Strategic Purchasing Policy Brief Series

Brief 7: Balancing act: balancing affordability, quality and access

About this series

National Health Insurance (NHI) refers to a wide-ranging set of reforms of the South African healthcare system, including the establishment of the NHI Fund as a new entity tasked with the *strategic purchasing* of healthcare.

The broad aim of the NHI reforms is to achieve universal health coverage (UHC) in South Africa. UHC offers "all individuals and communities the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. UHC emphasizes not only what services are covered, but also how they are funded, managed, and delivered" (World Health Organization 2019).

Much of the discussion in South Africa on how we achieve these aims has been divisive and polarised. For many, it is difficult to engage in the debates meaningfully without understanding the jargon and myriad of complex concepts. In support of meaningful discourse, we offer this series of briefs to deepen public awareness and enrich discussions on one particular aspect of the proposed reforms: the notion of strategic purchasing. What is strategic purchasing? Who will do the purchasing? How do we hold the purchaser(s) accountable?

The providers of healthcare services, both public and private, are important stakeholders in a healthcare system. The ways in which the proposed reforms are likely to impact on providers is an often-neglected perspective, one which we hope to consider here.

Seven briefs explore what a purchaser-provider split in a healthcare system is, what strategic purchasing is, the nuances of matching the need for care with the supply of services, how to ensure quality and access and how to balance all this with affordability.

At the time of writing these briefs, NHI as a concept was informed by the framework as set out in the draft NHI Bill (2019) which was preceded by a previous draft version of the Bill (2018), two White Papers (2015 and 2017) and a Green (Policy) Paper (2011).

This work was funded by the Hospital Association of South Africa, although the views presented here are the authors' own.

In this brief…

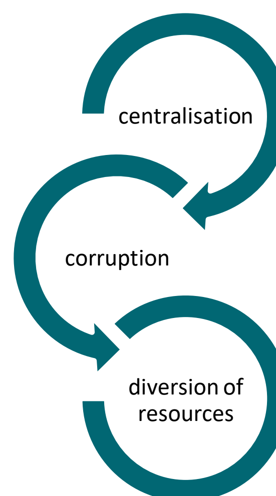
The prior briefs articulate the functions of the purchaser, and the requirements to realise a purchaser-provider split in South Africa. In this final brief we draw together the key themes and holistically consider the need to capacitate the Fund in terms of staff, systems, ongoing research and monitoring. We also consider what the critical issues are that the Fund will need to get right in order to ensure buy-in from its clients (the South African population) and from healthcare providers. The term purchaser-provider split signals a divide between the Fund and providers. Given that a healthcare system is largely driven by those at the coalface delivering care to clients, there is a strong need for provider support, mutual trust and ongoing collaborative effort.

Why it matters…

Given the current and foreseeable fiscal climate, it is clear that the NHI Fund will need to function within a budget envelope. This means that the Fund will need to balance access, quality and affordability. The system will require a certain level of stability to engender trust (from the perspective of both its clients and providers), especially because it is likely that the system will be partly based on contributory fees. This means that clients need to feel that their health benefits are the same or greater than before (particularly given constitutional requirements for progressive realisation), while providers need to feel that their reimbursement is fair and market-related given their level of expertise. This brief will explore the risks and concerns that have been articulated about NHI in a frank way and also provides suggestions for ways in which policy risks can be reduced over the short- to medium-term in moving towards NHI.

Big risks

There are at least three big risks to changing from our current health financing approach to a single purchaser in the context of a purchaser-provider split. These risks have been voiced by a variety of stakeholders, in the design phase and lead-up to implementation of NHI, through the media and other fora. These are:



- **The risk that nothing will improve: Centralisation and current weak government capacity**, combined with the inherent **time-lags** and **inflexibility** of government could generate a situation where we will be paying more for the same (perceived) low-quality care that is currently available in the public sector (Vegter 2018) (Businesstech 2018);

- **Corruption:** the risk that given access to a large sum of money by a few people and an existing track-record of corruption in government, funds will be misused (Gonzalez 2018; Vegter 2018);
- **Diversion of resources away from healthcare costs** and towards administrative costs in keeping the big machine of the NHI Fund going: *the risk that health services will suffer as a result of even higher administration costs* (Vegter 2018).

