

Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge?

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1. Introduction

This paper provides input to the *Sub-Committee on the Triple Challenges of Poverty, Unemployment and Inequality* of the *High Level Panel on the Assessment of key Legislation and the Acceleration of Fundamental Change*. More specifically, it focuses on the challenge of unequal access to quality health care.

The terms of reference for this research specify that the focus should be on the *health system*. While there are many factors that influence health such as housing, access to potable water and sanitation, educational status and income levels (termed social determinants of health), these are outside the scope of this paper. Given the focus of the Sub-Committee, there is also a specific emphasis in this paper on *inequality* in the health system.

The paper begins by briefly reviewing some key concepts underlying the analysis presented in this paper. A brief overview of health status and the distribution of morbidity (ill-health) and mortality (deaths) in South Africa is then provided; this provides insights into the need for health services. There is then a detailed analysis of the health system in South Africa, specifically from the perspective of access to and utilisation of health services. This includes, where relevant, a review of health legislation introduced since 1994 in terms of its likely impact on addressing inequality in access to quality health services. As the mandate of the High Level Panel is not only to take “stock of the past performance of the South African legislative sector” but also to ensure “the continued advancement of the sector in executing its constitutional mandate”, the paper then considers recent policy proposals to reform the South African health system, particularly the National Health Insurance (NHI) proposals and alternative suggested approaches.

2. Towards conceptual clarity

Annex 1 contains a glossary of terms of relevance to the issue of inequalities in access to quality health care, and other terms used in the report that some readers may not be familiar with. This section briefly explores three concepts that are fundamental to the focus of this paper, namely access, health service quality and inequality, with further detail about these concepts provided in Annex 2.

2.1 Access to health services

Access relates to the opportunity to obtain and appropriately use quality health services. It is concerned with the “degree of fit” or compatibility between the health system on the one hand and individuals who need to use these services on the other hand. Access is generally seen as being multidimensional or having different elements. In this paper, access dimensions are summarised as: the availability (or physical access), affordability (or financial access) and acceptability (or cultural access) of health services¹. The availability dimension of access deals with whether the appropriate health services are available in the right place and at the right time to meet the needs of the population. Affordability concerns the ‘degree of fit’ between the full costs of using health care services and individuals’ ability-to-

¹ McIntyre D, Thiede M, Birch S (2009). Access as a policy-relevant concept in low- and middle-income countries. *Health Economics, Policy and Law* 4: 179-193.

pay in the context of the household budget and other demands on that budget. Acceptability is concerned with the fit between provider and patient attitudes towards and expectations of each other. Beliefs and perceptions also influence acceptability.

2.2 Quality of health services

The most widely used definition of health care quality is that developed by the Institute of Medicine (IOM)²: "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The IOM further indicates that quality health services should be: effective; efficient; equitable; patient centred; safe; and timely. The UK National Health Service (NHS) has also provided a helpful definition of quality of care, which they see as relating to three areas: clinical effectiveness, patient safety and patient experience³. This could be further summarised as technical and interpersonal excellence.

2.3 Inequality and inequity

Health inequalities are defined as differences in health status between groups within a country. Inequalities across groups are most frequently considered in terms of socioeconomic position, race, ethnicity, place of residence/geographic location, gender and age.

From a health system perspective, inequalities similarly refer to differences across groups such as in access to quality health care. The internationally accepted definitions of health system equity, in relation to financing and utilisation of health of services respectively, are:

- Payments towards funding of health services should be according to ability-to-pay (or income); and
- Use of health services should be according to need.

These definitions imply that an equitable health system will have both income and risk cross-subsidies.

3. Introduction to assessment of South African health system and legislation

The government elected in the first democratic elections in 1994 inherited a highly fragmented health system, with separate public and private health sectors and a multiplicity of health departments in the public sector, including one for each of the 4 former provinces and 10 former 'homelands'. While public sector health services had been officially desegregated in 1988, historically 'black' health care facilities and the 'homelands' health departments had been systematically underfunded during the apartheid era. For example, average per capita public sector health care expenditure was R55 in the 'homelands' compared to an average of R172 in the rest of South Africa in the 1986/87 financial year⁴. Thus, the health system was not only fragmented, but had large disparities in resource distribution between geographic areas and between individual facilities within the public

² Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academy Press.

³ Department of Health (2008). *High quality care for all: NHS next stage review final report*. London: The Stationery Office.

⁴ McIntyre DE (1990). *Public Sector Health Care Expenditure in South Africa, 1970 - 1990*. Cape Town: Health Economics Unit, University of Cape Town.

sector. Although South Africa was already devoting a relatively large amount of resources to the health sector (8.5% of GDP in 1992/93), it had very poor health status indicators relative to comparable middle-income countries, indicating poor use and distribution of available health care resources⁵.

Since 1994, a range of legislation and policies has been introduced; an overview of the key health legislation is provided in Annex 3. In addition to the National Health Act, which provides the legislative framework for the overall health system, several of the other Acts have focused on regulating different health professionals (establishing professional Councils to regulate training and take disciplinary action where necessary, introducing a year of compulsory community service, etc.), or on specific health issues such as unwanted pregnancies (Termination of Pregnancy Act), mental health and the control of tobacco products. Other significant legislation since 1994 relates to the re-regulation of medical schemes, the establishment of the National Health Laboratory Service (NHLS) and taking steps to improve access to medicines.

Instead of considering each piece of legislation in detail and in isolation, the following sections consider issues around equitable access to quality health services and make reference to relevant legislation, and its potential role in addressing the inherited health system challenges, as part of this assessment. Before presenting the health system assessment, a brief overview of current and recent trends in health status is provided; this provides insights into the need for health services in the South African context.

