Spotlight on NHI: Q&A with the head of the NHI office – The Citizen 23 October 2019

By Marcus Low for Spotlight•

Some key questions about NHI have crystallised in recent months. Spotlight put 12 of these questions to Nicholas Crisp, head of government's NHI office.

Commentators have in recent months raised many questions about how South Africa's proposed National Health Insurance (NHI) system might function – or not function. Spotlight formulated 12 of these questions and sent them to Nicholas Crisp, the person heading up government's NHI office. Below we reproduce Crisp's answers in full.

Q1: What happens if there are not enough Office of Health Standards Compliance (OHSC) accredited facilities in an area?

Imagine for example a small rural town where the only health facility is poorly managed and cannot be accredited. Does the fund accredit this under-performing facility, or does it not accredit the facility and leave the people of the town with no facility?

Crisp: The OHSC is a statutory compliance body responsible for measuring compliance to the standards set by the National Department of Health. The NHI is a financing mechanism managed by a body to be known as the NHI Fund. The NHI (and fund) are not the health services and will not deliver any health services. Services bodies are either public (provincial and local governments) or private. The NHI Fund will be responsible for accrediting providers (public and private) that will be providing health service benefits in the NHI benefits package and who will be paid by the fund for that service.

So, there are two issues here: i) a process to measure and systematically improve quality as defined in standards; and ii) accreditation to render a set of services for which the NHI Fund considers the provider to be safe and competent to do. Neither of these processes is punitive. The whole purpose is not to disadvantage the public (and often the poorest have access to the poorest performing services) but to increase access to services of constantly improving quality. The detailed methods and operating procedures to do this are all part of this coming phase of the roll-out.

Q2: Will the OHSC's standards for accreditation be lowered to allow for NHI?

Most public healthcare facilities currently do not meet OHSC standards and the last decade suggests that a massive improvement of facilities by 2026 is unlikely – something that will leave many public sector facilities unable to contract with NHI if current OHSC standards are maintained.

Crisp: This is partly answered above. Standards refer to national health systems, norms and standards. These standards include measures of:

- Patient safety;
- Clinical care;
- Governance (management, finance, procurement, human resources, ICT, corporate governance, quality, risk, research, and communication);
- Patient experience of care;
- Access to care;
- Facilities, environment and infrastructure; and
- Public health

The fund is responsible for "strategic purchasing", the strategic aim of which is to catalyse health systems and service improvement. The NHI Fund will purchase from whichever provider/s offer(s) the appropriate services of the best quality to the public. To participate (and by implication be paid from the fund), a provider must have acceptable "standards" and will be accredited to deliver only those benefits that, in the opinion of the fund, it can do. The fund will work with all providers, including the public sector, to find ways to improve any providers whose standards are unacceptable.

Q3: Apart from the threat of not contracting a facility, what leverage will there be under NHI to improve the quality of service provided at a facility?

The underlying concern here is that facilities will be incentivised to do just enough to remain contracted, but that there will be little incentive for facilities to excel beyond that. Holding chronically under-performing facility managers accountable is already a challenge in the public sector – without the current competition in the private sector, the same might happen to private sector facilities.

Crisp: The health service delivery system has its own drivers and leverage to improve services. The challenges that the public service experiences differ from province to province and from one locality to another. Clearly, the public service must provide many services that are (in the pure sense) economically not viable, and they use budget methods to cross-subsidise and disburse resources as equitably as they can. Introduction of accredited private providers will already introduce competition for the public facilities, but by design will also provide mentorship and support to public service units. New leverage methods under discussion in the public sector include arranging governance interventions such as strengthened participation by communities through facility boards/committees and substantially greater delegated authority to the periphery, with sanction for non-performance. The balance is to use both incentives and sanction as motivational methods.

Q4: Why is the minister of health given such extensive powers in the NHI Bill?

A number of commentators have expressed concerns about the minister's extensive powers and pointed out that it opens the NHI Fund and NHI systems up to political interference. Given our recent history with State Capture, this seems extremely risky.

Crisp: A major challenge in the present system is its enormous complexity. By design, reinforced by the budget processes, the national minister is reduced to the executive head of the national Department of Health, rather than being accountable for the health of the nation. There are complex structural limitations that undermine cohesion and executive accountability. The NHI Fund will fundamentally change the way that benefits are accessed (services are delivered) because of the purchaser/provider split. The realignment of the public sector (function shifts) and of the private sector will be driven by who pays and how. The governance arrangements provided for in the bill seek to restore accountability of the minister of health for the whole health system. Implicit in establishment of a Schedule 3A (of the Public Finance Management Act) entity is a set of very tight reporting requirements, and no borrowing powers. The boards of Schedule 3A entities (there are 147) all report to line ministers. Whether there are further checks and balances that can be introduced into the process of selection of board members is something that stakeholders have raised, and this is likely to be considered by Parliament.