Centralisation and weak capacity: the risk that nothing will improve

A single purchaser, as the NHI envisions, essentially creates centralisation. In general, most countries are moving towards a decentralisation approach, where managers closer to the ground are able to make critical financing decisions for their constituents (Mitchell and Bossert 2010). The NHI Bill intends to address this by allowing for contracting units at the lower levels of the system for primary healthcare (South African National Department of Health 2017), where these units gets to decide on which providers to contract with and which combination of services would suit their specific population. This aspect of the proposed reforms is particularly light on detail, particularly in terms of the local-level capacity that will be required.

Centralisation, given the size and scale of the health system, may make agility and responsiveness difficult, allowing for a similar environment as we currently see in our public sector, where the management measures are too weak to change behaviour.

Having one purchaser also affords consumers no choice, which puts them in an unequal relationship with their healthcare insurer. It also removes the element of competition with regards to strong administration and client-centredness in terms of providing excellent service and access to care, which essentially removes the incentives for the insurer to improve on quality and experience. Without this incentive, the Fund could become an extremely sluggish bureaucracy that lands up impeding access rather than facilitating it.

Corruption

South Africa has high levels of corruption within its public sector, and the health sector has not been saved from this (Rispel, De Jager, and Fonn 2015). The NHI Fund, will, in theory, house all healthcare funding for the country. The risk inherent in this is that if an official is corrupt and uses their access to the Fund to manipulate tender processes or contracting decisions, the scale of corruption will be vast. The design of the NHI Fund and its governance structures does not seem to reflect lessons learnt from State Capture.

Given the Minister's dual role as responsible for the health system and for key appointments for the Fund, he or she may not have the requisite distance from the activities to be able to effectively safeguard its finances. The current draft NHI bill (2019) gives the Minister a disproportionate amount of power over highly technical details – the Minister is mentioned more than 140 times in the bill (Ashmore 2019). The challenges with internal

accounting officers in the public sector structure has partly contributed to the system's weaknesses that have allowed corruption to thrive. Clear safeguards and separation of powers between the Minister of Health's role and that of the accounting officer of the Fund will be required and have to be built into the relevant legislation.

As the Bill stands, the Minister appoints both the board and the CEO – another aspect of an inappropriate degree of political power.

Diverting resources to non-healthcare costs

The move to create a large Fund will require significant financial investment, beyond the current 'overhead' costs (National department of health (DoH), provincial DoHs and district health offices). Given the tight financial climate, funds moving away from direct healthcare provision is a tangible risk for the population and healthcare providers, who are already suffering the effects of limited budgets. There is large variation in administration costs associated with universal health schemes or social security insurance schemes globally, but in general they consume a large share of total expenditure. For a range of OECD and European Union (EU) countries, the administration costs associated with these schemes were an average of 4.7% of expenditure (3.8% for high-income countries), with costs being as low as 1.4% or as high as 16.9% in some countries (Nicolle and Mathauer 2010). The administration costs in low- and middle-income countries are typically higher than those achieved in high-income countries. Administration costs in high-income countries vary from 1.2% to as high as 26.6%, but it has to be cautioned that the data is often unreliable (Nicolle and Mathauer 2010). The unreliability of the data itself is a sign of the inefficiencies of these schemes, i.e. schemes do not always have a clear grasp on the costs associated with their functioning, thereby making accountability to their funders (contributors such as the salaried and other taxpayers) difficult.

These costs may well be worthwhile if the Fund is able to purchase strategically and significantly impact on the quality and efficiency of the system. The relationship between costs and value should be monitored and reported on – an additional important aspect of accountability.