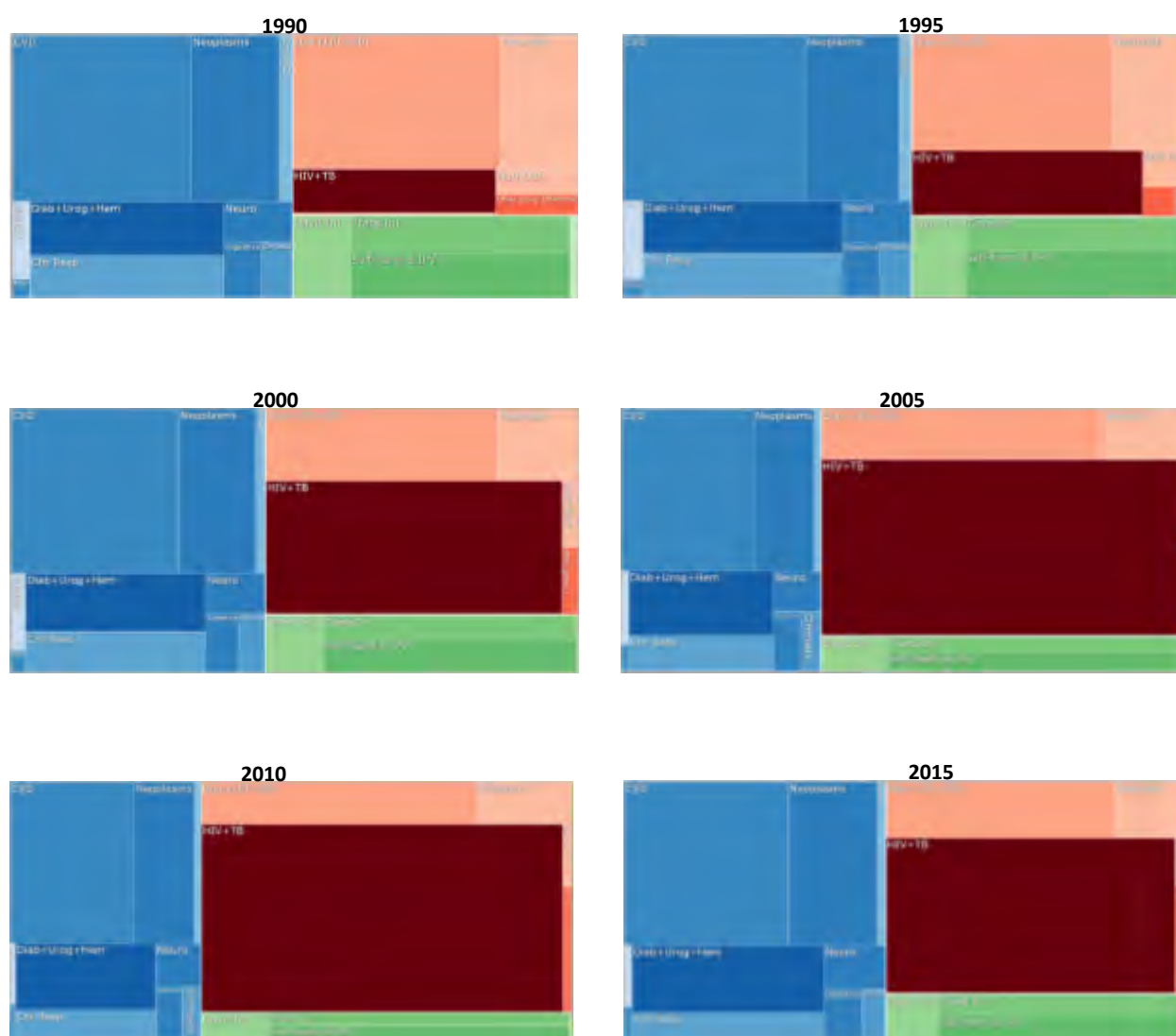
4. Health status in South Africa

After the first democratic elections, South Africa saw a rapid increase in annual registered deaths, rising from 317,727 in 1997 to a high of 614,014 in 2006. This then declined to 453,360 in 2014. The AIDS epidemic, and the initial refusal to introduce anti-retroviral (ARV) treatment and subsequent introduction of the largest ARV program globally, has been critical in this trend.

Figure 1 provides a visually helpful overview of changes in the cause of death in South Africa since 1990. The blue shaded blocks relate primarily to non-communicable diseases such as cardiovascular disease, cancers, diabetes and mental health; the orange shaded blocks include maternal and child health problems such as diarrhoea, neonatal problems and nutritional deficiencies; the green shaded blocks relate to injuries; and the maroon block refers to HIV and tuberculosis (TB) related deaths. Figure 1 clearly indicates the impact of the HIV epidemic, and associated increase in TB prevalence, becoming the single largest cause of deaths during the period 2005-2010. With the introduction of a massive ARV program, non-communicable diseases are now the single largest cause of death. The 2015 overview of cause of death graphically depicts what is known as the quadruple burden of disease, whereby South Africa faces substantial mortality in all four of the main categories of cause of death.

⁵ McIntyre D, Bloom G, Doherty J, Brijlal P (1995). *Health Expenditure and Finance in South Africa*. Durban: Health Systems Trust and the World Bank.

