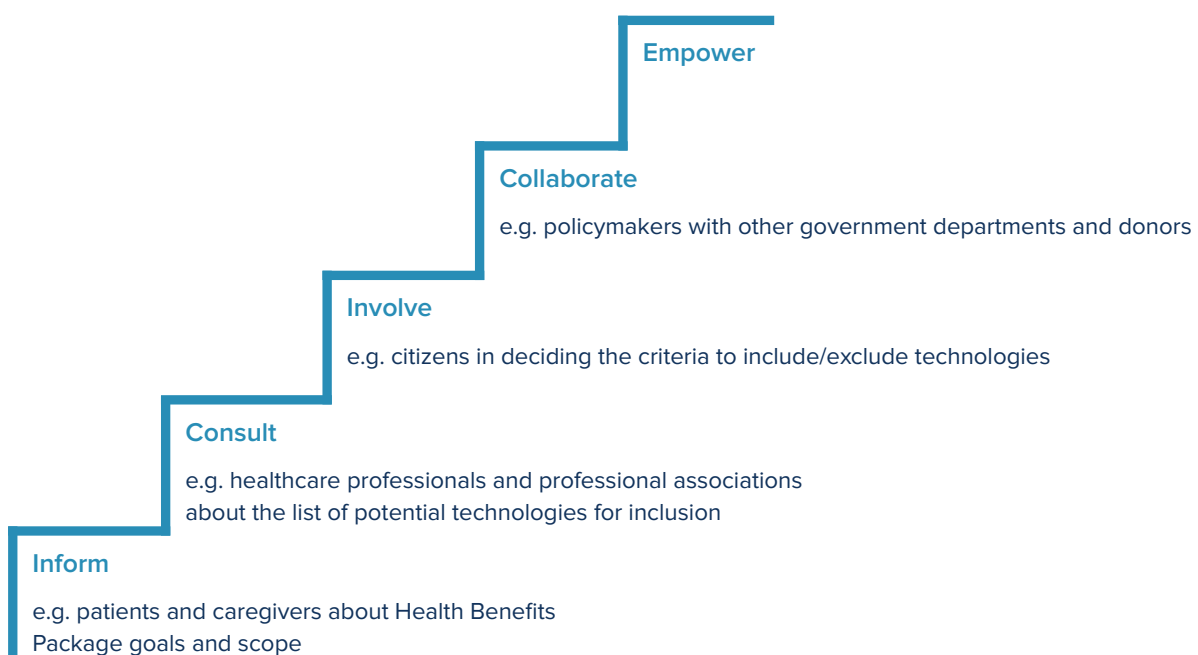
There is no one way to engage with stakeholders. This will depend on the role a specific stakeholder is expected to play in benefit design under NHI. It will also depend on the extent to which there is a need to build a stakeholder's capacity to fulfil that role, and the stage at which their engagement is relevant (e.g. design, methods, content development, updating, identification of priorities, production or commenting on evidence, etc.). Table 2 presents examples of different stakeholders and different capacities required all the way from the individual to the institutional and broader healthcare and policy system levels.¹⁶ Figure 3 presents examples of the different levels of stakeholder participation, which range from 'Informing' at one end of the spectrum to 'Empowering' at the other.¹⁴

One final way to approach stakeholder engagement further is through what is referred to as 'deliberative' processes.¹⁷ Deliberation is not the same as consultation; while there is limited evidence on what best practice is when it comes to deliberation, there is consensus that inclusive, evidence-informed deliberative processes accounting for medical and social science evidence and people's values, are most likely to produce the best guidance for the healthcare system and provide “balanced consensus”.^{17,18} This is an aspiration

Figure 2: National health sector stakeholders to the South African NHI Service Benefits



