



SECTION27 Health Reform Briefs

The South African health sector is on the cusp of change. The National Health Insurance (NHI) and a suite of related reforms is to be introduced over the next 15 years, with the selected NHI districts having received funding to pilot NHI-related innovations; the Competition Commission is set to launch a market inquiry into the private health sector; and various public sector reforms are in process, including the training of hospital CEOs, an audit of health facilities and the establishment of an Office for Health Standards Compliance, which will monitor public health services and address complaints of non-compliance.

In an effort to broaden discussion about the different ways in which the health sector is changing and to contribute to research in the sector, SECTION27 has decided to publish a series of technical briefs on health sector reform. SECTION27 seeks to influence, develop and use the law to protect, promote and advance human rights. The briefs will therefore look at reform in the health care sector through the lens of the Constitution and public interest, tying together economics, health systems theory and the law.

DESIGN OF NHI PILOTS IN SOUTH AFRICA - SOME CONSIDERATIONS

The South African Government is in the first phase of its journey towards a National Health Insurance system. This phase is primarily focused on the strengthening of health systems and improvements in the service delivery platform.

On 22 March 2012 the National Department of Health announced the identification and funding of 10 pilot sites that would influence “how the service benefits will be designed, how the population will be covered and how the services will be delivered.”

According to the Department of Health the pilot sites have the following aims:¹

1. To establish district health authorities that will be the contracting agencies for the delivery and provision of health services within a strengthened district health system and test aspects of a district health system. In particular, it will test:
 - The extent to which communities are protected from financial risks of accessing needed care by the introduction of a district mechanism of funding for health services.
 - The ability of the districts to assume the greater responsibilities associated with the purchaser-provider split required under a NHI.
 - The costs of introducing a fully-fledged District Health Authority as a Contracting Agency and the

¹ “NHI Pilot Districts Selection” on 22 March 2012,

implications for scaling up such institutional and administrative arrangements throughout the country.

2. To undertake health system strengthening initiatives in selected pilot districts². In particular it would strengthen primary healthcare, focus on the most vulnerable sections of society across the country and aim to reduce high maternal and child mortality.
3. To test innovations necessary for implementing National Health Insurance. These include the following:
 - The primary healthcare (PHC) package: The pilots would assess utilisation patterns, costs and affordability of implementing a PHC service package. They would also assess whether the health care service package, the primary health teams and a strengthened referral system will improve access to quality health services particularly in the rural and previously disadvantaged areas of the country.
 - The private sector: The pilots would assess the feasibility, acceptability, effectiveness and affordability of innovative ways of engaging private sector resources for a public purpose.

This brief aims at providing an overview of the role of pilot programmes, potential benefits of piloting and key aspects that should be taken into consideration in the design of pilots as we move closer to an NHI system. In this brief we do not assess the current performance of the existing pilots.



The "tent clinic" - Lusikisiki Village Clinic in OR Tambo District, the NHI pilot district in the Eastern Cape

The importance of piloting

Pilot approaches have been advocated as a means to reduce the risks associated with implementing complex health system reforms. They allow policymakers to "try out" alternative arrangements for the health care system in a relatively risk-free way. If policymakers are uncertain about the political support for, or technical feasibility of a new health system design, piloting the reform may allow them to determine these factors before institutionalizing such reforms or implementing them nationwide. More specifically, piloting has a number of advantages including the following:

- Piloting of reforms may generate lessons regarding technical design and implementation that can feed into the further implementation and refinement of the reform;
- Pilot projects offer an opportunity for greater control over the implemented intervention than is typically the case for broad-scale reform. This can contribute to the establishment of a powerful information base about the effects of reform;
- Pilots can provide the opportunity to build capacity in reform implementation through learning-by-doing, prior to attempting more widespread implementation;
- Pilot projects can demonstrate the benefits of reform in a very tangible and experiential manner. This may be important to convert reform sceptics who have difficulty understanding how the proposed reform would work, and can also help develop reform champions.

In the context of the proposed NHI, the pilot programmes should be implemented in a manner that ensures that providers can deliver services and support the decision-making process on alternative policy choices before wider implementation.

The opportunity provided by the pilot experiences is therefore the following:

- The creation of an empirical information base on advantages and disadvantages of alternative reform designs.
- A demonstration of how the new system would work and a test of the feasibility.
- Building capacity for further implementation.

² Division of Revenue Act 5 of 2012.

NHI Pilots in South Africa

In the case of the South African NHI, which encompasses an ambitious and wide-ranging set of healthcare reforms, pilot programmes play an integral role. While the pilots are currently in their first phase, as we move closer to implementation it would be cause for concern if the pilots did not adequately test the various components of the envisaged system. While some aspects of health reform need to be trialed at a national level, there are several components that can be trialed at district level.

