INCLUSIVE SOCIETY
INSTITUTE

REIMAGINED PATHWAYS FOR UHC IN SOUTH AFRICA:
A CRITICAL POLICY ASSESSMENT OF NHI CHOICES

INCLUSIVE SOCIETY
INSTITUTE

Inclusive Society Institute

132 Adderley Street

Cape Town, 8000

South Africa

NPO Registration: 235-515

DISCLAIMER

Views expressed in this report do not necessarily represent the views of the Inclusive Society Institute or those of their respective Board or Council members.

Authors: Percept Actuaries and Consultants

Edited: Daryl Swanepoel

9 October 2020

ACKNOWLEDGEMENTS

This research and publication was made possible through the kind support of the Friedrich Ebert Stiftung. It is part of a larger exchange of public policy and governance ideas between South Africa and Germany.

SETTING THE SCENE

The Inclusive Society Institute fully supports the notion of an affordable and universally accessible health care for all. As such, it endorses the objectives of the National Health Insurance (NHI) Bill which is currently before Parliament. The ability of a state to care for the health of its citizens is a measure of its commitment to human rights and its standing within the economic development evolution. A healthy nation is after all a pre-requisite for a growing and prosperous economy.

Whilst the urgency and the importance of the NHI Bill is recognised and appreciated, its legislative passage must be accompanied by its realisation in every-day South African life. In this regard, certain questions remain unanswered: Can the country afford it, and are other less intrusive pathways available to incrementally achieve its objectives?

The research which the Inclusive Society Institute has embarked on goes to the heart of these two questions. It recognises that the health policy dialogue is taking place in the absence of an agreed long-term financing roadmap and that there is still much uncertainty as to the practical manifestation of the envisaged system, especially as it relates to the role of the private sector / public sector mix. The Institute is concerned that the absence of a funding plan may undermine the just objective of improving the overall quality of health care in the country, and that an over-ambitious approach may undercut its potential.

To this end, the Institute's NHI research is aimed at providing options to aid policymakers in the health policy choices they are about to make. The first part of the Institute's research, the literature review and stakeholder engagements, assessed the level of consensus within the sector, and delineated the areas of agreement, dispute and those that required further consideration. This, the second part of the research, provides a series of pathways to universal health care. It attempts to stimulate thinking as how best to tackle the all-important national project of providing an inclusive universal health care system, where the healing of the patient is based on the condition that needs to be treated, not their social or economic standing. The final phase of the Institute's NHI research will endeavour to cost the pathways elaborated on in this report.

The Institute offers this research to public policymakers as a further tool to inform their decision-making, in the hope that it contributes to rationalising the national dialogue towards what is achievable and practical in current-day South Africa. The progressive realisation of the constitutional right of access to universal and affordable health care – which an inclusive and socially just society demands – is best achieved by choosing workable programmes over unattainable aspirations.

Daryl Swanepoel, Chief Executive Officer of the Inclusive Society Institute

EXECUTIVE SUMMARY

This document aims to open debate and discussion about alternative pathways to universal health coverage (UHC) beyond the proposals contained in the Draft NHI Bill (2019). The proposed reforms, as they stand, represent a combination of policy building blocks sequenced in a particular way. This design is by no means the only path to UHC.

There are several reasons to revisit our chosen reform pathway. We find ourselves in changed circumstances, entering a period of austerity, accentuated by Covid-19. The reform pathway, as currently conceptualised, requires substantial reorganisation of a fragile system in a relatively short time frame. This big bang approach poses several risks; the biggest risk being that our system is never reformed because of resistance from across the political spectrum.

In Part A of this document we synthesise the various arguments around limited or reduced support for many of the critical positions taken in the Draft NHI Bill.

Incremental reform processes, with realistic milestones, are better suited to building trust and stakeholder buy-in. Our starting point is one of an ailing public sector, a resource-intensive private sector, fragmented financing, inequities within and between the public and private sectors, weak accountability, and a significant trust deficit. It is a far cry from the widely-supported principles of equity, efficiency, quality, sustainability and good governance which guide the reform process. One way to ensure that UHC continues to move forward is to remove the specifics of the modes of implementation in the policy documentation and to incrementally build stakeholder consensus as we move through the reform process. This will allow for a more agile and responsive process which is cognisant of shifts in context.

Building trust in the State's ability to steer the system through the reform process is not just a 'nice-to-have' but has been shown to dramatically improve and strengthen UHC implementation in other countries. There is a large trust deficit in South Africa, in part due to the many false starts for UHC over the years, but also due to missed opportunities to showcase the public sector's strengths. The wounds from State Capture and the failure of numerous large state institutions mean that reform processes that rest on the creation of new centralised institutions reliant on top-down accountability mechanisms are unlikely to be favoured over those that are more participatory in nature.

The starting point for reform is one of the most contentious areas. Does the implementation of a single purchaser (the NHI Fund) require strengthened service delivery in the public sector? Or is the only way to strengthen service delivery by creating a single purchaser? There is consensus that irrespective of the exact route taken, the private sector cannot continue to function as is and will require reform. And regardless of the reform pathway, there will be a role for the private sector in the system. Reform of the system requires stewardship, and the National Department of Health (NDoH) will need to play this role.

Considering the positions taken by the NHI Bill on certain certain critical building blocks in a health financing system, relative to the UHC objectives, allows us to identify alternative approaches to achieving these same objectives. We do this using Joseph Kutzin's framework of the functions in a healthcare system which include revenue collection, pooling, purchasing and service delivery.

The details on revenue collection to fund the NHI Fund are still limited. In terms of pooling in the form of a single fund envisaged under NHI, the primary objective being pursued through this reform is equity. This could, however, be achieved in other ways, including income cross-subsidisation at the premium collection stage; virtual pooling in the form of risk equalisation or reinsurance; the further risk-sensitisation of the Provincial Equitable Share (PES) through better use of data; and the fast-tracking of the medical scheme Prescribed Minimum Benefit (PMB) review to establish a coherent package of services across both sectors.

In terms of purchasing, it is foreseen that the NHI Fund will act as the single purchaser of healthcare by entering into contracts directly with accredited healthcare providers (public and private) on the basis of a basic benefit package. It is assumed that this approach will help to achieve the objectives of quality, efficiency, good governance, and stewardship. Nevertheless, the same objectives could be achieved through alternative approaches: by creating a multi-funder environment and allowing patients to choose providers; by ensuring top-down and greater bottom-up accountability; and by increasing the public sector's contracting with the private sector.

In terms of the last health system function – service delivery – it is planned that under NHI, accreditation will be used to guarantee a minimum level of quality. The private sector will be contracted to provide primary healthcare, but there is no mention of contracting with private hospitals or specialists. It is anticipated that these reforms will help achieve the objectives of greater equity, quality, efficiency, and improved governance and stewardship. There are, however, other approaches available to achieve the same objectives. Procurement legislation could be changed to become more flexible to allow for private provision of care. A combination of reimbursement approaches, such as capitation and performance-based financing (along with strong accreditation mechanisms), could incentivise improved service delivery.

In Part B of this report, we outline several scenarios that allow the reader to reimagine UHC implementation in South Africa. The four scenarios are: 'Status Quo Gold Standard', 'NHI Rejigged', 'Power to the People', and 'Reorienting Towards Value'. We used the comprehensive literature review conducted prior to this report, as well as interviews and documentation, to pinpoint these scenarios. At their core, each scenario addresses the five policy objectives embedded within them, and therefore the scenarios present a reimagining of the 'how' for NHI (see Table 1). These scenarios may help the South African Government and the various UHC stakeholders to continue furthering the important UHC agenda, without risking the public purse or service continuity as it does so.

Table 1: Alternative UHC scenarios explored in this document

Scenario	The crux for the patient	The crux for the system	UHC policy objectives achieved
Status Quo Gold Standard	Better service delivery through improvements in quality of care and system hardware.	Better data quality and transparency to facilitate evidence for decision-making.	• Equity within the public sector, but not between sectors. • Improved public sector governance. • Sustainability of the public sector strengthened, but costs likely to continue to spiral in the private sector. • Public sector efficiency improved through data and decision-making. • Minimum quality standard is raised.
NHI Rejigged	Better regulation of private sector that will bring down high costs. Improved quality of care in the public sector.	Earlier development of basic benefit package. Development of transitional central risk equalisation fund across sectors to lay foundation for NHI Fund.	• Equity within each sector, and then improved equity between sectors. • Improved governance in both sectors. • Improved sustainability in both sectors. • Efficiency gains as a result of shifts in incentives in the private sector. • Minimum quality standard is raised as equity improves.

Power to the People	User given a choice of insurer by allowing for multiple purchasers, but with a centralised risk equalisation fund to ensure equity across funds. This should ensure administration of funds is more responsive to client needs (smaller bureaucracies).	More competition between insurers to encourage better administration of funds. Government is able to hold insurer to account because they are not solely reliant on them.	• Equity across the system as a whole. • Governance strengthened through bottom-up accountability. • Sustainability driven through strategic purchasing and competition between purchasers. • Competing insurers as an incentive to drive efficiency. • Quality driven through greater participation.
Reorienting Towards Value	Better quality of care. More affordable care.	More cost-effective care. Improved equity between sectors. Better data quality to compare and measure providers.	• Equity achieved over time through alignment across sectors. • Governance strengthened through bottom-up accountability. • Sustainability achieved through orientation towards value. • Efficiency driven through bottom-up reorganisation of service delivery. • Quality becomes key focus of this approach.