Figure 3: Examples of levels of stakeholder participation



Source: Glassman et al.; 2017.¹⁴

Table 2: Examples of target stakeholders and capacity needs

Stakeholder group	Capacities required
Environment	
Health system	<ul style="list-style-type: none"> To support the capacities required at the different INNE levels by institutionalising evidence-informed priority-setting agencies at provincial, national and regional levels (as deemed appropriate). This perhaps can be seen as one of the goals for the capacity-building activities. Other activities or interventions at the health system level may help or hinder the development and uptake of evidence.
Networks	
Funders and development partners	<ul style="list-style-type: none"> To commission, receive, interpret and use (as they judge to be appropriate) the methods and outcomes of HTA/priority-setting research to inform decisions about both investment choices in global health and single technology or program choices at a national level, including investments to support effective priority-setting and health system strengthening. To have common understanding, for instance through a common theory of change, of the outcomes, preconditions, and underlying assumptions of investments to support priority-setting and health system strengthening; and to support knowledge translation efforts towards those outcomes.
Nodes (organisations) and individuals	
Consumers of evidence	
Policy and professional decision-makers	<ul style="list-style-type: none"> To commission, receive, interpret and use (as they deem appropriate) the methods and outcomes of HTA and priority-setting research. To disseminate the outcomes of HTA research, and follow-up/monitor impact.
Health service managers	<ul style="list-style-type: none"> To understand implications of competing spending options and to manage resources accordingly. To create and manage local capacity for communications, knowledge translation and setting clinical standards.
Courts and the judiciary	<ul style="list-style-type: none"> To understand the rationale for priority setting, and the tools and processes for evidence-informed priority-setting. To respect and rely on the government's healthcare coverage choices where these have been made through evidence-informed priority-setting mechanisms in a procedurally legitimate manner as set out in law, while maintaining appropriate independence. To hold decision-makers accountable in the priority-setting process, for example through engaging in judicial review.
Patients and the public	<ul style="list-style-type: none"> To understand the implications of policy and clinical decisions, identify the extent to which they are evidence-informed and represent efficient and ethical use of public monies. To understand that unavoidable trade-offs have to be made in priority-setting and the associated ethical implications. To participate in the process of decision-making, recognising the need that decisions have to be made, and highlighting the extent to which they reflect societal values.
Producers of evidence	
Academic institutions, researchers and research managers	<ul style="list-style-type: none"> To understand policy and professional decision-makers' needs. To identify those needs that can be satisfied by HTA research. To conduct and manage the required research without partisan advocacy and to the required standards. To communicate research effectively to meet the needs of decision-makers.
Knowledge brokers	
Knowledge brokers, including priority-setting institutions	<ul style="list-style-type: none"> To understand the cultures of both research and decision-making environments. To assess and communicate research evidence and policy needs. To identify the 'right' stakeholders from both sides and to convene, facilitate and mediate between them such that there is meaningful knowledge transfer between researchers and decision-makers (and between government agencies and local hospitals, professional organisations and community workers, and so on).
Media organisations and journalists	<ul style="list-style-type: none"> To report in an objective and impartial manner stories linked to priority-setting in health and to institutions set up by governments to make such decisions. To encourage public debate in a positive way, and improve policymaking through holding decision-makers accountable to the general public.

Source: Li et al.; 2019.¹⁶

HTA = health technology assessment; INNE = Individual, Node, Network, Environment.

that those driving development of the NHI service benefits as a central feature of the NHI vision ought to pursue while monitoring its effectiveness and cost effectiveness.

Finally, there is a financial cost to stakeholder engagement processes, and money going towards engagement is money not spent on frontline services. Therefore, engagement and participation by different groups must be organised in a way that maximises the impact of their input and minimises the costs. This is a daunting task, but the wide range of independent parties available in South Africa to support the NDoH in this work represents an invaluable resource. Box 1 provides two brief examples of stakeholder engagement in other countries.

Conclusions

This chapter gave an overview of the development of the NHI SBF as an innovative approach to establish a national health benefits package, or what in South Africa is referred to as 'Service Benefits', that is situated at the centre of NHI reform. It provides an explicit list of the conditions and healthcare services to be covered under NHI and provided by public and private sector providers in South Africa, as well as the per patient resources required to deliver those services, as reflected in existing national clinical guidelines and policy. The SBF represents a new and unique contribution to the global UHC movement with consequent potential as a global public good. The chapter reviewed the design and development of the SBF and outlined lessons learnt to date. These include the role of stakeholder

engagement across NDoH directorates; the need to restructure the SBF and provide for common nomenclature and coding systems to support national health sector coordination; and the role of alignment and standardisation in the development and implementation of health policy, guidelines and HMIS. The chapter also highlights the role of the SBF as a tool to support good governance in benefit design.

Finally, a recommendation was made linked to the first lesson, namely that a wider set of national health sector stakeholders be engaged to address fragmentation in understanding the service benefits available across the spheres of Government and current differences in the service benefits available across the public and private sectors. This will be critical to drive incremental alignment, but equally to build trust, establish buy-in, leverage complementary expertise held in the private sector and build a common understanding that will ultimately enable a smoother transition to NHI.

The design and implementation of NHI is a political process as much as a technical one. Therefore, while much of the preparatory technical groundwork is being done, implementation is contingent on progress with the necessary legislative processes to finalise the NHI Bill and establish the NHI Fund. As this progresses, however, stakeholder engagement in the NHI service benefits will be key, including discussion on how existing roles and responsibilities must evolve and capacities be built under NHI to allow for the establishment of a single unified health system that accelerates progress towards UHC in South Africa.

Box 1: International examples of stakeholder engagement

A good international example of stakeholder engagement is the National Institute for Health and Care Excellence (NICE) in the United Kingdom, the National Health Service (NHS) priority-setting body. Public engagement has played a major role and the Institute has had a dedicated budget line since its establishment in 1999.¹⁹ But even in a well-resourced system, engagement can threaten the legitimacy of the process. A recent study found that almost 80% of the financial interests of public and patient organisations actively contributing to NICE guidance were not known to NICE decision-making committees.²⁰ Amid increasing pressure on the NHS to do more with less, NICE seems to have backed away from its longstanding commitment to explicitly acknowledging societal values in its decision-making process.^{21,22}

This is a cautionary tale for a country with fewer resources and a deeply rooted sense of solidarity and commitment to equity as to how best to design and sustainably finance stakeholder engagement processes.

Another example is the Health Intervention and Technology Assessment Programme (HITAP) in Thailand, responsible for informing updates in the country's Essential Medicines List and the service benefits set by the National Health Security Office. The HITAP is highly participatory: it is involved in selecting interventions and technologies for assessment, through to final decisions, and beyond that to communicating decisions and running awareness-raising and capacity-building events for stakeholders.²³

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