Q5: What mechanisms and structures will there be to help normal people to hold district health management offices (DHMOs) and contracting units (CUPs) accountable?

The NHI Bill is not clear on how accountability will work at a local level and how the consultative structures envisaged in the National Health Act will look under NHI. It seems clear that local level accountability structures will be key to making NHI work, but the bill is silent on such structures.

Crisp: This is quite correct, local accountability is paramount to improving the services. But this is not an NHI Fund function, it is a function of the providers. As listed above, one of the core standards that OHSC measures is governance (management, finance, procurement, human resources, ICT, corporate governance, quality, risk, research and communication). So, while the NHI Bill provides for DHMOs and CUPs, the detail of how these building blocks will function in the system must be provided for in the National Health Act and its regulations (which is what s36 and s37 of the NHI Bill state). A lot of work has been done on DHMOs, and provincial departments of health are systematically remodelling the design and function of their district offices. Work has also been done on "sub-districts" and, over time, these will transform into CUPs.

Q6: Why are district health management offices defined as components of national government?

This appears to be a centralisation of both power and management. It risks making the healthcare system less sensitive to local contexts and less accountable at a local level. It also raises questions regarding the reduced role of provincial departments of health under NHI.

Crisp: This observation is valid and has been raised by many commentators. The role of provincial departments of health needs to change as the NHI Fund prepares to purchase health benefits (services) directly from public hospitals and collectives of PHC providers. The intention is that provincial departments of health must play a far more direct role in policy formulation at national level (through the National Health Council) and that they must be the custodians of governance and oversight over the services, rather than their present role of purchaser and provider. These changes will evolve in this next phase of NHI implementation. Parliament will likely debate the functions and form of district health management offices.

Q7: How transparent will the dealings of the NHI Fund and related structures be?

Given South Africa's recent history with corruption, it seems critically important that the management of the NHI Fund is as transparent as possible. The public should, for example, be told why one private facility was contracted with the NHI fund while another was not contracted. The public should also be given detailed justifications for the inclusion and exclusion of treatments in the package of NHI benefits. Unfortunately, the bill hardly mentions transparency – which is worrying since transparency in the public healthcare sector currently varies from good in some areas, to very poor in others.

Crisp: The systems being developed to support the NHI functions allow for a high degree of transparency. Benefits, and the process of deriving them; accredited providers, and their performance scores; user registration statistics; the Fund bank accounts and cash flow; procurement of goods and services, as well as price setting will all be transparent. OHSC inspection reports are already on that entity's website and they have published their PAIA policy on the site. The NHI Fund, once it is a juristic entity, will do the same.

Q8: By how much will South Africa's total health spending (public plus private) increase or decrease under NHI?

There has been some confusion over how the financing of NHI will work with some commentators asking serious questions about the available numbers. It is understood that public sector spending will increase through various forms of taxes, but it is not clear by exactly how much and how taxpayers at various income levels will be impacted. An additional extra R30-billion raised through taxes etc has been mentioned, but what is the longer-term trajectory? It is also not clear exactly how private medical schemes will be impacted and by how much medical scheme contributions are anticipated to decrease. As in other areas, the more reliable estimates we have on the table, the more informed our public discourse on these issues will be.

Crisp: This is a lengthy discussion with many ifs and buts. The starting point is that the country spends about 8.5% of GDP on health. Just under half is paid directly from taxes through budget allocations to organs of state (mostly provincial departments of health but also Correctional Services, military, municipalities and the national department). Citizens and others in the country spend a similar amount to purchase services privately (mostly pre-financing through medical schemes, but also significantly out of pocket cash). Both sectors are failing. The public sector can't cope with the sheer volume of work and the private sector has begun to price itself into extinction. Together the systems have failed to achieve a situation where the public is protected from catastrophic disaster due to ill-health, and access to services is as inequitable as it was pre-1994. The NHI is predicated on the principles of social solidarity and equity (large single pooled fund to spread risk through formulae-based allocation and strategic purchasing). How to do this is complex and will evolve over time. The challenge is how to affect the redistribution without eroding services. And this is where additional funds arise. If new money is added to the pool, then there is less need to "shift" resources in the existing pool. However, there is a lot of room to shift resources. There is waste in both public and private sectors and it is the elimination of waste that will reduce the need for new funds. At the same time, there are some service deficiencies where new funds are needed.

In times of economic abundance, new funds are more available and many changes can be effected simultaneously in a short time-frame. The corollary is true, and that is where we find ourselves. So, the simple truth is that less change is possible now than was hoped for. This means that the NHI Fund will be able to procure a more constrained set of benefits initially. It does not change any of the imperatives to improve the public sector services and to regulate the private sector appropriately in the coming five or six years. The R30-billion that is mentioned is to introduce a set of additional services that are designed to reduce inequitable access for the poor.