LIST OF FIGURES

LIST OF TABLES

ACRONYMS AND ABBREVIATIONS

Acronym/abbreviation	Full description
DHIS	District Health Information System
DHO	District health office
GDP	Gross domestic product
GP	General practitioner
HIS	Health information systems
HMI	Health Market Inquiry
HR	Human resources
HRH	Human Resources for Health
IYM	In-year monitoring
MoF	Minister of Finance
NCS	Norms and Core Standards
NDoH	National Department of Health
NHA	National Health Act
NHI	National Health Insurance
NHRPL	National Health Reference Pricing List
OHSC	Office of Health Standards Compliance
PDoH	Provincial Department of Health
SAG	South African Government
UHC	Universal health coverage
VAT	Value-added tax

CONTENT

1. INTRODUCTION

In South Africa, we are at a critical point in the road with universal health coverage (UHC): an NHI Bill is currently up for discussion and scrutiny by the Parliamentary Health Portfolio Committee. With a high volume of submissions received, media reports have focused on how the Committee will be able to effectively process all these submissions. The massive response to the call for submissions indicates the level of public and stakeholder interest, support, and concern that the envisaged health-system-wide reform through NHI has evoked.

Given the long history of the reforms, the severely constrained fiscus, and lessons from the Covid-19 pandemic, it is important that we pause to reflect on the range of policy choices and sequencing that are possible to achieve UHC. Large-scale reform processes need to be reflective, and open to learning and course correction.

This document has two main contributions (Part B): the disaggregation of the reform process into its constituent building blocks with an analysis of how these could be reconceptualised in a way that allows the system to achieve the same policy goals; and the presentation of four alternative conceptualisations of how UHC could be achieved in South Africa: 'Status Quo Gold Standard', 'NHI Rejigged', 'Power the People' and 'Reorienting Towards Value'. These are not the only possible alternatives but also serve to illustrate that we have choices about how to proceed.

However, to know where we are going, we need to start at the beginning (Part A). We first consider the principles guiding the reform process and the various arguments for strengthening the current health system, before focusing on the areas of consensus, uncertainty, and dispute in the NHI Bill.

2. WHAT ARE WE TRYING TO ACHIEVE? FIRST PRINCIPLES

South Africa has been grappling with the path to UHC for over two decades. Despite differences in policy, rhetoric and plans, the intention has always been the same: to **improve equity** between the provinces and the health sectors, to **ensure quality** care is provided at the lowest possible cost, and to ensure the health system is **governed optimally** and with sound leadership. As support for this report, we conducted a comprehensive literature and stakeholder review of NHI in South Africa. Based on this, we identified five **policy objectives** that have been consistently present across policy documentation, while South Africa has tried to move closer and closer to UHC. These policy objectives are:

1. To improve **equity** in the health system, including the sharing of resources (human and other) across the public and private health systems.
2. To address **escalating costs** in the private health sector and contain future escalations in costs across the health sectors.
3. To provide **universal access** to **quality** health care.
4. To ensure **efficiency** in service provision and administration.
5. To ensure **good governance** and **stewardship.**

These key objectives of the health reform process will be used as a benchmark against which to assess the feasibility of various policy choices and pathways that have been put forward during the UHC debate. This report may also assist in guiding the sequencing of current reform proposals. Through this document, we propose that the combination of cost, quality and efficiency could be collectively reconceptualised as **orienting the South African healthcare system towards value.**

3. WHERE TO BEGIN?

From the literature review, which included submissions on the Draft NHI Bill as well as more formal literature, there was a fundamental disagreement between the South African Government (SAG) and others on how the shift to UHC should begin. The disagreement, at its core, comes down to whether we should strengthen the public health sector first, or whether we should begin with massive system restructuring to improve quality and equity across the entire health system.

3.1 The argument for starting with the public health sector

Many stakeholders believe that the current state of the public health sector is a non-starter for NHI (1–3). Beset with ailing infrastructure and poor quality care (4,5), many think that rolling out UHC within the current system is impractical and doomed to fail. Furthermore, the narrowing fiscal envelope for public healthcare is likely to slow down the State's ability to improve these infrastructural or resourcing issues in the short term. This means that the State risks collecting funds to enable UHC without having the resources to successfully do so. The result is that citizens resent having to spend more money on healthcare (through tax) while still experiencing the same poor quality, and this will negatively impact on people's trust in a state-run system, like NHI. Therefore, if rushed and implemented poorly, there will be long-term damage to the UHC project in South Africa.

There are three main reasons why some stakeholders believe that the State should start within the public health sector, in order to lay a better foundation for the larger system restructuring envisioned in the Draft NHI Bill.

1. Restoration of faith in the system through high-quality services is required to enable a smooth switch to UHC. The primary argument for starting with the public health sector pertains to the quality of services currently provided. The National Treasury has expressed its concerns with health departments' inability to spend and as such, when announcing the 2019/20 budget, the Minister of Finance (MoF) announced that unused NHI grant funds would be redirected to fund additional Human Resources for Health (HRH). Increasing availability of healthcare personnel is one way in which public health departments can improve the quality of care provided.

In addition, most public health facilities are old, and require major renovations to be fit for purpose (6). Facilities are often under-resourced, not only by staff but also with equipment and other goods and services. This results in poor quality of care and is partly responsible for the proliferation of medicolegal claims against the State. It currently takes a very long time to upgrade facilities, given budget challenges and poor oversight of construction projects. Therefore, by starting on these upgrades now, using the Office of Health Standards Compliance (OHSC) assessments to guide the Department on where to invest, the public health sector could dramatically improve quality for its users. This would also restore faith in the system for many users and make the switch to UHC, with the public sector as the main vehicle for healthcare, more palatable to the South African population.

2. Large scale contracting of private providers is risky and could divert funds away from essential services. The difficulties associated with contracting are illustrated throughout the history of the NHI reforms. In the first phase of NHI, provincial departments of health (PDoHs) were able to contract in private general provider (GP) services. However, the project was largely a failure due to issues with payment and a lack of oversight (7). Nevertheless, in phase II of NHI (the phase we are currently in), the scope of private-sector provision was to be widened, to allow for contracting of services for high-risk maternity clients, among others (8). This has not happened yet. There was also an attempt to tender for oncology services from the private health sector, given the collapse of oncology services in the public health sector. However, the tender was never awarded. In August 2019, the National Treasury reported substantial underspend on the NHI grant (9).

The Covid-19 pandemic increased the demands placed on the health system, in particular, the public sector. This created the need for the public system to purchase from the private sector to keep up with the requirements. However, developing a mutually agreed upon

structured payment model with a clear package of care proved challenging (10). As a result, private facilities were reluctant to accept non-insured Covid-19 patients as they could not be transferred to a public facility once stabilised due to the lack of public sector capacity (10).

This has left many feeling that the State is not using available funds to strengthen the public health sector and has brought into question the State's ability to manage the NHI Fund. Most importantly, many believe that this was a lost opportunity to not only showcase the State's ability to procure efficiently, but also for vulnerable users to be afforded better care that will improve their health outcomes, a key objective of UHC **(quality).**

Departments of health could experiment with contracting private services now without big bang NHI reforms. To improve **equity,** the departments of health could begin to contract with private sector services for vulnerable groups or for services that are currently unavailable. Building up a contracting capability will take time and will require learning from experimentation.

3. Pervasive state sector corruption first requires establishment of good governance and oversight before centralising funds. It is worth noting a final argument that underscores why stakeholders want the State to start with the public health sector. Corruption in the State has been brought to the fore as we have been emerging from a period of extensive State Capture. Many have concerns that centralising funds into an NHI Fund, before good governance has been embedded and corruption dealt with to prevent misuse of funds, is simply too risky. Stakeholders are therefore eager to cement the governance principles and oversight mechanisms to protect healthcare funds before moving to NHI implementation which would radically centralise health budgets. If open to corruption, the damage is even more devastating, given the quantum.

In Section 7, we use these arguments for starting with the public sector to build a UHC scenario where no purchaser-provider split is implemented, and the public sector is simply strengthened. Given that public healthcare is currently available, at no charge for the indigent, it can be argued that UHC is already present, but the quality, efficiency and effectiveness of the system is poor. This scenario therefore details the steps to improve the existing UHC platform with no system restructuring. This improvement to services and quality would impact over 80% of South Africa's population.

3.2 The argument for implementing UHC policy alongside health system strengthening

Given that South Africa has been on the UHC trajectory for several years now, some – especially those within the public sector – believe that without the impetus that new policy brings, the public health sector will remain ailing and under-resourced. Some of the difficulties experienced by departments of health in contracting private providers relate to outdated and ill-suited public financial management regulation. Similarly, to truly improve quality, the system needs to change the kind of data that is collected, and make data more readily accessible for analysis. These shifts require regulatory change. A number of stakeholders believe that the NHI Bill will provide the mandate to begin these reform processes – many of which will take several years to enact. Another reason to begin implementation is that the NHI structure may help to stimulate systemic change, given the shifts in control from PDOHs to district health offices (DHOs). The NHI finally mandates the move to decentralised governance, and literature abounds on the reasons why this is better for population health and service delivery (11). Again, without the impetus for UHC from NHI implementation, this is unlikely to happen, as decentralisation has formed part of district health services policy since 1997 with limited success (12).

There is broad consensus on the principles of NHI. Therefore, while the approaches are contested, it is widely supported that the health system needs to be reformed. Therefore, some feel that with this level of support for NHI principles, the mechanisms and methods can be worked out along the way without delaying the implementation phase. **It is important to note that currently, the Draft NHI Bill is specific on the mechanisms and approaches for NHI.** Some loosening of this language could assist in getting the principle of UHC through and allow for further discussions and debates on the 'how'.