Stepping stones to limiting the 'big risks'

NHI policy papers (Green, White and the draft Bills) all speak of the rollout of NHI taking place over three phases. Phase 1 (2012-217) was viewed as the testing phase of health systems strengthening initiatives, while Phase 2 (2017-2022, or the current phase) is the phase during which supporting legislation has to be developed, the foundations of the Fund have to be established and interim purchasing of health services for vulnerable groups (women, children, the disabled) has to take place. Lastly, in Phase 3 (2022-2026), additional resource mobilisation by the Fund may start (e.g. premium or contribution collection from salaried employees), while it is intended that the Fund will start to purchase services from providers (the Bill refers to "selective contracting of services from private providers").

The current weak economy and low growth environment does not bode well for a fast implementation of NHI- and the National Treasury has made this clear in the 2019 Medium Term Budget Policy Statement. These timelines should be replaced by measurable milestones.

There are real questions about how the short term (in terms of NHI implementation) is defined, what hurdles should be in place before the next phase commence and whether the NHI implementation period will take longer than foreseen by the drafters of the Bill. Irrespective of final timelines, it is possible for the health system to start preparing for the implementation of NHI by taking the following steps in the interim:

Strengthen the purchasing function now

We suggest strengthening our purchasing function in the short term in both the public and private sectors. Certain key elements of the purchasing function can be strengthened prior to implementation: accreditation, health technology assessment, information system strengthening, clinical coding, levelling of professional rules across the public and private sectors and experimentation with provider contracting are all examples.

Enable innovation in service-delivery models

The current budget structure limits innovation in public service delivery. Learning sites will be essential to enable experimentation and testing of alternative service delivery models. This can be done ahead of full implementation. There are numerous pragmatic impediments to innovation which will need to be interrogated and dismantled – budget structures, salary determination, Public Financial Management Act (PFMA) rules etc. Similar to the strengthening of the purchasing function, certain rules of the HPCSA will also have to be amended to allow for team-based remuneration that will be required as part of new models.

Demonstrate quality improvement

Whilst the commitment to requiring providers to be accredited in order to contract with the NHI Fund is important in terms of ensuring minimum quality standards, there is a concern that this is not practical in terms of guaranteeing geographic access. The processes for strengthening providers who do not meet accreditation criteria should be implemented in the short-term – a graded system with a strong quality improvement approach is required. This will help to build public confidence that the public sector is capable of providing high-quality services.

Prevent resource allocation shocks

Current budget processes are not set up to ensure that funds follow clients. There are steps that can be taken to transition current budget allocations to allocations that are more responsive to need. We could, for example, begin to run shadow payments for DRGs.

It is essential that budgeting and contracting takes place in as nimble a way as possible, with clear quality measurement and benchmarks associated with contracting. In a recent reflection article on lessons from the United Kingdom's National Health Services (NHS), the authors (Friebel et al. 2018) conclude that while the increasingly widespread articulation of the need for universal health coverage is laudable, the benefits of universal health coverage are very closely linked to the provision of quality services (and not merely coverage). Quality therefore has to be clearly supported and linked to budget and financing processes.

The NDoH and National Treasury (NT) are planning to pilot a project where public sector clients can see private general practitioners (GP), with GPs reimbursed on a capitation basis. Furthermore, this capitation rate will explicitly include a value-based care element, that is, a built-in financial incentive for quality and team work. The NT has created a dedicated funding pool for the project, to allow for this type of contracting, however it is unlikely that the funding will be flexible enough, given current public financial management (PFM) rules, to facilitate these financial incentives. Therefore, this project could be used as a test case for changing PFM rules to allow for this sort of flexibility. Agile budgeting under UHC is critical to ensure that funds are used to incentivise quality, without losing important financial controls.