Figure 1: Causes of death in South Africa (relative share of total deaths per 100,000 population caused by indicated condition) 1990-2015⁶



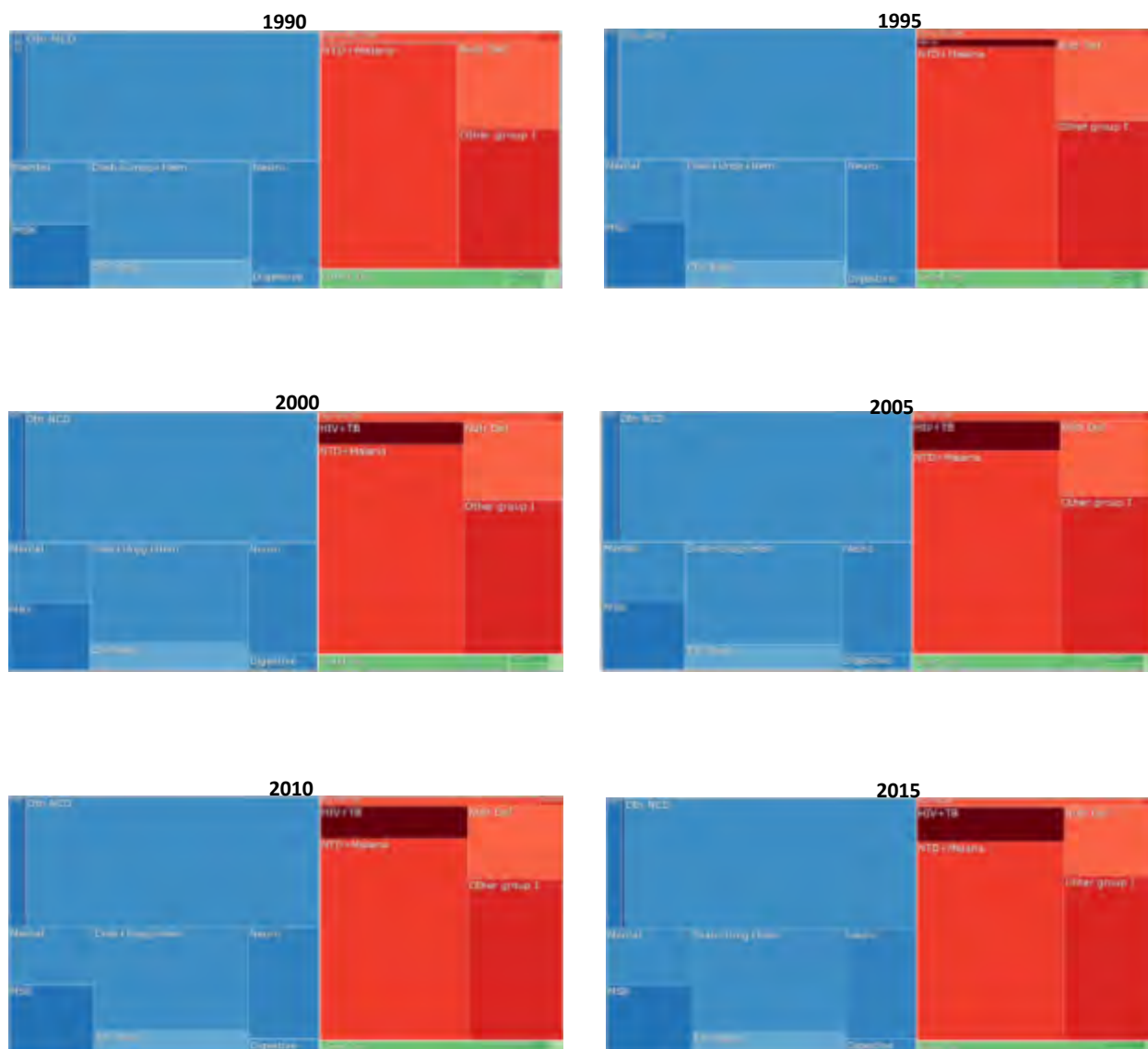
Annex 4 provides detailed trends for individual causes of death for the period 1980 to 2015. These figures show the general downward trend in mortality rates over this period, but a temporary increase in death rates for tuberculosis, diarrhoeal disease, respiratory tract infections, maternal disorders and some non-communicable diseases from the mid- to late-1990s to mid 2000s, and a massive increase in HIV-related deaths over this period, which has been decreasing since 2010.

Figure 2 provides an overview of the trends in the prevalence⁷ of diseases in South Africa since 1990. It shows that while the prevalence of HIV and TB has increased over time, the biggest burden of ill-health from a prevalence perspective relate to non-communicable diseases and maternal and child related illness.

⁶ Global Burden of Disease Study 2015. Global Burden of Disease Study 2015 (GBD 2015) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2016. Available from <https://vizhub.healthdata.org/gbd-compare/>.

⁷ Prevalence refers to the number of cases of a disease present in the population at a particular time. This should be distinguished from incidence, which refers to the number of *new* cases of a disease within a given period of time.

Figure 2: Disease prevalence in South Africa (relative share of total cases of disease per 100,000 population attributed to the indicated condition), 1990-2015