There exists a strong belief among many NHI stakeholders that a single purchaser is needed to effect improvement in service delivery, i.e. without a purchaser-provider split, accountability won't exist, and accreditation of service facilities will not be achieved. However, as shown in Section 7, the objectives that UHC seeks to achieve can be met in other ways. A purchaser in the form of a single fund is not a prerequisite for improved transparency, centralised stewardship, quality improvement strategies and various other policy actions which are being pursued on the back of NHI.

4. SEPARATING THE PRINCIPLES FROM THE APPROACHES AND MECHANISMS

Table 2 (below) is taken from the comprehensive literature review mentioned in the executive summary (7). It succinctly describes where there are disagreements on the approaches and mechanisms of NHI. We will unpack each one and suggest alternative pathways that still achieve the principles of NHI, albeit through different mechanisms.

Table 2: Areas of consensus, uncertainty, and dispute on the NHI Bill among critical stakeholders

Accepted - preferred route	Uncertain - possibly revisit	Disputed - consensus required
1. There is a need for UHC, due to inequity between health systems.	1. Choice of a ***single*** purchaser and payer.	1. Timelines and progress milestones.
2. Wide engagement on the Bill is required to shape an effective health system and to build buy-in.	2. The creation of a purchaser-provider split.	2. The role of medical schemes/the private health financing sector: supplementary or complementary?
3. Greater levels of collaboration between the public and private sector is welcomed.	3. The view that the NHI Board be appointed by the Minister of Health, and the CEO of the Fund appointed by the Board.	3. Quality assurance and quality improvement mechanisms.
4. Primary healthcare is recognised as the appropriate point of entry into the health system.		4. The extent of pluralistic purchasing.
		5. Reimbursement mechanisms for providers.
		6. Fiscal controls and affordability (what are we buying)?
		7. Governance mechanisms.
		8. Accountability mechanisms.
		9. Who to cover: refugees and undocumented migrants.
		10. Constitutionality issues not captured by the above.

Linked to the 'fundamental misalignment' we described in Section 3, is the widespread concern that the current **policy implementation timelines are unattainable.** Several Bill submissions described feeling rushed into formalising the Bill and lamented the lack of tangible benchmarks and milestones that would help the South African population to hold its government to account. This is linked to the issue of 'where to begin' because it dictates the milestones and short-term activities of the Department of Health. For example, if the State implements NHI as currently envisioned, then some of the milestones to be included will be the contracting of private providers for public sector clients, at agreed-upon tariffs. However, if the State were to start with strengthening the public health system

first, the milestones could include, for example, 'number of public sector health facilities who meet the Office of Health Standards Compliance (OHSC) accreditation standards'.

Some NDoH policymakers, however, recognise the impossibility of achieving the NHI implementation timelines set out in the Bill, strengthening the case for a step-by-step approach. Given the technocratic realism around timelines, the legislation should be amended to take this into account.

An option to reach consensus on timelines, is to break NHI policy down into discrete actions that can then be monitored. For the actions pertaining to strengthening the public health sector, no new policies are required, the current National Health Act (NHA) is sufficient. Therefore, the system could begin to build trust and support for the greater NHI vision by showcasing its capabilities within the public health sector. Using this method doesn't mean the State has to discard the current NHI Bill or goal. Rather, it would be about breaking the policy up into its component pieces. Each component piece may require legislation enactment, but this should become easier and easier as the State builds up credibility. Some examples of the components are provided in Table 3.

Table 3: Examples of how NHI timelines can be linked to activities and milestones achieved

Component	Activities	Mechanism
Component 1	Improving public health infrastructure.	Using OHSC assessments to guide need and costing, and to assess progress.
Component 2	Improving data collection, recording and use in the public health sector.	Implementation of electronic health records and individual-level data collection. A national data repository that is freely accessible for researchers and policy-makers to guide evidence-based decision-making.
Component 3	Improving quality in the public health sector.	Filling of vacant posts, and agile contracting to allow movement according to need.

5. TRUST AS A CATALYST FOR UHC REFORM

The practice of building trust between stakeholders is critical. Ultimately, trust is built by doing what you say you are going to do and by working together on a shared problem that allows disparate groups to feel heard and build consensus.

In the extensive report of the Dullah Omar Institute (13) on decision-making in health, NHI is used as a case study to consider the various positions of different stakeholders and players in the South African health system. The report makes the absence of trust clear, even between different government entities, like Treasury and departments of Health.

To date, the shift to NHI has been marred by a lack of true consultation and consensus-building between stakeholders. Many stakeholders feel that their proposals and recommendations were not taken into account in the final version of the NHI White Paper or the latest Draft NHI Bill. Non-NDoH government bodies similarly felt their recommendations were ignored. We see this most clearly in the lack of an accompanying financing document from National Treasury for the NHI Bill.

The ability to successfully implement UHC reforms rests to a large extent on building trust between the State and private providers, a process which should begin ahead of financing reform implementation. Private providers currently contract with multiple purchasers and are understandably nervous of engaging with a single purchaser as they become dependent on that purchaser being rational, fair and effective. There are already examples within the private sector where providers feel over-powered by funders. Additionally, past experience of contracting with the NDoH has not been positive, and trust will need to be re-established to attract sufficient private providers into the reformed health financing space.

In Sweden, it has been found that the most effective implementation of a purchaser-provider split was in those regions that moved beyond formal agreements and competition, to dialogue and consultation to shape the future of healthcare (14). Cooperation and trust were found to be important qualities in the creation of a purchaser-provider split. Similarly, in Germany, it was found that a medium-term process of working intensely with important stakeholder groups supported a transition process to a reformed health financing space (15). This engagement meant the perspectives of all stakeholders were captured and shared publicly, facilitating transparency and thereby trust. Another useful approach in Germany is that the committee which is tasked with making health financing decisions is representative of many different stakeholders (15). These international lessons are important for South Africa and sound the call to focus on consensus-building and open dialogue before settling on the modes and mechanisms of implementation. There is currently not enough trust in the health system between different stakeholders to power a big bang approach to UHC. Change will have to be incremental with more accountability built along the way.

6. THE CURRENT FISCAL CLIMATE MAY FORCE A CHANGE IN APPROACH AND CADENCE

In this section, we make the case that we will need to work with what we have (available funds, infrastructure, and human resources) given the difficult economic and fiscal situation South African currently finds itself in.

6.1 The dire global economic situation and South Africa's fiscus

The global health crisis that rapidly arose as a result of the Covid-19 pandemic has triggered the deepest global recession observed in the last eight decades. This has come about due to the Covid-19 national lockdown policies to curb the spread of the disease. These lockdowns resulted in the loss of trade and tourism, and decreased capital investments which escalated debt both at the individual and the macro level. These disruptions have been further compounded by the effects on wellbeing and the massive shock to healthcare systems worldwide. Countries that had historically weaker health systems fared worse in the pandemic (16,17). While the exact impact remains uncertain, contraction in economies and long-term negative consequences are expected globally, particularly in emerging markets and developing economies.

The World Bank predicts an average contraction of 2.5% in the global economy in 2020, largely as a result of the disruptions caused by the pandemic (17). A decline in per capita income by 3.6% is also anticipated, resulting in an increase in the rate of extreme poverty. Furthermore, the effects of the pandemic on schooling and access to healthcare may worsen the long-term economic impact. While global economic growth is expected to rebound to 4.2% in the following year, the decline in the economy may be as much as 8% globally, and a 5% contraction in output in emerging markets and developing economies may be observed in 2020, with only a 1% recovery in 2021.

Although policy measures have been put in place by most countries to combat the economic effects of the pandemic, the recession is likely to send many individuals into extreme poverty. The economic downgrades expected globally may undo years of progress and decrease the chances of many countries achieving the Sustainable Development Goals.

South Africa is no different and has been hard hit by the pandemic. The country was already vulnerable to economic decline preceding the pandemic, with a contraction of 1.4% and 1.8% observed in the fourth and third quarters of 2019, respectively (18). However, the impact of Covid-19 was far-reaching and worse than could have been anticipated. The national lockdown regulations were set in motion from April 2020 and continue to date. The second quarter of 2020 was particularly hard hit as a result of the most restrictive parts of the lockdown falling within this period (19).

Despite fiscal and monetary attempts at tackling the dire economic constraints caused by Covid-19, the national budget remains in deficit due to the increased expenditure and decrease in tax collection, and is likely to have lasting impacts. Due to these constraints, rapid growth in healthcare expenditure as a share of GDP is unlikely. Rather, there exists the very real possibility of cuts to healthcare budgets. This threatens UHC implementation.

6.2 Dramatic need for Human Resources for Health

The Covid-19 pandemic has highlighted the need for a strong health workforce in order to provide equitable access to quality healthcare and has shed light on the inadequacies in our current Human Resources for Health HRH mix and availability across and within the sectors. Investing in HRH is essential for the implementation of UHC, and the National 2030 HRH Strategy outlines optimistic targets

for HRH in South Africa (20). However, the fiscal climate threatens to undercut the laudable goals of the 2030 HRH strategy and as such, we need to keep finding ways to innovate our service delivery platform to ensure healthcare workers are used optimally.

6.3 The need to work smarter with what we have

Considering the potential that no additional funding will be allocated to healthcare and the possibility that funding may even be reduced, it is imperative that existing resources and infrastructure are utilised efficiently and effectively.

Public sector

To do more with less, innovative ways of thinking about the path taken to achieving UHC are required. The retention of the current workforce and the redistribution of teams in an equitable way may assist in making better use of scarce HRH. Similarly, there is significant scope to improve the allocation of existing resources across geographies.

