How the National Health Insurance will change how healthcare is bought, sold and managed – Fin 24 Jan 29 2020

The NHI Bill has led to heated debate. Some media coverage of the Bill demonstrates a lack of clarity about the proposed reforms.

However, much of the controversy is attributable to different levels of 'buy-in' to the NHI's goal: Moving towards a universal healthcare system underpinned by principles of universality (i.e. everyone benefits, not just a privileged few); and social solidarity whereby there are both income and risk cross-subsidies in the overall health system.

Universal healthcare systems are a fundamentally redistributive policy, and as such, it is not surprising that it has generated intense debate.

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The NHI Bill can and must be improved, but it provides the basis for moving to a universal healthcare system. It is 25 years since the first democratic elections, and there must be greater and faster progress in addressing the serious challenges facing the South African health system. This can only happen if the public conversation focuses on how best to obtain a universal healthcare system, backed with clear explanations of how any proposed reforms will achieve this goal.

Substantial progress cannot be achieved by 'fiddling around the edges' of the status quo. Fundamental system-wide changes are required.

Most obviously, the NHI proposes a change to how healthcare is funded and will introduce a single pool of tax money, allocated to the NHI Fund, for health services benefiting everyone.

This is why health funding in South Africa right now just doesn’t work

Once the reforms are fully implemented, medical schemes will only provide "complimentary cover," i.e. cover services not funded under the universal health system, such as elective caesarean section deliveries. The intention of a single NHI Fund is to reduce fragmentation in funding pools for healthcare to maximise income and risk-cross-subsidies.

Currently, the money South Africa uses to buy healthcare sits in several different pockets or "pools" — across dozens of individual medical schemes and also in the public purse. When money is split like this over many, smaller pools — that in the case of medical schemes are accessible only to a privileged few — this limits any one pool's ability to enable cross-subsidisation based on income or risk. In other words, with so many different pots of money the country is unable to effectively use funds from the rich to help cover the poor or payment from more healthy people to offset costs incurred by those of us who are sicker.

But when a single body like an NHI Fund purchases services for the whole population, international experience shows it comes with very low administration costs. In South Korea's model, administration costs amounted to 3.6% of total health expenditure. In Thailand, the figure was less than half that, shows research published in 2016 in the *South African Medical Journal*.

Yes, your taxes could go up, but what you spend out of pocket on healthcare will likely go down

When it comes to changes in taxes, proposed changes relate mainly to gradually increasing tax funding for the health sector, including introducing new "NHI-related" taxes. This is in line with international evidence that this kind of mandatory prepayment financing is critical for a universal health system.

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This isn't just about a simple absolute increase in tax funding, but more importantly, it represents a change in the relative share of overall health financing that taxes make up.

Meanwhile, contributions to medical schemes and out-of-pocket payments will likely decline over time in the absence of user fees at public hospitals and through a relative shift away from voluntary insurance, co-payments and benefit restrictions.

The NHI will change how our healthcare is managed. Here's why.

But probably the most significant proposed change relates to purchasing, mainly how an NHI Fund will strategically buy health services for the whole population from both public and private providers. The Fund — and its contracts with private and public healthcare providers — will need to stipulate what kinds of services are covered, as well as what steps people take to access them in what health professionals often call referral pathways.

The state, meanwhile, will have to monitor service provision, including quality and should pay health facilities or professionals for the services they provide in a way that incentivises quality, efficiency and equity in service provision.

In addition to financing changes, several shifts in service delivery and management are needed. Most importantly, operational management of service delivery must be delegated to individual public sector hospitals and groups of local primary health providers, called Contracting Units for Primary Healthcare or CUPs.

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CUPs — which have been successful in Thailand — will consist of all public clinics and community health centres in an area as well as the teams of community healthcare workers that are already linked to these facilities. Ideally, CUPS should also include a district hospital as well as private sector providers to increase access to integrated, comprehensive primary healthcare.

Shifting the management responsibility for service delivery to hospitals and CUPs is necessary to enable facility managers to be responsive to strategic purchasing incentives, and population needs as well as to be held accountable for their performance.

This will, in turn, requires a realignment of service delivery management functions in provincial health departments towards an increased emphasis on oversight and support functions. There will be an ongoing need for national health department involvement in ensuring an adequate supply of health service infrastructure and human resources.

What could these proposals mean for healthcare in South Africa? For one, a single large purchaser like the NHI Fund will hold considerable power in managing increases in provider payment rates, experts argue in a 2017 paper by the World Health Organization. Meanwhile, clear referral pathways between the different levels of care will promote service provision at the lowest possible cost.

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And if the NHI Fund does indeed allocate funding for patients based on local realities — such as levels of chronic illness or the size and age profile of the population in an area — in what economists call a needs-based capitation, this will promote equity in healthcare services across geographic areas. To encourage this kind of equity, a universal health system in South Africa should include patient transport between facilities as a patient benefit, especially to those living in rural areas.

But new healthcare management arrangements also run the risk of becoming a potential source of inefficiency if responsibilities are duplicated among local, provincial and national management layers. This again must be avoided by realigning the functions of existing health department structures (national, provincial and district) in line with the delegation of service delivery management to hospitals and CUPs and centralisation of purchasing responsibilities within the NHI Fund.

The bottom line? The status quo is unacceptable

Finally, there is also an understandable lack of trust in government when it comes to managing and legitimate governance concerns given the last decade of extensive misuse of public funds and weak governance. But this should not prevent efforts to make substantial progress towards fulfilling the Constitutional commitment that "everyone has the right to have access to healthcare services."

Instead, the focus should be on how to ensure good governance. Governance and accountability structures should not only be seen to be important at the level of the NHI Fund but also at the service-delivery and management levels.

The health system status quo is not acceptable; 25 years since our first democratic elections, very little has changed for the worst-off in our society. Indeed, inequalities in income and across many sectors have increased. Taking explicit policy steps to move towards a universal healthcare system will not only improve access to quality healthcare for all but will contribute to the redistributive agenda of the country.

We must recognise that many of the criticisms of the proposed reforms are coming from the perspective of seeking to protect vested interests or a privileged position and are generally at odds with the principle of social solidarity that underpins universal healthcare.

If those criticising the NHI BIll honestly believe that the underlying policy approach is incorrect, then the onus is on them to provide detailed proposals for systemic change and demonstrate how it will achieve a truly universal healthcare system.

The focus of the public conversation should be firmly centred on how best to achieve a universal healthcare system.

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