Pilot programmes offer a chance to collect data and outcomes on various alternate mechanisms without committing to them on a national scale. For example, different programmes can trial different provider payment mechanisms, or referral systems. In addition, it is a chance to trial the same system across different populations (such as urban and rural populations) to try and understand what adjustments should be made to ensure that the reform runs optimally. While providing decision-making authority to management in pilot districts has the advantage of building district capacity and allowing for context-specific solutions, it can have the adverse effect of all districts choosing to trial the cheapest or easiest innovations. As such, it becomes important for there to be some central direction and allocation of programmes to different districts to ensure that more innovative, but difficult solutions are not ignored. This could be done by fiat, but could also be done in innovative ways, for example, districts could tender to run specific trials (for example, capitation, or Diagnosis Related Groups (DRGs) as alternate provider payment mechanisms). Funding could be allocated on the basis of the difficulty and cost of the pilot.

A NHI system would generally have several components, many of which have different configurations that can be trialed. This section attempts to lay out some of the aspects of the NHI that should be trialed. In particular, we look at the following areas:

1. Baseline data
2. Governance, accountability and institutional structures
3. Provider payment mechanisms
4. Cost control
5. Quality control
6. Benefit packages

1. Baseline data

Pilot programmes can provide an information base to test assumptions about populations and districts. The early phase of the pilot

period can be used to collect detailed baseline data which can serve two purposes, firstly, informing the type of interventions required, and secondly, providing a basis against which indicators can be measured. The type of information that is useful includes the following:

Demographic data on the catchment population:

This can have several components:

- Information that maps the disease burden. This is important for costing and developing a benefit package as well as for providing indicators that improvements in health can be measured against.
- Economic aspects: This can be used to provide information that will feed into national financing strategies. These include the general level of income and structure of the economy in the district, in particular the proportion and rate of increase of the work force in the formal versus informal sector as well as the rate of economic growth. These are relevant for both tax and insurance systems. The larger the informal sector, the greater the administrative difficulties in assessing incomes, setting health insurance contributions for informal sector workers and collecting contributions.
- The characteristics of those that access care: This information can inform the costing and scope of services required (for example, by tracking undocumented migrants that access care, tracking the burden of disease, changes in utilisation etc).

Data on facilities:

We understand that geo-mapping of facilities is occurring as part of the pilot programme. This data would be very useful in providing important information that can be used in various ways, including understanding the extent to which private providers can be contracted, transport subsidies that may be required, facilities that need to be built and the level of care that will be provided at each facility.

2. Governance, accountability and institutional structures

Pilot programmes should test out different means of institutional, accountability and governance structures to determine how best

to structure a NHI. These can include the following:

- Structures for assessing levels of decision-making and responsibility: Pilot programmes should test different organization structures and hierarchies of management, and provide insight into the relative effectiveness of these. At a national level this can include the different means of providing leadership and direction to the district health system, its divisions, departments, units, and services. At district level it can also include areas of responsibility such as the ability to make decisions that relate to the recruitment and development of staff, the acquisition of technology, service additions and reductions, and allocations and spending of financial resources. Data and lessons derived from this can assist the Department of Health in defining the appropriate structure and allocation of responsibility.
- Performance measures: Pilots need to develop performance measures that guide the organization in areas such as: governance, strategic management, clinical quality, clinical organization, financial planning and marketing, information services, human resources, and supplies. The pilots can provide insight into what performance measures can be used and which are ultimately useful.
- Accountability mechanisms: Pilots need to strengthen existing accountability mechanisms and, if necessary, create further mechanisms to facilitate public participation in the monitoring of health care services and ensure accountability. An essential determinant of achieving universal coverage is the extent to which the population has a voice in social policymaking and this is particularly relevant in the context of the social solidarity model that has been developed. As such, the piloting of possible mechanisms is useful for the purpose of establishing the best accountability mechanisms, for ensuring such accountability, and for getting 'buy-in' from the public.
- Reporting mechanisms for active purchasing in order to contain hospital prices and volumes: The active purchaser model seeks to leverage the health insurer's authority and market power to promote value for the patient. Active

purchasers can use a range of tools under the administrative authority from regulation, negotiation, and consumer education to achieve better prices and higher-quality. Since effective active purchasing requires resources, data-driven knowledge of the market and the expertise to negotiate with providers, it cannot be done effectively without appropriate infrastructure. Pilots should investigate the ability to use current information for active purchasing and the type of additional information required.

3. Provider Payment and Service Delivery

Provider payment is one of the key issues in purchasing arrangements and is of fundamental importance in the process of achieving universal coverage since it can greatly affect the cost of cover and hence feasibility. In a system that aims to contract with providers, piloting of different methodologies is essential. Pilots should explore various aspects of provider payment mechanisms.

The design of the payment mechanism is important in ensuring that quality and efficiency is incentivized. Some key considerations are whether to include capital expenditure in provider payment rates, and how best to incentivize efficiency. Some countries cover capital expenditures in their provider payment rates, while others cover all or part of capital costs from other sources, such as national and/or local budgets. Many systems use a combination of one or more of these methods, combining global budgets and rates per individual or day spent at the facility. To address cost-increasing incentives of individualized payment and fee-for-service systems and to introduce efficiency incentives that are absent from global budget reimbursement, many countries are moving toward a system of reimbursing hospitals according to a DRG based system. Other payment methods which offer greater control over total costs include case-based methods, capitation, global budgets and block contracts.