The pandemic has halted or, in some cases, inhibited the progress. However, it has also stimulated innovation through the incorporation of various technology-enabled solutions to accessing healthcare in part due to a relaxation in associated telehealth regulations. Making use of the innovations that are found to be more cost-effective may help to reduce spending while also decongesting the health system.

With a focus placed on primary healthcare as a means of enabling UHC, current infrastructure may be well utilised. **Promoting and strengthening PHC systems presents a way to lower the costs associated with management at higher levels of care.** Currently, ward-based outreach teams are established throughout South Africa (21). These teams provide care at a community level and consist largely of nurses and community health workers. These teams have been found to be both effective and cost-effective when providing care to impoverished, high-risk individuals (22). The cost-effectiveness of using community health workers is further increased when they have access to information and technology systems as this allows for the smallest workforce required and more streamlined care through the availability of data (23).

Private sector

The recommendations from the Health Market Inquiry (HMI) present a detailed roadmap for reforming the private sector – specifically in relation to escalating costs (one of the core policy objectives).

Legislation that facilitates multi-disciplinary teams and global fees would be catalytic in curbing costs (24). It would also improve quality and health outcomes in the private health sector (24).

Despite the high expenditure of the private sector, a low proportion of the population is currently part of private risk pools (with the associated social solidarity mechanisms). Including the private sector in the financing of the NHI may assist in diverting some of the strain currently placed on government because of the pandemic. This will be further discussed in the alternative scenario below.

Excess capacity exists within the private sector, and this may be utilised in order to improve access and quality of care provided to those currently receiving care within the public system. Making use of the private healthcare system through contracting of private services may also aid in decongesting the public health system, thereby improving quality. This would require mechanisms for tariff negotiation, as well as the data and technical capabilities to support contracting. Reform of the now-outdated National Health Reference Price List (NHRPL) tariff system would be a good starting point. A recent (2018) project undertaken by National Treasury and NDoH to explore private sector contracting for Primary Healthcare (PHC) services using capitation was illustrative of a consultative process together with the required technical work.

The public sector has a shortage of medical specialists available to provide care. By allowing the private sector to train additional registrars, ggovernment may be relieved of some of the financial burden while still increasing the workforce substantially (if they ensure these registrars still provide services to the public sector).

Attention should also be placed on stabilising the operating environment of the medical schemes market. This includes reforming the current minimum benefit package to enforce a reorientation of the private sector to PHC services, which would drive down costs.

Incremental reforms

With the aim of achieving UHC, South Africa can take incremental steps over time, despite the current economic climate. Making use of the current available infrastructure will allow the healthcare system to recover, improve quality and build capacity over time, while avoiding the massive financial implications of a radical shift to an NHI system. In implementing small steps over time, trust and transparency can also be built, improving social support of the system.

7. ALTERNATIVE CONCEPTUALISATIONS OF THE BUILDING BLOCKS OF NHI REFORMS

Rather than seeing NHI as one big bang approach to UHC, it is useful to think of many of the technical proposals, which form part of NHI, as being specific policy choices with regards to certain critical aspects of any UHC system. The most widely used conceptual outline of the various functions within a healthcare system is that proposed by Joseph Kutzin (25). Kutzin distinguishes between four key areas: revenue collection, pooling, purchasing and service delivery. This section draws extensively on work previously done by Percept on the purchaser-provider split and its various important dimensions (26–28).

A summary of each section's content in the form of health systems functions, policy goals to be achieved, specific policy architecture choices made under NHI, and potential alternatives are provided in Table 4 below. More narrative detail is provided in the sections below.

Table 4: A summary of the building blocks of NHI reforms and alternative policy options

Function	NHI approach	Policy objectives being pursued	Possible alternative options that could achieve the same objectives
Revenue collection and pooling	Once funds have been collected, most likely through NHI premiums and general taxes, most healthcare funds (excluding out-of-pocket expenditure) will be pooled in one fund and allocated based on need.	• Equity	Income cross-subsidisation can be done at premium collection stage. Virtual pooling, risk-equalisation and/or reinsurance, successfully used in systems such as the Netherlands and Germany. Further risk-sensitise the PES formula through use of better data. Fast-tracking of medical scheme PMB review to establish coherent package of services across both sectors.
Purchasing	The NHI Fund will act as the single purchaser of healthcare by entering into contracts directly with accredited healthcare providers on the basis of a basic benefit package.	• Quality • Efficiency • Governance and stewardship	Create a multi-funder environment and allow patients to choose providers. Ensure top-down and bottom-up accountability. Contracting with the private sector can be increased.

Service delivery	Accreditation is used to guarantee a minimum level of quality. The private sector will be contracted to provide primary healthcare, however there is no mention of contracting with private hospitals or specialists.	• Equity • Quality • Efficiency • Governance and stewardship	Procurement legislation is to become more flexible to allow for private provision of care. A combination of reimbursement approaches such as capitation and performance-based financing, along with strong accreditation mechanisms, incentivise improved service delivery.

7.1 Revenue collection and pooling

Revenue collection refers to the way in which a health system is funded. Examples include general taxation, taxes that are directed specifically to health and household/employer contributions to health insurance.

Pooling refers to the accumulation of money for healthcare for a specific population, such that the contribution by a specific household is not necessarily equal to their expenditure. Money can be accumulated in government departments, funding vehicles such as medical schemes or a new entity like the NHI Fund. Pooling offers the benefits of pre-funding, and the engineering of income and risk cross-subsidies (i.e. between healthy and sick, young and old).

What is proposed under NHI, and which UHC goals will it satisfy? The revenue collection components of NHI are not yet clear, but the fact that the NHI Bill puts forward a complementary role for medical schemes is driven by the assumption that the revenue currently spent on medical schemes will rather be channelled towards the NHI Fund. However, there is likely to be some degree of leakage, not yet quantified, from the financing system and, hence, the assumption that all money currently spent on medical schemes will be available for NHI is incorrect. The NHI benefit package, referral pathways, clinical protocols and queues are unlikely to be a substitute for the current care provided in the private sector, with reduced cover for elective care and less freedom of choice.

Revenue collection is likely to occur through some type of payroll tax for the formally employed and probably general tax increases. The fiscal allocation will be pooled in one fund, the NHI Fund, with a clear split between the purchaser and the provider (see below for discussion on the purchaser function).

Pooling all funds into one pool and allocating them based on need through a basic benefit package is thought to help meet the goal of improved **equity.**

How could the UHC policy goal of equity be achieved in other ways? There are other ways to achieve the goal of **equity** other than creating a single pool of funds. Income cross-subsidisation can be done at the revenue collection stage, resource allocation to sub-pools can be done on the basis of the needs of the population covered by the pool, and retrospective adjustments can made for higher than expected need. The technical methods used to balance resources between sub-pools are referred to as **virtual pooling, risk-equalisation** and/or **reinsurance,** and have been used successfully in systems such as the Netherlands and Germany. There is a parallel to the existing **provincial equitable share (PES) formula** which effectively splits the budget on a risk-based per capita basis. The PES can potentially be made more risk-sensitive by drawing on detailed improved population health data as these become available. The **fast tracking of the medical scheme PMB review** will also move us closer to a basic benefit package that is coherent across both sectors.

7.2 Purchasing

The **purchasing** function in a healthcare system is about deciding how to allocate money from the pool to providers of care. This means deciding what services to purchase for which client,[1] and how to pay for them. The terms purchaser and payer are sometimes used interchangeably, although it is possible to separate payment and purchasing functions. Our focus is on the concept of a purchaser because it is more strategic in nature. The term payer de-emphasises the need for explicit thought to be given to questions of what to purchase, from whom and on what terms.

What is proposed under NHI and which UHC goals will it satisfy? The NHI Fund is to act as the single purchaser of healthcare by entering into contracts directly with healthcare providers. Through the establishment of the NHI Fund as a purchaser, a clear purchaser-provider split will be implemented. Purchasing will be done based on a basic benefit package, yet to be defined. The intention is to select providers based on criteria such as the quality of service, geographical footprint and service capacity. The OHSC will play a certification function, assessing which providers meet minimum norms and standards, with the Fund being responsible for final accreditation. Providers that satisfy certification criteria and some additional accreditation requirements set by the Fund will be granted accreditation, and will thus be eligible to contract with the Fund. To date the OHSC has highlighted severe and widespread quality failings in the public sector, and it is unclear what the process is to ensure improvement within the envisaged timelines.

Accountability, and ultimately **quality** and **efficiency,** are expected to increase because of a more arm's length contracting relationship between the purchaser (the NHI fund) and providers of care (for example, individual public and private facilities). There is also an implicit assumption that by moving the direct funding (rather than purchasing) of healthcare away from PDoHs, **governance and stewardship** of health resources may improve through centralisation. There is, however, no evidence to support this assumption.

A key effect of the purchaser-provider split in the South African context is that it enables the NHI Fund to purchase healthcare goods and services from private healthcare providers in a way that is more flexible than under current procurement rules. For example, currently the public sector would need to enter into individual contracts with providers if they wanted to contract services from the private sector. Under the purchasing scenario set out in the NHI Bill, the provinces effectively move from being purchasers and providers currently to being primarily providers of care. The ability to purchase from both sectors is referred to as pluralistic purchasing.

There is a range of ways in which the purchaser can drive accountability through pluralistic purchasing. For example, the purchaser can put in place requirements, such as minimum quality standards, that providers have to meet in order to be contracted (ideally accompanied by mechanisms for driving quality improvement in those facilities that do not meet the standards). The purchaser can also pay providers based on the quality of care delivered, by using health outcome data to measure impact. Both of these concepts are articulated in the draft NHI Bill (29) at a conceptual level.