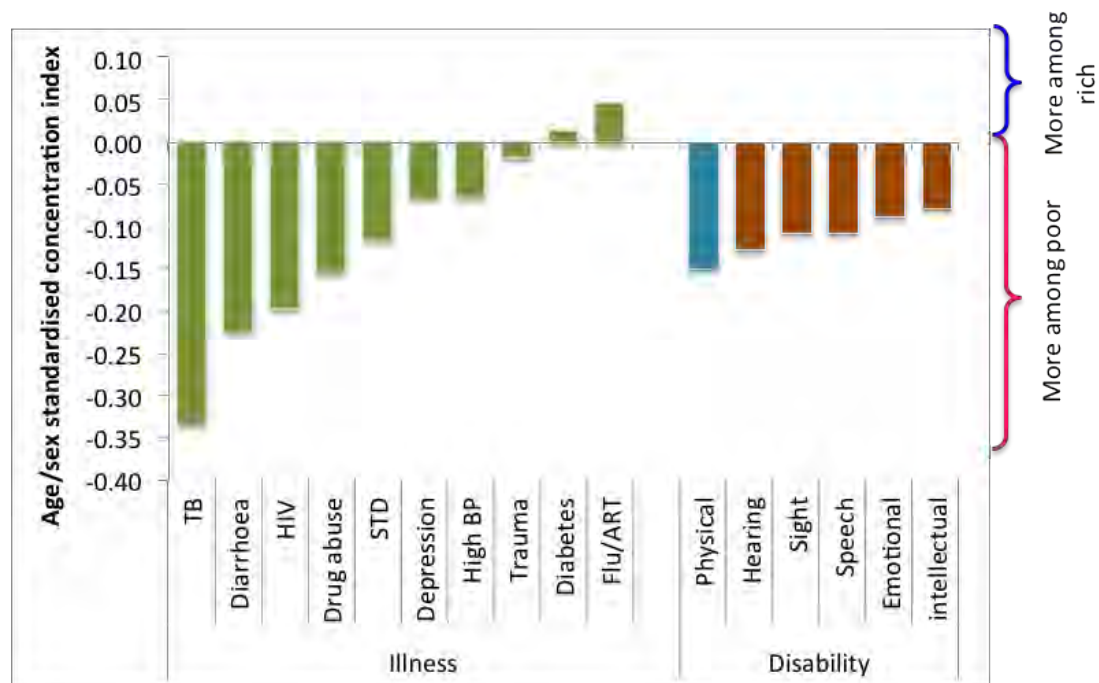
World Health Organisation (WHO) projections indicate that by 2030, the death rates from non-communicable diseases (NCDs) such as stroke, ischaemic heart diseases, road injuries and diabetes will be higher than in 2015 in the African region while death rates from communicable diseases particularly HIV/AIDS, respiratory infections, diarrhoeal diseases and malaria will be lower in 2030 than 2015⁸. Given that South Africa is further in its epidemiological transition than many other African countries, the burden of NCDs is likely to be even more dominant in future than suggested in the WHO figures.

Within the context of the focus on poverty and inequality of the Sub-committee for which this report is being prepared, inequalities in the distribution of ill-health is of importance. Figure 3 demonstrates the distribution of some of the most common illnesses and disabilities across socio-economic groups in South Africa. It presents the concentration index, which is a measure of the distribution of ill-health across socio-economic groups. The

⁸ WHO projections on mortality and cause of death:
http://www.who.int/healthinfo/global_burden_disease/projections/en/

value of the index ranges between -1 and 1, where a negative value means that ill-health or disability is concentrated amongst the poorest and a positive value indicates a concentration among the rich. Figure 3 indicates that there are considerable inequalities in the distribution of ill-health and disability in South Africa, with the burden of communicable diseases such as TB, HIV and diarrhoeal diseases being particularly high for poorer groups. What is particularly important to note is that there is a higher burden on lower socio-economic groups even in the case of non-communicable diseases such as hypertension or high blood pressure, which have been traditionally regarded as ‘diseases of lifestyle’ associated with wealth. Although there is a slightly greater burden of diabetes on higher income groups, it is relatively evenly distributed across socio-economic groups. As these data are based on individuals reporting that they have been diagnosed with these illnesses or disabilities, and as lower socio-economic groups have lower health service utilisation levels and thus more likely to have higher levels of undiagnosed illness and disability, Figure 3 is likely to be an underestimate of the extent of disparities.

Figure 3: Inequalities in illness and disability in South Africa (2008) ⁹



The implication of this distribution of illness and disability is that the need for health services to diagnose and treat these illnesses is greater among lower socio-economic groups. From a health system equity perspective, it is expected that utilisation would also be greater among these socio-economic groups.

It is important to recognise that these inequalities in illness burden are strongly related to inequalities in a range of social and economic factors (called social determinants of health), such as differential access to housing, sanitation, potable water, educational attainment, employment, regular income, etc. Therefore, addressing health status inequalities is not only dependent on ensuring equitable access to quality health services but also addressing

⁹ Ataguba JE, Akazili J, McIntyre D (2011). Socioeconomic-related health inequality in South Africa: evidence from General Household Surveys. *International Journal for Equity in Health* 10: 48

inequalities in these social determinants. As the terms of reference for this report specified a focus on the health system, these social determinants are not considered in detail.

5. Current situation in terms of equitable access to quality health services in South Africa

This section provides evidence on access to quality health services in South Africa and distribution in this regard. It draws on research published in peer-reviewed literature. The literature search undertaken for this purpose was not intended as a systematic review using Cochrane methods, but rather a means to ensure that all relevant peer reviewed literature was drawn on for this section¹⁰.

5.1 Service utilisation in South Africa

Given its multi-dimensional nature, health service access is difficult to measure in an integrated and comprehensive way. It is for this reason that the focus in health system assessments is often placed on evaluating utilisation of health services and because access enables use of health services.

Even though utilisation is easier to measure than access, there is no completely accurate information available on all health service utilisation in South Africa (see Annex 5 for details of available data and their limitations). It is, therefore, not possible to estimate health service utilisation *rates* or accurately estimate the distribution of utilisation across different types of health care providers using most of the sources of utilisation data.

Although deficiencies in the various data sources lead to different estimates, all the analyses of health service utilisation produce consistent overall findings¹¹, including:

- The majority of health service use in South Africa occurs in the public health sector, both for outpatient services (over 70%) and even more so for inpatient care (over 80%).
- Within each socio-economic group, there is a mix of use of public and private providers. In 2008, over 80% of service utilisation by the lowest income quintile (a quintile = 20% of households) occurred in public facilities with less than 20% in private facilities.