As far as the source of funds is concerned, s48 of the NHI Bill describes a range of sources but the bulk of NHI funds will come from tax via the fiscus (national revenue account) in an annual allocation approved by Parliament. (Cash is usually drawn down weekly.) Money matters are the function of National Treasury and the minister of finance. Although the bill raises the possibility of a payroll tax (remembering that voluntary contributions to medical aids that the employed public has become used to will largely disappear), the decision as to how to raise the money for health services rests with the minister of finance using the laws that s/he administers.

Theoretically, the NHI Fund can be implemented with no additional funds but that will severely curtail the ability to use the money lever to reshape healthcare delivery.

Private medical schemes will be impacted, as benefits are designated and they are disallowed from providing cover for that growing list. Medical scheme contributions are not anticipated to decrease. On the contrary, by their very nature the cost of belonging to a medical scheme will continue to rise.

Q9: What will the relationship be between the Office of Health Products Procurement (OHPP) and private facilities?

The NHI Bill proposes the establishment of an OHPP. It is not clear whether private facilities contracted under NHI will be able to purchase theatre beds (for example) from the open market, or only through the OHPP. If the latter is the case, private procurement will in effect become part of public procurement – something that in worst-case scenarios could leave private facilities with no choice but to purchase sub-standard equipment and to purchase from corrupt companies. (Spotlight has previously reported on the state's purchase of allegedly sub-standard equipment.)

Crisp: The Office of Health Products Procurement will provide a "centralised facilitation and coordination of functions related to the public procurement of health-related products, including but not limited to medicines, medical devices and equipment" (s38). This section describes the interaction with other functions so that the goods required are available to all NHI accredited providers at the published prices from all approved suppliers. Once again, the detailed policy, operating procedures and enabling digital platform must still be developed and rolled out. Any provider may procure goods other than those on the lists, but they will then be responsible for their own price negotiations.

Q10: Do you anticipate that public sector medicines prices will increase or decrease under NHI?

It is sometimes argued that high private sector medicines prices in effect subsidise low public sector medicines prices in South Africa. Whether this is true or not, it is true that private sector medicines prices are typically much higher than public sector prices. By bringing most purchasing of essential medicines under the NHI umbrella, might we not end up with prices that are higher than the current public sector prices?

Crisp: As part of benefit determination, clinical guidelines are developed and the Essential Medicines Lists and Essential Equipment Lists are constructed, and volumes predicted. As is the present case, prices are negotiated with volume as a strong lever. The real cross-subsidisation of any medicine price depends on many factors, of which volume is a significant element. The epidemiological profiles of public and private users currently are different, so which medicines are "subsidised" and by how much is unclear. International benchmarking of prices helps to keep domestic prices real.

Q11: Do you anticipate that the income of medical specialists will decrease under NHI?

The work of at least some types of medical specialists is likely to fall entirely, or almost entirely within the scope of conditions and treatments covered by NHI. This will mean that specialists can only charge NHI rates – which is likely to be substantially lower than their current private sector rates. Balancing the better regulation of specialist rates with the need to attract and keep specialists in the system is a difficult challenge – but one we must face head-on.

Crisp: Since I don't have insight into the income of private medical specialists, nor even their practice costs, any speculation will be ungrounded. With or without NHI as a purchaser, the cost of specialist services will come under the spotlight following the Health Market Inquiry (HMI) report. The NHI Fund will reimburse according to prices set for each published benefit. It will take some time to get to a point of price negotiations. What is more likely to impact on medical specialists will be the mandatory gatekeeping principle of patients entering the health system at PHC level (mostly GPs for patients presently using the private sector). The aim is to reduce the use of specialists in the care of uncomplicated conditions. However, there is abundant specialist care required by the presently uninsured population, so the numbers of really ill patients who will be referred for specialist services will (at least partly) offset those "lost" to gate-keeping. What we can confidently predict is an evolution of services to a more equitable balance. How the NHI Fund engages with providers and how prices are set is also something open to engagement and discussion.

Q12: Do you anticipate that the profitability of private hospitals and private hospital groups will decrease under NHI?

It seems likely that NHI will introduce price controls that will make it harder for private hospitals to be as profitable as they are now. This view is supported by the fact that hospitals will have less choice of who to contract with, since the NHI fund will be by far the largest purchaser of private hospital services from 2026. This change is likely to have an impact on the private hospital sector, and accordingly on the quality and nature of their services. How well do we understand what that impact will be?

Crisp: With or without NHI as a purchaser, the profitability of private hospitals and private hospital groups is likely to decrease. The HMI report has exposed various practices that are driving costs up and there will be a process to regulate the sector better. The NHI as a purchaser of services has a mandate to reduce the cost of healthcare to improve access to more people. This applies whether services are provided by private providers or the public sector. The essence of the negotiation on prices will be on fair practice, bearing in mind costs. The last comment is that the state has a constitutional obligation to all people living in the country. The service design and prices paid will be guided by universal health coverage principles and measurement. The focus is on the patient, and the income of the providers must be balanced by what is fair value for service. **MC**1

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