How could the UHC policy goals of quality and efficiency be achieved in other ways? It is important to recognise that the theoretical benefits sought through a purchaser-provider split are not always achieved. A single purchaser is not enough to change incentives – attention must be paid to how providers are contracted, how the purchaser measures their performance, and how the purchaser addresses poor performance. There are inherent risks associated with a large bureaucracy – an insufficiently motivated monopsony and the scope for large-scale corruption. In fact, many of the recent corruption and irregular expenditure scandals in South Africa have occurred in national-level and centralised bodies, including the Passenger Rail Agency of South Africa (PRASA) (30) and, most recently in the wake of the Covid-19 pandemic, the Unemployment Insurance Fund (UIF) (31).

---

[1] The term client is used instead of patient, because not all users of a healthcare system are ill. The envisaged health system encompasses preventative care, family planning and other services for those who are well. The term client is preferred to the term user as it more strongly signals the centrality of those receiving services in the system (as opposed to being passive recipients of care).

Much of the allure of a purchaser-provider split relies on the effects of competition between providers (see below) to incentivise quality and bring down prices. However, even in high-income countries like the United Kingdom, where there is a long-standing purchaser-provider split, there have not always been enough providers in each regional area for these competitive mechanisms to be key drivers of efficiency. In the case of Kenya, it was found that the purchasing done by the Kenyan Hospital Insurance Fund (KHIF) was not sufficiently strong to help achieve the objectives of equity, quality and efficiency (32). This was because provider monitoring and contracting by the Fund was generally weak and due to the limited geographic distribution of certain providers (32). Strategic purchasing will only ever be as good as the technical capabilities of the purchaser and requires access to good data and analytics.

Other ways to achieve the benefits of purchasing without a purchaser-provider split include investing in the resources or **capability for contracting with private sector resources** – this includes how to design contracts and how to determine tariffs. Driving accountability through a purchaser is a 'top-down' approach as opposed to a bottom-up approach where clients are empowered to demand quality care from providers. Ideally, you need both mechanisms in place. An over-reliance of top-down approaches erodes sensitivity to the client voice, their autonomy and their dignity. Further ways to achieve improved accountability, and ultimately also quality and efficiency, would include **giving clients choice** about which funder/purchaser to pay their NHI contributions to and having funders/purchasers compete in a **multi-funder** environment. However, as experienced in the medical scheme environment, the basis of competition is critical. The incentives need to be in place for funders to compete on the basis of their purchasing capability, and the optimal number of funders will require investigation.

7.3 Service delivery

Service delivery is the easiest part of the health system to understand. The service delivery function is performed by all the entities that provide healthcare goods and services. These include doctors, nurses, traditional healers, allied health professionals, pharmacies, and healthcare facilities like hospitals. The entities are referred to as providers, and can be either public or private.

What is proposed under NHI, and which UHC goals will it satisfy? Given the resources such as hospital beds and medical specialists in the private sector, this ability to purchase care from private providers would improve access (33) and thereby also equity, leveraging these resources for the population as a whole. However, the NHI Bill focuses on purchasing primary care from private providers and is largely silent on the possibilities of enabling access to private hospitals and specialists.

NHI holds the potential of simpler pricing and mechanisms for contracting. However, for some providers the accreditation criteria and data collection requirements that will be imposed could lead to an increase in their administrative burden.

Ultimately, we may see competition between public and private providers vying for contracts from the Fund, which could lead to innovation and improvements in the quality of care, as well as efficiency (more services could potentially be provided with the same level of resources). A fair playing field in terms of prices across the two sectors is an important consideration to ensure that competition is possible between the two sectors. Private providers are subject to different cost and financial structures to public providers, for example: value added tax (VAT) applies; there is a need to realise a return on capital; and, at present, there are different rules relating to employment structures.

The notion of competition across the two sectors is politically loaded. Private providers are likely to be concerned about the risk of political pressure to protect public providers from competition from the private sector, while public providers are likely to be concerned about the diversion of funds to private providers. There is a question of equity, presuming a quality differential between public and private providers: which patients will access private providers, and which patients will access public providers? The Bill is largely silent on principles to guide the allocation of funds across sectors.

How could the UHC policy goals of equity in access, quality and efficiency be achieved in other ways? A purchaser provider-split and a single fund are not necessarily required to establish equity through better access to private sector resources, nor are they required to improve the quality of healthcare services available in both the public and private sectors. If procurement legislation were to become more flexible, PDoHs would be able to purchase more services from the private sector, thereby increasing equity through improved access. Even within the current regulatory frameworks there is room for experimentation with purchasing.

Furthermore, improved quality and efficiency can be achieved without establishing a purchaser-provider split. One of the most prominent mechanisms through which quality can be promoted is through **alternative reimbursement approaches.** Neither a fixed-cost approach (salary remuneration), as is the case in the public sector, nor fee-for-service payment mechanisms, as is the case in the private sector, lend themselves to incentivising improving quality. Reimbursement mechanisms that reward high quality care, implicitly or explicitly, can play a large role in improving quality, although some of the pitfalls of performance-based financing (e.g. it may not have a long-lasting impact on organisational culture and the impact dwindles once incentives are removed) may remain and will have to be carefully managed. Ideally, a combination of reimbursement approaches such as capitation and performance-based financing may work best to achieve an optimal level of servicing (avoiding both under- and over-servicing) while also encouraging quality. This, coupled with strong accreditation mechanisms, either through the OHSC or through the establishment of a supply-side regulator as recommended by the HMI, can steer the health system to delivering high quality care (24).

Thailand offers an example of how strategic purchasing through alternative reimbursement mechanisms can work (34). In Thailand, the National Health Security Office (NHSO) acts as the strategic purchaser for the Universal Coverage Scheme (UCS), the scheme which covers the population not covered by the Civil Servant Medical Benefit Scheme (CSMBS). The NHSO uses a capitation approach to remuneration in its negotiation and purchasing of services from the Bureau of Budget representing the Thai Government and its healthcare providers. The purchasing done by the NHSO on behalf of the UHC in Thailand is cited as an example of a strong strategic purchaser (35).

8. ALTERNATIVE UHC DESIGNS

In this section, we present a series of alternative design visions for achieving UHC in South Africa. These are intended to stimulate dreaming, visioning and alternative ideas of what UHC could look like. It is also intended to help break the stalemate in discussions between stakeholders.

There is no one right path to achieving UHC. The conceptualisation of UHC as set out in the NHI Bill is only one, very particular way of achieving the most important objectives underpinning UHC. However, these objectives can also be achieved in other ways, as discussed below. Irrespective of the reform pathway chosen, there will be a role for the private sector in the system. Reform of the system will require stewardship, and the NDoH will need to play this role.

8.1 'Status quo gold standard': No purchaser-provider split and strengthening the public sector

As discussed, there is a strong push for the public sector to first focus inwards, strengthening its hardware and software for NHI implementation. Hardware refers to the tangible components of the health system, like HR, finances, and infrastructure. Software refers to the relationships and culture within the system. There are substantial hardware failings in the current system, such as ailing infrastructure, and scarce human and financial resources. Some of these issues are borne out of systemic software issues, such as poor leadership and governance, while others are a product of an under-invested system. Therefore, to strengthen the public health sector, one would need to approach the challenges with both facets in mind.

We suggest three sets of approaches to drive improved equity and quality of care that do not require the creation of an NHI Fund.

8.1.1 Improving data quality

A way to have better accountability and governance in the health system is by ensuring that the health information systems (HIS) are accurate and up to date, to allow for evidence-based decision-making. Given that HR make up the lion's share of public health expenditure, an appropriate place to start would be the PERSAL system. PERSAL is a National Treasury-owned system which should be an up-to-date record of all government personnel, including details such as where they work and what their role is. PERSAL is unfortunately notoriously inaccurate for several reasons:

- The system is not owned by the PDoHs, and therefore, it is difficult to adjust it to be reflective of the reality on the ground.
- Sometimes a person is hired and placed in the incorrect post on PERSAL, due to errors in capturing or purposefully, as that is the only available post with a budget associated.
- PERSAL needs to be manually updated/analysed to reflect resignations or vacant posts – this makes it difficult to plan around imminent retirements and difficult to hire within the allocated time frame on vacant posts.

Each PDoH should do a PERSAL clean-up and verification process. The National Treasury should support the provinces to be able to allocate staff to their correct posts or provide an option where someone is paid from one cost centre but is allocated to a different facility. The long-term goal would be that PERSAL posts accurately reflect organograms, and that the organograms accurately reflect the need.

By doing this, the system would have a much better idea of how HR are shared across the provinces and districts and ensure that no 'ghost staff' are being paid for services no longer rendered.

The next HIS worth strengthening is the District Health Information System (DHIS). The DHIS2 has been developed to allow for an electronic health record and is slowly being rolled out at facility level. However, training and usage still need to take place. Furthermore, work should begin to translate the patient-level data that will arise in the DHIS2 into cost and health outcomes data. This data should be de-identified and made publicly available for citizens, clients and research use to measure progress in the health system. By actively tracking costs, health outcomes and data stratified by age, sex and condition, the system would be able to begin to measure ***value.*** One would expect that as the system strengthens, we should see an improvement in health outcomes, morbidity and mortality in the public sector users. It will also allow for much more robust planning.