Ensure client accountability is built in from the beginning

The creation of a purchaser-provider split is in and of itself a move towards strengthening accountability. However, this will not be sufficient to ensure accountability. Clear design principles in terms of bottom-up accountability have to be built into the NHI Fund and its relationship with providers and clients from the beginning. The current health system has a lack of clear bottom-up accountability mechanisms (described in an earlier brief): clients cannot control providers by withholding payments as it is a free system, and by-passing as a signal of disapproval is also not encouraged (clients are typically encouraged to seek healthcare services from their closest primary healthcare providers and are then referred upward in the system if needed). Consumer choice mechanisms therefore have to be built into NHI from the beginning. One possibility is to allow clients to change their main (primary) healthcare provider once a year and if such a change is enacted, to ask them for reasons for the change. If clients are able to move based on poor performance, the money will follow the client and a clear signal will be received by the provider. However, there is an inherent tension between reimbursement mechanisms proposed by NHI (capitation) and consumer choice and flexible and innovative ways will have to be found to overcome this.

Patient-reported outcome measures (PROMS) are a powerful tool for enhancing the voice of the client in the system. These can be used in conjunction with simple rating systems.

Be willing to compete

All policy papers on NHI have it set up as a single purchaser, although in earlier discussion papers this had not been the case. Earlier conceptualisations of NHI focused on building on the existing medical schemes environment and creating a multi-purchaser system (Van Den Heever 2016). However, since the move to the Green (2011) and then White papers (2015 and 2017) and now the draft NHI Bills (2018 and 2019), NHI has been firmly conceptualised as a single purchaser system. This implies strong centralisation in terms of both the pooling and the purchasing functions. The system will not be able to generate some of the benefits associated with competition (potentially both greater quality, efficiency and client accountability) that would be possible if there were multiple purchasers, with clients being allowed to move between purchasers at set times of the year (i.e. select a better performing purchaser). Equally important, the Fund should be able to compete for providers to contract with it. There is a concern that in a multi-purchaser design that private providers will opt out of contracting with the Fund. However, it is preferable for the Fund to be incentivised to build trust and credibility so that the provider willingly chooses to contract with it.

Even though we find ourselves at a very late design phase of the NHI, it is still possible (pre-NHI implementation) to contemplate and decide on a multiple purchaser scheme at this late stage as the NHI Fund is not yet operational and the expenses and binding constraints associated with a single fund can still be avoided.

Invest in people now

Reflection on years of provision of universal health coverage by the UK's NHS has shown that getting the human resources right is critical to the success of UHC (Friebel et al. 2018). South Africa's last Human Resources for Health (HRH) Strategy in 2011 (Department of Health 2011) was never comprehensively implemented. The development of a clear human resources operational plan was articulated as an outcome of the Presidential Health Summit that took place in October 2018 (Gonzalez 2018). HRH shortages have been noted in terms of doctors (GPs), specialists, nurses and dentists. Ensuring a sufficient healthcare workforce is available by the time of the first roll-out and implementation of NHI is something that must happen now already and requires continual planning and engagement to ensure future availability. Under-staffing and low HRH capacity will strengthen the notion of weak government capacity and quality, leading to lack of trust and buy-in to NHI as a concept.

Much needs to be done to improve public-sector working conditions, improve absorption of the training pipeline into the system, improve the ability of doctors to work across both sectors, strengthen task-sharing and the role of mid-level health workers, and fix the current problems with vacancies. This will be critical to re-gaining the trust of healthcare providers.

Conclusion

There is a clear recognition and consensus amongst most stakeholders in South Africa that our population deserves access to appropriate, affordable, sufficient and high-quality health services and resources. This is not currently the case, hence the political commitment to shift the status quo.

There is, however, still much uncertainty about how NHI will achieve this. There are a number of interim and proactive steps that can already be taken now to strengthen and prepare the system for NHI implementation in order to actively manage the biggest risks. This will help to build the credibility that the State is capable of managing large-scale health system transformation.

Critical to the success of NHI will be addressing the concerns and risks that are commonly articulated by a wide range of stakeholders. Without client trust and accountability, NHI will not succeed as especially contributing clients will not be willing to use NHI services if their needs are not met. Similarly, without provider trust and support, the NHI will lack the building blocks of a system able to deliver quality care.

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