¹⁰ A literature search was conducted using EBSCO Host (including Academic Search Premier, CINAHL, EconLit and Medline databases), with a focus on the period since 2000. The following search strings were used: “health financ*” AND South Africa; (“health care” OR “health service*”) AND access* AND South Africa; (“health care” OR “health service*”) AND quality AND South Africa. Peer-reviewed publications include: journal articles, books and book chapters which have been subject to a peer-review process and university dissertations and theses that have undergone examination.

¹¹ Booyesen F (2003). Urban-rural inequalities in health care delivery in South Africa. *Development Southern Africa* 20(5): 659-674.

Knight L, Maharay P (2009). Use of public and private health services in KwaZulu-Natal, South Africa. *Development Southern Africa* 26(1): 17-28.

Ataguba JEO, Goudge J (2012). The impact of health insurance on health-care utilisation and out-of-pocket payments in South Africa. *The Geneva Papers* 37: 633-654.

Burger R, Bredenkamp C, Grobler C, van der Berg S (2012). Have public health spending and access in South Africa become more equitable since the end of apartheid? *Development Southern Africa* 29(5): 681-703

Alaba OA, McIntyre D (2012). What do we know about health service utilisation in South Africa? *Development Southern Africa*; 29(5): 704-724

Christian CS (2014). Access in the South African public health system: Factors that influenced access to health care in the South African public sector during the last decade. Masters thesis. Bellville: University of the Western Cape

Conversely, over 70% of health service utilisation occurred at private service providers for the highest income quintile and less than 30% occurred in public facilities¹².

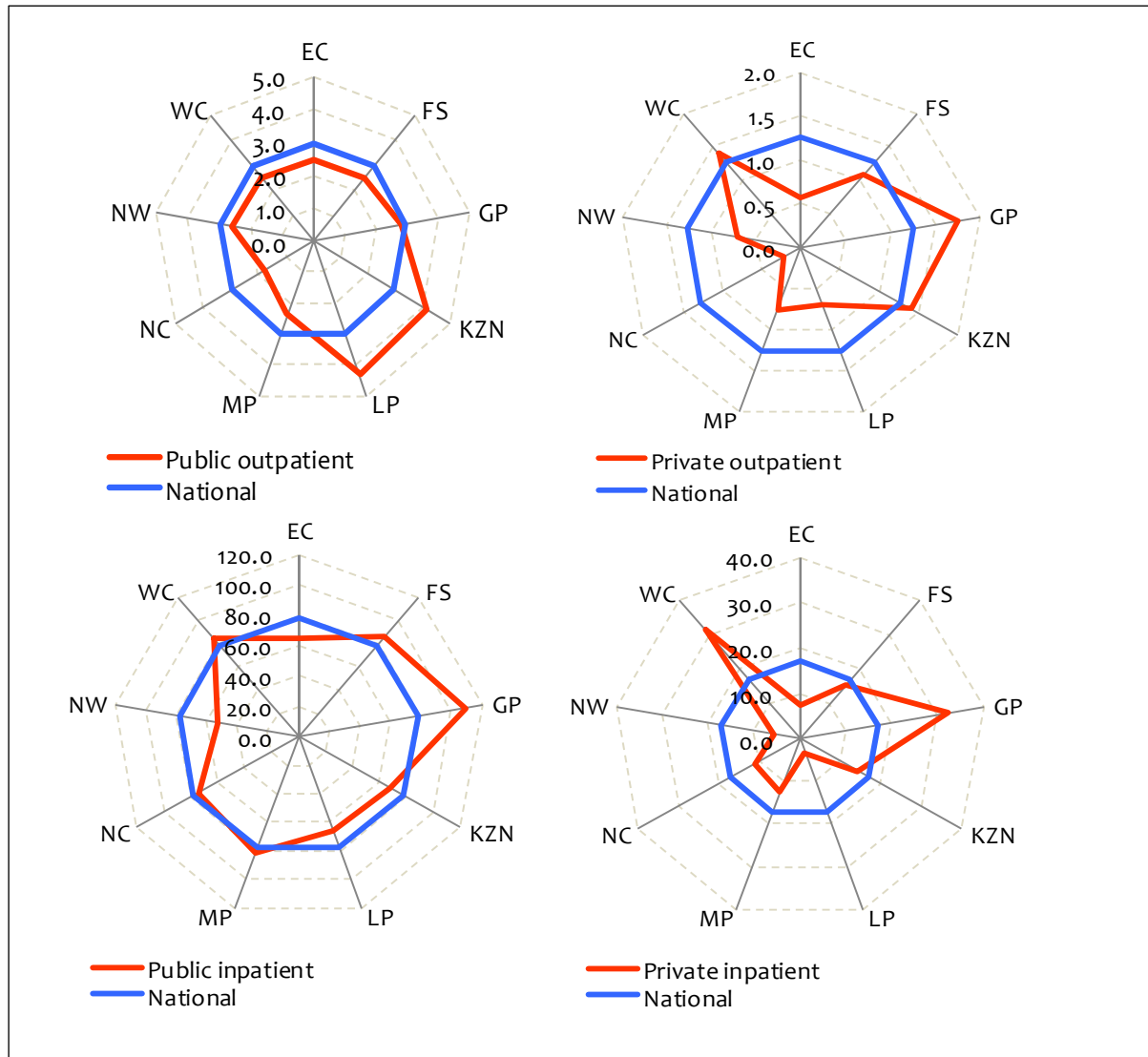
- The main determinant of use of private providers is membership of a medical scheme. This is particularly the case for inpatient care, with private hospitals almost exclusively being used by medical scheme members. When non-scheme members use a private provider, it is mainly to consult a general practitioner or visit a retail pharmacy.
- Not only do medical scheme members use private sector services more than non-scheme members, they have higher overall utilisation rates with an average of 5.5 visits to a health care provider per medical scheme member per year compared to an average of 4.1 visits per year for non-scheme members¹³.
- There are also differences in utilisation rates across socio-economic groups, with higher overall utilisation amongst the richest groups, as well as differences across rural and urban areas and between provinces. Figure 4 provides an overview of utilisation of public sector and private sector services in each province using the total population as the denominator. Total utilisation combining the sectors, of an average of 4.2 outpatient visits per person per year and 95 inpatient admissions per 1,000 population are broadly in line, although somewhat low in the case of outpatient services, with the utilisation levels recommended by the World Health Organisation (WHO) of 5 outpatient visits and 100 inpatient discharges¹⁴. The inpatient utilisation of private hospitals is 139 admission per 1,000 medical scheme members (above the WHO level), while it is 89 per 1,000 non-medical scheme population (below the WHO level). Given the almost exclusive use of private hospital inpatient services by medical scheme members, these estimates are a fair reflection of differences in utilisation between these groups.