All provider payment methods have their advantages and disadvantages, which relate to the nature of the incentives they provide for over or under provision and care of good quality. International experience shows that payment systems and the incentives they create have a powerful effect on all aspects of health service organization and delivery. The potential for such dramatic effects on the structure and performance of the delivery system make it imperative that provider payment systems be designed with some a

priori analysis of what the new incentives will be and how providers will respond.

Pilot projects should aim to provide evidence and experience in testing out different provider payment methods such as capitation for PHC and case-based payments in hospitals and different performance incentive structures, and should document their outcomes in order to secure future sustainability of the envisaged system.

In addition, pilots would do well in experimenting with developing standardized systems to manage service delivery, implementation of electronic identification of patients, assessing charges, and how hospitals will be able to bill the future NHI fund for services and recover costs (though this is likely to only become more relevant in the second stage of NHI implementation).

4. Cost Control

Cost control is important both from a global perspective within the district system and from a provider perspective. International experience shows that it is necessary for new provider payment systems to be accompanied by mechanisms to control overall health care expenditures. Expenditures can be controlled on the supply side by limiting overall payments that will be made to providers. Regulation of overall health care spending is introduced in some form in many countries. Expenditure caps can be imposed at the level of the total system (UK), at the level of the hospital (Canada), or at the level of the individual provider (Germany). Supply side expenditure controls have proven extremely difficult to impose if health care financing is not channeled through a single payer.

Cost control measures can also be introduced on the demand side by controlling utilization by individuals and imposing cost-sharing that will indirectly reduce demand for health care services. Countries that have relied on demand-side strategies to control costs (US, Korea), have not been successful at containing overall costs, and have introduced economic barriers to obtaining health care that have adversely affected equity.

The pilot programmes should therefore trial different supply side constraints to see what is effective.

For example, where private providers are available, pilot projects should test out the feasibility of contractual arrangements with non-state providers and trial different payment mechanisms that ensure containment of costs.

In addition, given the focus on building up district health systems, pilots should further try out different gatekeeper policies in order to encourage people to access the most local source of care first to reduce avoidable admissions. In order for these policies to be effective, primary care levels must be easily accessible and of good quality, and the referral process needs to work smoothly. Incentives to retain patients at the lowest desirable level should not constrain appropriate referrals.

In addition, different means of structuring district budgets and incentives should be trialed to see what systems are most efficient.

5. Quality Control

Cost containment alone is insufficient, and it is important that indicators that rely on cost-containment are combined with those that assess quality. While the Office of Health Standards Compliance is being established, it will require a range of mechanisms and policies including formal quality control systems, standard treatment protocols, quality standards, peer reviews, random checks of provider practices, shared governance structures etc.

The development of appropriate information systems has been identified as a crucial element of continuous quality improvements in addition to consumer choice as a way to maintain incentives for quality of care. Pilots should aim at testing the feasibility of data collection and enforcement of quality standards to arrive at uniform policies.

To this end pilots should focus on the need to ensure that patients will receive the promised health insurance benefits. This implies that health services that are part of the health insurance benefit package need to exist or be created by the health insurance funds and possible non-compliance by service providers needs to be addressed.



6. Defining Benefits

The determination of a basic package is a process that has to involve research and analysis of data and the answering of difficult political questions mainly relating to which benefits are worth supporting and are affordable and which are not. Pilots are key in collecting the necessary information and data on health seeking behaviour, utilization, risk factors, feasibility and costs in order to inform the policy process, guide investments in cost-effective basic public health services and to decide on the range of services, breadth and depth of coverage and level of cost sharing.

They also provide a key opportunity to learn about cost structures, productivity, performance of public health care providers, priority services, the ability to negotiate and set tariffs with providers, induced demand for health care services and levels of accountability.

International experience shows that the benefit package will in effect be limited by the skills mix, training, medicines and equipment available at different levels of care, as well as by how well referral mechanisms work. It will also be affected by the attitudes of providers and how they choose to ration access.

Whereas some countries choose to decide on an explicit benefits packages (Australia, Malaysia, Mexico, Colombia) some choose to

provide the public sector with recommendations on what types of services should or should not be financed (UK). Other countries have chosen a middle way (Argentina, Chile) where access is not explicitly denied but certain services are explicitly prioritized.

Conclusion

It is clear that the NHI pilots have the ability to enhance the planning, design and implementation of the NHI and to further the aim of meeting constitutional obligations. However, this is dependent on the pilots providing data and information that can direct policy and planning through implementation of a rights-based plan. It is therefore essential that the pilot programmes focus on collecting data that provides a good informational base in line with constitutional requirements and that, where relevant, this data is published and made available for public discussion. The data collection should allow for comparisons across districts and across programmes so that evidence-based decision-making can occur.

In addition, there needs to be a strong role for national decision-making to ensure that all the components necessary for the NHI are trialed across districts and to prevent gaps in information and knowledge from occurring. It is also essential that once the data and information becomes available that it is fully utilised and evaluated, and that these results are published to allow for public engagement with the process and accountability.

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