By making data publicly available for measurement, the public sector will start to build trust among its clients and guardians. Validation of PERSAL and other management HIS will reduce wastage in the system, and free up funds for new, necessary appointments. This will showcase better governance of public funds in the public health system. Better data availability for decision-making and health system design will also help to address the UHC objectives of improved **quality** and **efficiency.**

8.1.2 Taking steps toward quality

Certification is one of the building blocks for quality. At its simplest, certification entails the assessment of healthcare facilities, whether hospitals, clinics or other types of health facilities, against a defined set of standards (36).

South Africa began actively working towards certification in 2008, developing the first set of Norms and Core Standards (NCS) in 2010. The NCS were then used to measure public facilities from 2011, with the process managed by the NDoH. In 2013, the National Health Act was amended and the OHSC was set up as a semi-independent certification body.

If the information collected through healthcare quality measurement processes is publicly shared, consumers of healthcare can use this information to make better decisions about where to obtain high(er) quality healthcare. The information then becomes part of a larger accountability process. If the information is actively used by both funders and purchasers of healthcare, as well as clients of the health system, it can help the system to become more efficient by directing healthcare in the direction of providers who are better and more efficient (37). This assumes, of course, that clients will have a degree of choice as to where to access care.

Certification by the OHSC should be a first step in getting public facilities' infrastructure up to standard. The data coming from the OHSC should allow the NDoH and PDoHs to prioritise, with the lowest scoring facilities getting maintenance and infrastructure upgrades first. Infrastructure upgrades can be expensive, and therefore, it may take several years to bring the full sector to an acceptable standard. We therefore suggest that a realistic target is set for each year, and progress is reported on publicly. If the OHSC results do not influence spending decisions, then the assessments will be a waste of limited public resources. The health outcomes published (as described above) should also show the facility where the data was collected, to illustrate the relationship between outcomes and certification, which would shift the sector to measuring ***quality and not just who was able to meet the minimum standard on the day of inspection.***

Publishing data on quality will focus the public health sector on the performance of the health system and the areas that require urgent attention. This transparency will foster trust and create further impetus for better care.

8.1.3 Budget and spending transparency

In August 2020, President Ramaphosa announced that all personal protective equipment tenders and contracts would be published openly, for all citizens to scrutinise. This was an act by the President for the State to be more accountable to its citizens. Organisations like the Budget Justice Coalition and Vulekamali have attempted to make public sector budget data available in an easily accessible format. This has been in partnership with the National Treasury. Making PDoH expenditure data and in-year monitoring (IYM) monthly progress available publicly will assist in more accurate evidence for resource allocation decisions and set up the PDoHs to be more accountable to the public. Furthermore, transversal tenders for key goods and services, managed centrally at either the province or nationally, could assist to bring down costs – but only if the tender prices are made public. This would assist in getting better economies of scale and locked-in unit prices, particularly for routine spending items such as groceries, that would relieve some of the administrative burden and reduce the opportunity for corruption and predatory pricing by suppliers.

There is also a case to be made for using the current resources more equitably. The current process to revise the PES formula is a step in this direction. Including risk adjustment measures that are closely linked to health outcomes is an important way to ensure maximum effectiveness of spend. Currently, the system is characterised by historical budgeting. This embeds annual mis-allocations into the system and makes it difficult for districts and provinces to allocate resources in terms of what their performance data is showing them.

PDoH expenditure data and IYM monthly progress available publicly will assist in more accurate evidence for resource allocation decisions, and set up the PDoHs to be more accountable to the public.

8.2 'NHI rejigged': NHI, but sequenced differently

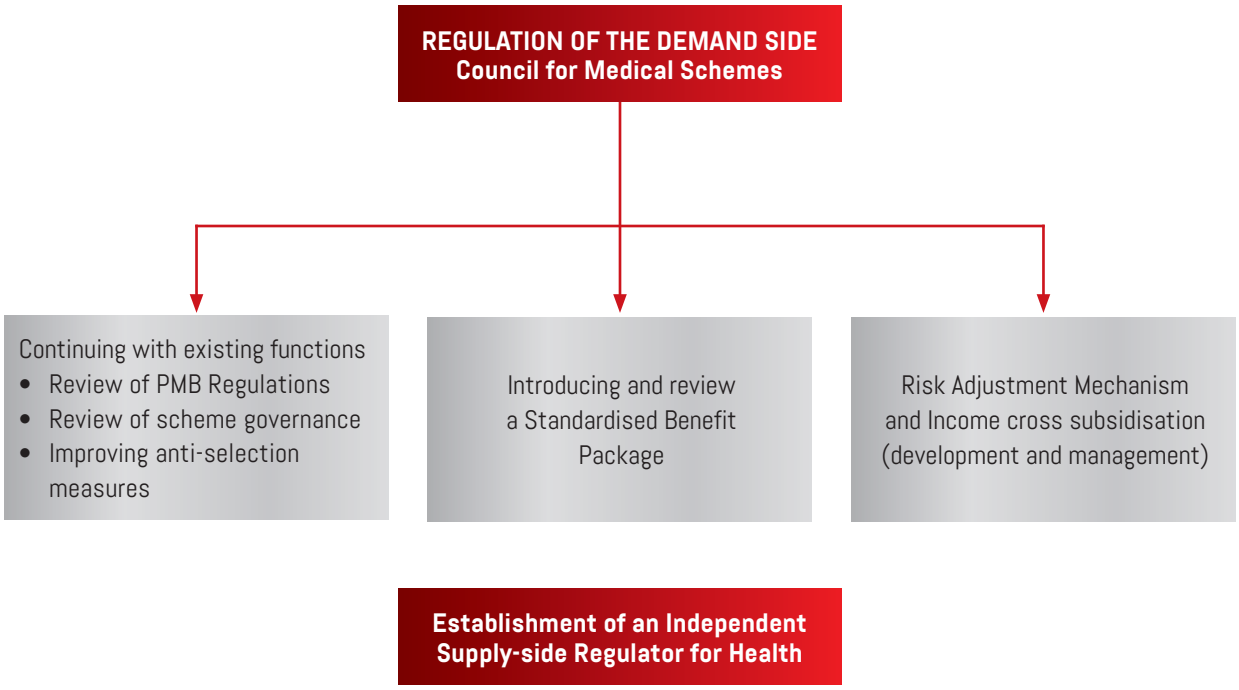
Currently, the NHI has three distinct phases. While the first phase focused on piloting of innovations, the second phase deals with the establishment of the NHI Fund. This is a substantial jump and requires legislation changes such as the promulgation of the Bill. This could take years given the lack of consensus on NHI generally. Therefore, another option to begin implementation of UHC is to sequence the building blocks differently, to lay the foundation for NHI down the line.

8.2.1 Improving equity in each of the sectors (private and public)

The findings from the HMI are clear, and offer implementable solutions to the problem of escalating cost and over-utilisation in the private sector. Given that private sector spend makes up more than half South Africa's total health expenditure, despite only caring for ~16% of the population, its regulation is critical.

The recommendations from the HMI are multiple and are outlined fully in the publicly accessible report (Figure 1). The major take-home in terms of NHI is that the NDoH, in the current regulatory environment, does have the mandate to regulate the private sector, and that it has not fully stepped into this role. This opens the door for more transparency on pricing, pooling, and ensuring quality care and value for money in the private sector.

Figure 1: Some of the key recommendations of the HMI (24)



In tandem with the private sector regulation process, the public health system could embark on the quality improvements discussed earlier in this report (see Section 3.1. Investing in infrastructure, data collection and use, and better resource allocation).

As part of this quality improvement, the Government could also develop the regulations to allow for easier purchasing of private sector services for the public sector population. Furthermore, testing out the contracting mechanism and the work to negotiate fair tariffs could provide test cases for the NHI Fund when it does go live. There is also an opportunity to build trust in this process before the NHI is fully functional, which could ensure more support from private providers. A NHI Fund may also be established to experiment with strategic purchasing from both the private and public sectors on a small scale.

As discussed in previous sections, availability of data is a core tenant of a functional and responsive health system. The NHI Bill currently discusses the need for a central repository for data across the health sectors. This will take time to develop and to ensure smooth dataflow between providers, sectors and funders. Given that this data repository will need to be across the sectors, there needs to be engagement on the specifications, scope and regularity of data.

8.2.2 Improving equity between the two sectors

In parallel to improvements in both sectors, a process of improving equity between the two sectors should be embarked on. This will firstly require the establishment of the same benefit package between the two sectors. As suggested previously, the CMS's PMB review process should be fast-tracked to move the basic benefit package in the private sector closer to the public sector package. A clear basic benefit package for the public sector should also be defined and costed. Once basic benefit packages are operational in both sectors, the key challenge which has to be acknowledged will be moving from multiple funds (medical schemes and the NHI Fund or via the various PDoHs) to a single fund. A risk equalisation fund, allowing for risk-sharing across the two sectors, could assist with the transition process. There could be an interim process of consolidation and putting in place criteria for fund performance across the two sectors, but also for the central risk sharing fund. Over time, learnings from purchasing and the central risk-sharing fund will enable moving to the final end-point of a single NHI Fund.

8.3 'Power to the people': Purchaser-provider split but with multiple purchasers

In the two scenarios presented above, there is an implicit assumption of limiting choice for those citizens that mainly rely on the public sector to one fund or purchaser. In the first scenario, citizens that currently use the public sector will remain reliant on its delivery capacity, and where some services are purchased from the private sector, its purchasing capacity. In the second scenario, the same applies, although a single NHI Fund may be established over time. In both scenarios, choice, and therefore power to citizens, is limited.

Competition between multiple purchasers allow for bottom-up, or social, accountability. Clients of the UHC system should be able to exercise their assessment of the quality and efficiency of purchasing by being able to switch purchasers at least once a year.