¹² Burger et al. (2012) *op cit*.

¹³ Alaba and McIntyre (2012) *op cit*.

¹⁴ WHO (2013). *Service Availability and Readiness Assessment (SARA). An annual monitoring system for service delivery. Reference Manual. Version 2.1.* Geneva: World Health Organization.

Figure 4: Outpatient and inpatient utilisation rates by province in South Africa, 2008 ¹⁵



Note: Outpatient and inpatient utilisation are visits per person and admissions per 1,000 population per year respectively. The provinces are Eastern Cape (EC), Free State (FS), Gauteng (GP), KwaZulu-Natal (KZN), Limpopo (LP), Mpumalanga (MP), Northern Cape (NC), North West (NW), and Western Cape (WC).

Within the public sector, the following pattern of utilisation of different kinds of facilities prevails¹⁶:

- Those living in rural areas, those who are not medical scheme members and the lowest socio-economic groups mainly use public clinics or community health centres for health care.
- The distribution of use of clinics, community health centres and district hospital outpatient departments is what is termed 'pro-poor', i.e. the lowest socio-economic groups use these services more than higher socio-economic groups. The use of

¹⁵ Ataguba JE, Day C, McIntyre D (2014). Monitoring and evaluating progress towards universal health coverage in South Africa. *Plos Medicine*, 11(9): e1001686

¹⁶ Ataguba JE, McIntyre D (2012). Paying for and receiving benefits from health services in South Africa: Is the health system equitable? *Health Policy and Planning*, 27 (Suppl 1): 35-45

Ataguba JE, McIntyre D (2013). Who benefits from health services in South Africa? *Health Economics, Policy and Law*. 8: 21-46.

Burger et al. (2012) *op cit*.

Alaba and McIntyre (2012) *op cit*.

outpatient services at higher level public hospitals, particularly central hospitals, is what is termed 'pro-rich' in that higher socio-economic groups use these services more than lower socio-economic groups. It should be noted that the highest socio-economic quintile tends to use public sector services the least, largely due to the majority of medical scheme members being in this group. Nevertheless, the second highest and middle socio-economic quintiles have the highest use of non-district public hospitals, which results in the pro-rich overall distribution of service use in these hospitals.

- In terms of use of inpatient services, there is a similar pattern with district hospitals being pro-poor but higher level hospitals, particularly central hospitals, being pro-rich.
- There has been a substantial increase in the use of primary health care facilities (clinics and community health centres) between 1993 and 2008; while in 1993, only about 40% of the utilisation of public sector health services by the three lowest socio-economic quintiles (60% of the population) occurred in a primary health care facility, this had increased to over 70% by 2008 ¹⁷.

A recent study has found substantial inequalities in the use of critical maternal health services such as antenatal care and skilled birth attendance. It is of considerable concern that inequalities in use of these services have increased between 2008 and 2012¹⁸.

5.1.1 Key policy issues from evidence on health service utilisation

From the perspective of promoting equity in access to quality health services in South Africa, the following key issues should be taken into account:

- The public sector is the main provider of health care services in South Africa and is used by the full range of socio-economic groups; even the highest income quintile uses public sector services, albeit largely at the central hospital level. Ensuring quality health services within the public health sector should therefore be a policy priority.
- Services at public sector primary health care facilities and district hospitals are most widely used by lower socio-economic groups. Promoting equitable access to quality health care therefore requires a particular emphasis on ensuring quality within these facilities.
- There is limited use of higher level referral hospitals by lower socio-economic groups; given that the greater burden of illness across a wide range of disease categories suggests that this should not be the case. Ways of promoting equitable access to these facilities requires attention.
- Private health care providers play a complementary role, with private hospitals being primarily used by medical scheme members and private primary care providers being more widely used, but still by a minority of the population. Mechanisms for drawing on these providers to improve access to quality health care require consideration.

5.2 Access to health services in South Africa

As indicated earlier, it is difficult to measure access in an integrated and comprehensive way. Nevertheless, using the access framework outlined in the earlier section, information on various aspects of the different dimensions of access can be provided. There is extremely limited data on private sector providers, and any estimates that have been produced have been hotly contested. For this reason, and because the public health sector is the largest

¹⁷ Burger et al. (2012) *op cit*.

¹⁸ Wabiri N, Chesich M, Shisana O, Blaauw D, Rees H, Dwane N (2016). Growing inequities in maternal health in South Africa: a comparison of serial national household surveys. *Pregnancy and Childbirth* 16: 256.

and most widely used health service provider, the focus is on indicators of access to public sector health services.

5.2.1 Information on the availability of health services

The distance people need to travel to a health facility is a key element of the availability dimension of access. There are considerable differences in households' proximity to a health facility between rural and urban areas, across provinces and between socio-economic groups in South Africa. For example, one analysis of General Household Survey (GHS) data for the period 2002-2008 indicated that about 20% of households in the lowest income quintile lived an hour or more from the nearest public clinic and 36% lived an hour or more from the nearest hospital, compared with less than 5% of households in the highest income quintile¹⁹. There was a similar finding from an analysis of the 2008 National Income Dynamics Survey (NIDS); 20% of the lowest income quintile lived more than 5 km from the nearest clinic compared with only 5% of the richest quintile.²⁰

The likelihood of using a health service is far lower for those living furthest from health facilities. A very detailed household survey combined with a geographic information system analysis in the Hlabisa sub-district of KwaZulu-Natal found that households within 30 minutes of a clinic were 10 times more likely to make use of a clinic than households having to travel for 90-120 minutes to a clinic²¹. These disparities persist even in relation to critical health services where lack of access can have serious consequences for premature death, such as attended deliveries. An analysis of the NIDS data found that children in households that lived more than 2km from the nearest clinic were 8 percentage points less likely to have had a doctor or nurse present at birth than those within 2km of a clinic²².

The number and distribution of health facilities clearly influences various communities' proximity to a health facility. The availability of health personnel is also a key element of access to quality health care. Figure 5 provides an overview of the national average and provincial distribution of usable public hospital beds (including all levels of hospitals as well as specialised psychiatric and TB hospitals), nurses employed in the public sector (including professional and enrolled nurses as well as nursing assistants), and generalist and specialist doctors employed in the public sector. Relative to WHO recommended availability indicators of 2.5 hospital beds per 1,000 population and 230 core health workers (doctors and nurses) per 100,000 people²³, South Africa has a relatively low level of public hospital beds of 1.9 per 1,000 people dependent on public hospital inpatient services (non-medical scheme members) but has public sector core health worker levels that exceed the WHO recommendation at 339 nurses and doctors per 100,000 population, although staffing levels are lower than the average in upper-middle income countries of 503 per 100,000 population²⁴.

¹⁹ Christian (2014) *op cit*.

²⁰ McLaren ZM, Ardington C, Leibbrandt M (2014). Distance decay and persistent health care disparities in South Africa. *BMC Health Services Research* 14: 541.

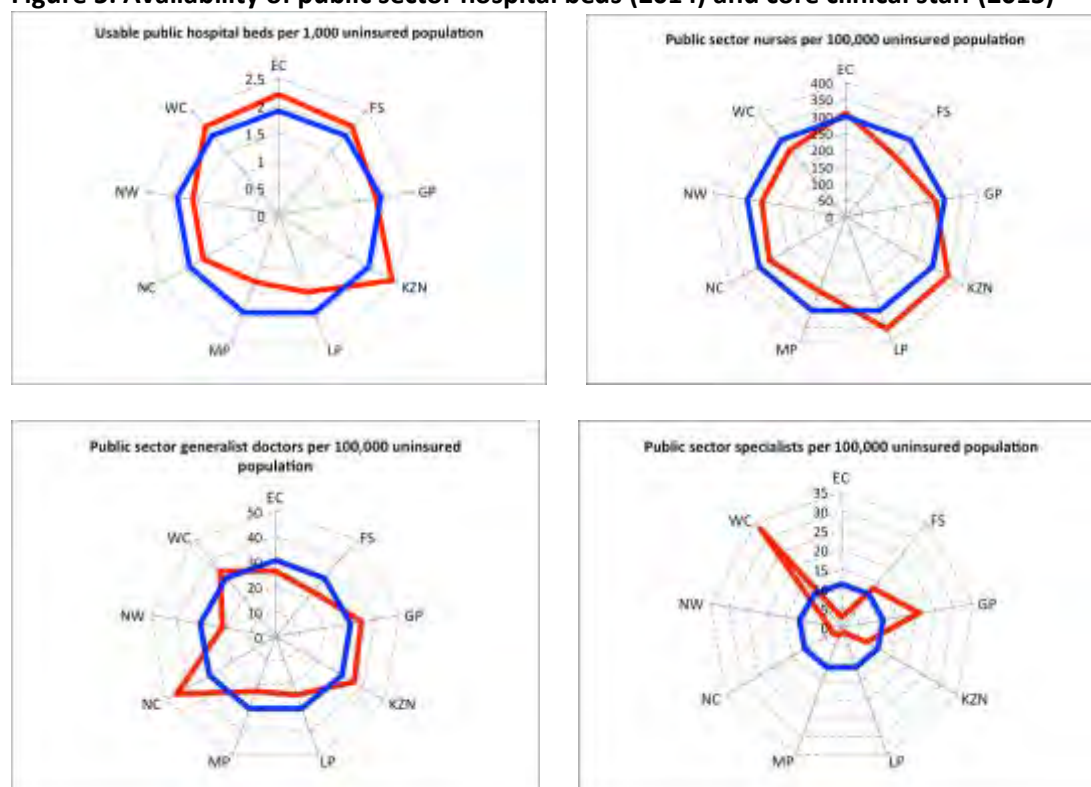
²¹ Tanser F, Gijsbertsen B, Herbst K (2006). Modelling and understanding primary health care accessibility and utilization in rural South Africa: An exploration using a geographical information system. *Social Science and Medicine* 63: 691-705.

²² McLaren et al (2014) *op cit*.

²³ WHO (2013) *op cit*.

²⁴ World Bank database: <http://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=XT> and <http://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=XT>

Figure 5: Availability of public sector hospital beds (2014) and core clinical staff (2015) ²⁵



Note: Blue line is the national average and red line shows actual provincial availability. The provinces are Eastern Cape (EC), Free State (FS), Gauteng (GP), KwaZulu-Natal (KZN), Limpopo (LP), Mpumalanga (MP), Northern Cape (NC), North West (NW), and Western Cape (WC).