Not many countries go for a single purchaser model, and there are some risks associated with this model and the centralisation which accompanies it, such as a lack of competition and sluggishness. Although having a single purchaser brings monopsony power in price negotiations with providers, these benefits may be outweighed by the loss of efficiency through the absence of competition and choice. Given that there are already several purchasers in the private sector who could perform the funder role if need be, it makes sense to develop legislation to allow for multiple purchasers, even if South Africa does decide to remain with the single NHI Fund. The process of enabling multiple purchasers should be up for discussion and thorough review. However, some of the possibilities include allowing the current Government Employees Medical Scheme (GEMS) to act as a purchaser in parallel to the NHI Fund, and putting the opportunity to manage two or more additional purchasers out for bid to the private sector. Any bid document and the selection of the final purchasers should be a public process, with information shared freely.

As long as a carefully designed benefit package is developed, risk pooling and sharing can be implemented through a **central risk equalisation fund.** It is recommended that this fund be free of political management and interference through the implementation of various best practice governance arrangements. A critical learning from the German health financing system has been to keep the bureaucracy that supports the financing system as lean, efficient and technical as possible (15). The German risk equalisation fund (Central Fund) is a system of algorithms managed by a small group of staff at the national insurance office. It is mainly staffed by data scientists who are able to derive and implement these algorithms. The same approach can potentially be taken in South Africa.

South Africans feel the State is not responsive to service provision needs. A much greater level of bottom-up accountability is needed than is currently available in the health system. Selecting a UHC model with multiple purchasers is the most direct way to establish bottom-up accountability.

84 'Reorienting towards value': a value-based approach to UHC

Taking a value-based approach to UHC is strongly coherent with the principles laid out in the South African reform process. The notion of 'value' is about optimising patient outcomes, within a financial envelope. It implies a population health perspective – optimising patient outcomes, not for individual patients, but across the system as a whole – which in turn implies a focus on equity and access.

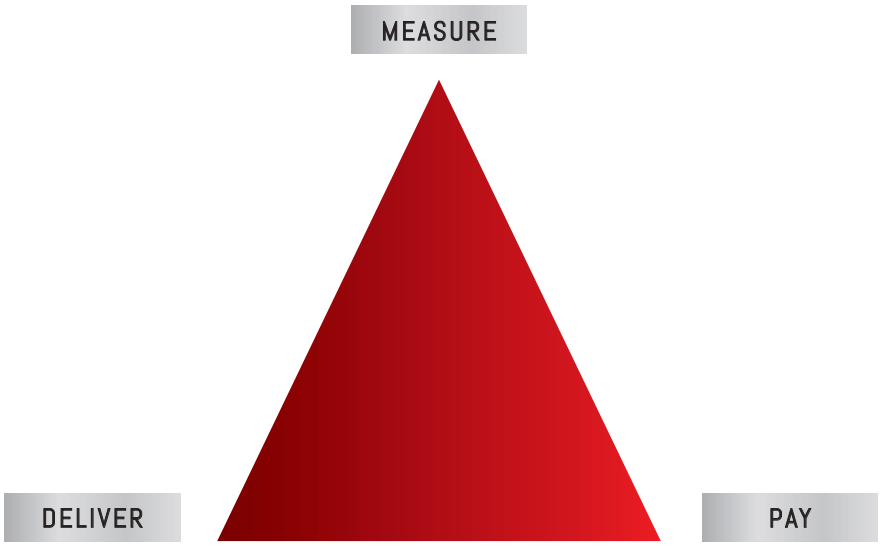
In the conceptualisation of access to quality care for all, it front-ends the notion of quality and forces deeper thinking about what we mean by quality, how to measure quality and how to incentivise quality. Historical approaches to UHC, which focus on the access component of the conceptualisation, **run the risk of orienting health care systems to volume, instead of value.** This creates a long-term sustainability risk because the cost of the system increases as volumes rise. The implicit assumption is that a higher volume of service delivery leads to improved outcomes, but global research indicates that this is not true. The role of volume orientation in the South African private sector is illustrative of the risks associated with this paradigm. Research from the Lancet Global Commission on High Quality Health Systems indicates that "of the mortality amenable to healthcare, 60% is due to poor quality of care, compared to 40% due to lack of access" (4).

Value-based approaches have a continuous improvement mindset built in – something that is lacking in the current articulation of the NHI reforms. With a value-based approach, it is less about accrediting facilities, and more about working with facilities to improve the quality of care that is delivered.

The current policy lens on UHC focuses on scale and centralisation to achieve health system transformation. A value-based approach, by contrast, "requires local specificity and, once validated in the local setting, implementation at scale to truly transform systems" (38). The value-based approach builds accountability in a way that is strongly participatory, leveraging the use of data instead of through the creation of a purchaser-provider split (Figure 2). This directly questions the idea of whether a monopsony can generate the degree of behavioural change required throughout the system.

Approaching the reforms with value located front-and-centre provides an alternative sequencing of reforms by starting with measurement, then focusing on delivery, and only then considering mechanisms to pay for care. This approach to reform sequencing is referred to as the 'Leapfrog to Value' approach which has been designed with low-and-middle-income countries (LMIC) context in mind.

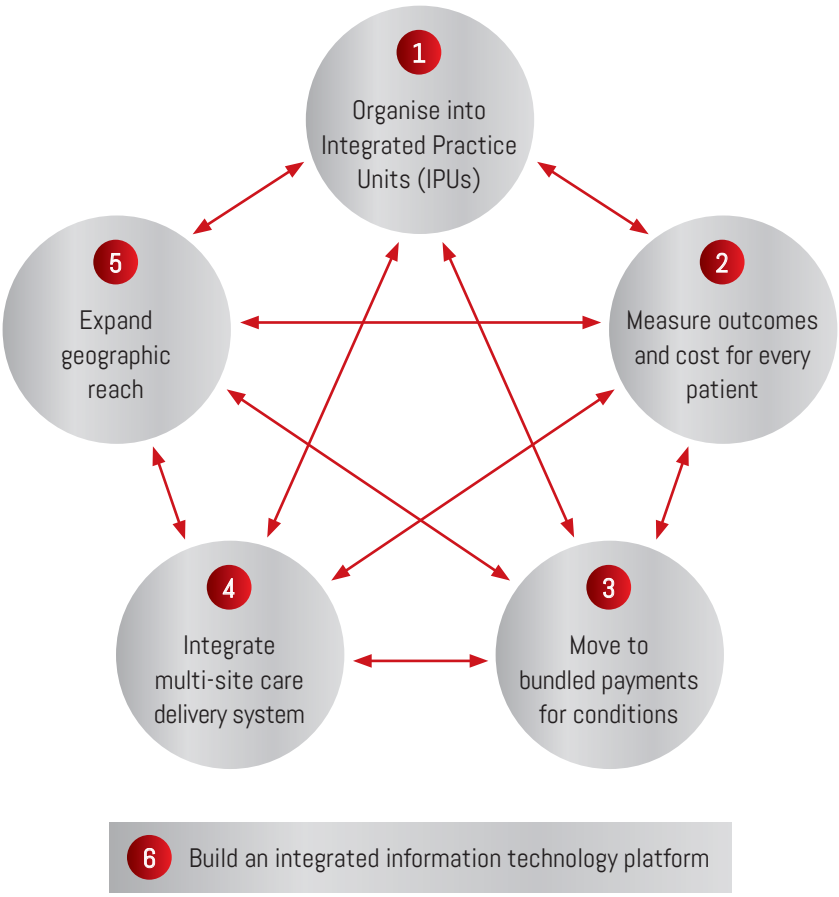
Figure 2: Components of value-based care (38)



The required measurement reforms are significant – they require the tracking of cost and outcome information per patient. The progress to a unified health system begins by measuring the same patient outcomes across the two sectors, reforming the same patient care pathways across public and private providers, and ultimately paying for care in the same way across both sectors.

The Porter model of value-based care also provides some insight into the necessary reforms to support improved outcomes (Figure 3).

Figure 3: Porter and Teisberg model of value-based care (39)



The starting point in the Porter model, requires reorganisation in integrated practice units – these are effectively multi-disciplinary teams. The Health Professions Council of South Africa (HPCSA) regulations currently stand in the way of the creation of these teams in the private sector, pointing to the urgent need for review of their rules (24). The Porter model places more emphasis on payment than the Leapfrog to Value model, reflecting the orientation of the model to the American health system which is largely private. The scope for payment reform that will drive quality improvement behaviours is far more limited in our public sector where staff are salaried and therefore not financially incentivised.

9. CONCLUSION

This document aimed to stimulate thinking around alternative ways that UHC can be achieved in South Africa. There is overwhelming consensus that UHC is an important goal, and that its objectives are ones that South Africa should subscribe to. It is the path to achieving the objectives that has remained contentious. Therefore, in this document, we have proposed alternative pathways for achieving the UHC objectives. The alternative building blocks and scenarios (Table 1 repeated as Table 5 in this section) were borne out of the NHI Bill submissions, interviews and key literature and documentation. The scenarios are not exhaustive or mutually exclusive. Ultimately, we recommend a slow and steady approach to building the foundation for UHC, with several accountability mechanisms built in – both top-down and bottom-up. Regulating the private sector and improving quality in the public sector are two areas of broad consensus that could begin in the interim, even if the private sector is eventually relegated to complementary care only.

Mutual trust between the State, private sector and South African citizens is not just a 'nice to have'. It has been shown to meaningfully improve the rollout and implementation of UHC in other countries. Therefore, the process taken to begin UHC reform is exceptionally important for long-term sustainability of UHC in South Africa. We recommend alternative pathways are sought out, given the stalemate due to the current pathway proposed in the Draft NHI Bill.

Table 5: Summary of alternative UHC design scenarios

Scenario	The crux for the patient	The crux for the system	UHC policy objectives achieved
'Status Quo Gold Standard' 'Status Quo Gold Standard'	Better service delivery through improvements in quality of care and system hardware.	Better data quality and transparency to facilitate evidence for decision-making.	• Equity within the public sector, but not between sectors. • Improved public sector governance. • Sustainability of the public sector strengthened, but costs likely to continue to spiral in the private sector. • Public sector efficiency improved through better data and decision-making. • Minimum quality standard is raised.
'NHI Rejigged'	Better regulation of private sector that will bring down high costs. Improved quality of care in the public sector.	Earlier development of basic benefit package. Development of transitional central risk equalisation fund across sectors to lay foundation for NHI Fund.	• Equity within each sector, and then improved equity between sectors. • Improved governance in both sectors. • Improved sustainability in both sectors. • Efficiency gains as a result of shifts in incentives in the private sector. • Minimum quality standard is raised as equity improves.

'Power to the People'	User given a choice of insurer by allowing for multiple purchasers, but with a centralised risk equalisation fund to ensure equity across funds. This should ensure administration of funds is more responsive to client needs (smaller bureaucracies).	More competition between insurers to encourage better administration of funds. Government is able to hold insurer to account because they are not solely reliant on them.	• Equity across the system as a whole. • Governance strengthened through bottom-up accountability. • Sustainability driven through strategic purchasing and competition between purchasers. • Competing insurers incentivised to drive efficiency. • Quality driven through greater participation.
'Reorienting Towards Value'	Better quality of care. More affordable care.	More cost-effective care. Improved equity between sectors. Better data quality to compare and measure providers.	• Equity achieved over time through alignment across sectors. • Governance strengthened through bottom-up accountability. • Sustainability achieved through orientation towards value. • Efficiency driven through bottom-up reorganisation of service delivery. • Quality becomes the key focus of this approach.

REFERENCES

1. Section27, Treatment Action Campaign. *Submission on the National Health Insurance Bill 2019.* 2019.
2. South African Medical Association. *Comments in respect of White Paper for National Health Insurance for South Africa: towards universal coverage.* 2016.
3. South African Private Practitioners' Forum. *Submission on Draft NHI Bill to the National Department of Health.* 2018.
4. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. *High-quality health systems in the Sustainable Development Goals era: time for a revolution.* Lancet Glob Heal. 2018;6(11):e1196–252.
5. Kruk ME, Ataguba JE, Akweongo P. *The universal health coverage ambition faces a critical test.* Lancet. 2020;6736(20):9–10.
6. Office of Health Standards Compliance. *Annual Inspection Report.* 2018.
7. Inclusive Society Institute. *Universal health coverage pathways for South Africa.* 2020.
8. National Department of Health. *National Health Insurance Policy (White Paper).* 2017.
9. fin24. *Treasury worried about NHI funds not being used as planned, MPs hear.* 2019.
10. Daily Maverick. *Urgent need for payment deal on non-medical aid Covid-19 patients in private health facilities.* 2020.
11. Abimbola S, Baatiema L, Bigdeli M. *The impacts of decentralization on health system equity, efficiency and resilience: A realist synthesis of the evidence.* Health Policy Plan. 2019;34(8):605–17.
12. South African National Department of Health. *White Paper for the transformation of the health system in South Africa* [Internet]. 1997. Available from: https://www.gov.za/sites/default/files/gcis_document/201409/17910gen6670.pdf
13. Waterhouse AS, Mentor-lalu V, Daphine A. *Decision-Making on Health in South Africa – What Can We Learn From NHI?* 2017.
14. Siverbo S. *The Purchaser-Provider Split in Principle and Practice: Experiences from Sweden.* Financ Account Manag [Internet]. 2004 [cited 2019 Jul 16];20(4):401–20. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=611192
15. Inclusive Society Institute. *Lessons for South Africa on Transitioning to Universal Health Coverage from the German Experience.* Cape Town; 2020.
16. United Nations Industrial Organization. *Coronavirus: the economic impact* – 10 July 2020. UNIDO. 2020.
17. World Bank Group. *Global Economic Prospects.* 2020.
18. Statistics South Africa. *GDP falls by 2,0%. Statistics South Africa.* 2020.
19. Statistics South Africa. *Steep slump in GDP as COVID-19 takes its toll on the economy. Statistics South Africa.* 2020.
20. National Department of Health. *2030 Human Resources for Health Strategy: Investing in the Health Workforce for Universal Health Coverage.* 2020.
21. National Department of Health. *Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams.* 2018.
22. Daviaud E, Besada D, Council SAMR, Budlender D, Sanders D, Kerber K. *Saving lives, saving costs Investment Case for Community Health Workers In South Africa.* 2018.
23. Bennett R, Marcus TS, Abbott G, Hugo JF. *Scaling community-based services in Gauteng, South Africa: A comparison of three workforce-planning scenarios.* African J Prim Heal Care Fam Med. 2018 May;10(1).
24. Health Market Inquiry. *Final Findings and Recommendations Report.* 2019.
25. Kutzin J. *A descriptive framework for country-level ananlysis for health care financing arrangements.* Health Policy (New York). 2001;56(3):171–203.
26. Percept. *Strategic Purchasing Policy Brief Series Brief 1: Implementation of a purchaser-provider split.* 2019.
27. Percept. *Strategic Purchasing Policy Brief Series Brief 2: What is strategic purchasing?* 2019.
28. Percept. *Strategic Purchasing Policy Brief Series Brief 5: Certification, accreditation, quality measurement and quality improvement.* 2019.
29. National Department of Health. *National Health Insurance Bill* [Internet]. Pretoria: Government Gazette; 2019. Available from: https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf

30. Malingo B. *Prasa suspends 12 senior officials to root out "corruption and fruitless expenditure."* Times Live [Internet]. 2020 [cited 2020 Sep 29]; Available from: https://www.timeslive.co.za/news/south-africa/2020-03-13-prasa-suspends-12-senior-officials-to-root-out-corruption-and-fruitless-expenditure/
31. Nicolson G. *UIF bosses suspended as auditor-general details Covid-19 relief chaos.* Daily Maverick [Internet]. 2020 [cited 2020 Sep 29]; Available from: https://www.dailymaverick.co.za/article/2020-09-02-uif-bosses-suspended-as-auditor-general-details-covid-19-relief-chaos/
32. Munge K, Mulupi S, Barasa EW, Chuma J. *A critical analysis of purchasing arrangements in Kenya: The case of the national hospital insurance fund.* Int J Heal Policy Manag [Internet]. 2018 Mar 1 [cited 2020 Sep 29];7(3):244–54. Available from: https://pubmed.ncbi.nlm.nih.gov/29524953/
33. Dell AJ, Kahn D. *Geographical maldistribution of surgical resources in South Africa: A review of the number of hospitals, hospital beds and surgical beds.* South African Med J [Internet]. 2017;107(12):1099. Available from: http://www.samj.org.za/index.php/samj/article/view/12143
34. Patcharanarumol W, Panichkriangkrai W, Sommanuttaweechai A, Hanson K, Wanwong Y, Tangcharoensathien V. *Strategic purchasing and health system efficiency: A comparison of two financing schemes in Thailand.* Fan VY, editor. PLoS One [Internet]. 2018 Apr 2 [cited 2020 Sep 29];13(4):e0195179. Available from: https://dx.plos.org/10.1371/journal.pone.0195179
35. Hanson K, Barasa E, Honda A, Panichkriangkrai W, Patcharanarumol W. S*trategic purchasing: The neglected health financing function for pursuing universal health coverage in low- and middle-income countries: Comment on "what's needed to develop strategic purchasing in healthcare? Policy lessons from a realist review."* Int J Heal Policy Manag [Internet]. 2019 Aug 1 [cited 2020 Sep 29];8(8):501–4. Available from: http://ijhpm.com
36. Jovanoviæ B. *Hospital accreditation as method for assessing quality in healthcare.* Arch Oncol. 2005;13(4):156–7.
37. Carvounes A, Childs B, Dreyer K, Kantor G, Ranchod S. *Quality Measurement and Reporting in the South African Private Hospital Industry*. Cape Town; 2017.
38. Leapfrog To Value. *How nations can adopt value-based care on the path to universal health coverage.* 2019.
39. Institute For Strategy And Competitiveness, Harvard Business School. Key Concepts.

NOTES

INCLUSIVE SOCIETY
INSTITUTE

This report has been published by the Inclusive Society Institute.

The Inclusive Society Institute (ISI) is an autonomous and independent institution that functions independently from any other entity. It is founded for the purpose of supporting and further deepening multi-party democracy.

The ISI's work is motivated by its desire to achieve non-racialism, non-sexism, social justice and cohesion, economic development and equality in South Africa, through a value system that embodies the social and national democratic principles associated with a developmental state. It recognises that a well-functioning democracy requires well-functioning political formations that are suitably equipped and capacitated. It further acknowledges that South Africa is inextricably linked to the ever-transforming and interdependent global world, which necessitates international and multilateral cooperation. As such, the ISI also seeks to achieve its ideals at a global level through cooperation with like-minded parties and organs of civil society who share its basic values.

In South Africa, ISI's ideological positioning is aligned with that of the African National Congress (ANC) and others in broader society with similar ideals.

www.inclusivesociety.org.za