There is considerable variation in the availability of hospital beds and health professionals across provinces; unsurprisingly the starkest differentials are seen in the distribution of doctors, particularly specialists. From an efficiency perspective, it is generally accepted that highly specialised services should be concentrated in facilities such as central hospitals, which to some extent explains the high levels of specialists in the Western Cape and Gauteng, and to a lesser extent the Free State and KwaZulu-Natal. Nevertheless, the extremely low levels of specialists within public sector facilities in Limpopo (1.5 per 100,000 population), Mpumalanga (2.2 per 100,000), the Eastern Cape (2.6 per 100,000), Northern Cape (2.7 per 100,000), North West (3.6 per 100,000) and even KwaZulu-Natal (7.7 per 100,000), compared to Gauteng (20.7 per 100,000) and the Western Cape (33.1 per 100,000) is of concern. Ensuring that South Africans in need of specialist services are able to access such care within the context of this geographic distribution requires careful consideration.

Historical facility and human resource distribution patterns have a strong influence on the distribution of financial resources. There remain substantial disparities between provinces and health districts in public spending on primary health care, which as previously highlighted is the level of care that has the most pro-poor utilisation. In the 2015/16 financial year, the national average of public sector spending on primary health care was R993 per capita (non-medical scheme population), but ranged from R826 in Mpumalanga and R1,107 in Gauteng, and from R567 in Alfred Nzo district in the Eastern Cape to R1,761 in

²⁵ Data from: Day C, Gray A (2016). Health and Related Indicators. In: Padarath A, King J, Mackie E, Casciola J, editors. *South African Health Review 2016*. Durban: Health Systems Trust. (The South African Health Review (SAHR) is an annual, peer-reviewed publication, which is highly regarded for providing the most accurate and up-to-date data available within the context of existing information system limitations.)

Namakwa district in the Northern Cape²⁶. Given the human resource intensive nature of health services, it is unsurprising that statistical analyses found that three-quarters of the difference in per capita expenditure between provinces was explained by variations in the facility and personnel to population ratios. In particular, each percentage point increase in the number of doctors was associated with a 0.49% increase in health spending. Historical inequalities in the distribution of facilities and personnel, which are entrenched in outdated post structures, contributes to continued inequalities in resource allocation. As noted by the researchers: “Historical infrastructure inequalities may have created an infrastructure–inequality trap, in which the distribution of funds to those with greater “absorptive capacity” exacerbates inequalities”²⁷.

There have been efforts to improve the distribution of health facilities, such as the RDP clinic upgrading and building program in the 1990s, through which 1,345 new clinics were built and 263 were upgraded²⁸. There have also been more recent efforts through mapping of health facilities and catchment populations and a comprehensive facility audit in 2011-2012 to determine where renovations and new clinics were required.

However, progress in planning for the development and distribution of health human resources has been extremely limited. There have been “... several unfortunate policy decisions – such as the offer of voluntary severance packages to public sector staff in the mid-1990s that had the effect of moving (often skilled) staff out of the public sector and into the private sector, international agencies or early retirement”²⁹. Health professional to population ratios in the public health sector declined as a result of this and other policies, including the closure of many nursing colleges in the late 1990s. A new human resource strategy was released in October 2011³⁰. Although there have been concerted efforts to increase health professional training intake in universities and a program for training doctors in Cuba, there is no available comprehensive assessment of the implementation of this strategy. The introduction a year of community service for a range of health science graduates has been an important legislative intervention to increase staffing in public sector facilities. However, there have been implementation challenges, with a key criticism being the lack of adequate supervision and support for those undertaking community service. Another policy initiative relating to health sector human resources, and that is of great importance in providing what are termed ‘close-to-client’ health services, is the Ward-Based Outreach Teams (WBOTs) that are part of the PHC Re-engineering initiative. WBOTs are a team of community health workers (CHW) who provide a range of preventive and promotive services and also identify household members who should be seen by a nurse or doctor and refer them to the clinic. There are a range of other services they could provide (e.g. distributing chronic medicines to members of their community to relieve the pressure on health facilities). There has been variable implementation of this initiative across provinces, and finality has not been reached on whether or not this important cadre of health workers will be employed by the public health sector.

²⁶ Massyn N, Peer N, English R, Padarath A, Barron P, Day C editors (2016). *District Health Barometer 2015/16*. Durban: Health Systems Trust.

²⁷ Stuckler D, Basu S, McKee M (2011). Health care capacity and allocations among South Africa’s provinces: Infrastructure-inequality traps after the end of apartheid. *American Journal of Public Health* 101(1): 165-172.

²⁸ Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D (2009). The health and health system of South Africa: historical roots of current public health challenges. *Lancet*; August 2009: 11-28.

²⁹ Coovadia et al (2009) *op cit*.

³⁰ Department of Health (2011). *Human resources for health South Africa: HRH strategy for the health sector: 2012/13-2016/17*. Pretoria: Department of Health.

There has also been little progress on changing the way in which financial resources are allocated to promote distribution in line with relative need for health services. Soon after the 1994 elections, there was a move to allocate public health sector resources from a national level to individual provincial health departments using a needs-based resource allocation formula. However, this was rapidly overtaken by the introduction of a fiscal federal system under the Constitution adopted in 1996 whereby provinces are allocated an “equitable share” of nationally collected revenue as a global budget, based on a formula which includes indicators of need for health and education services. Provincial cabinets have considerable autonomy in deciding how much is allocated to the health and other sectors. This has contributed to continued inequalities in public health spending across provinces. In addition, no provincial health department has adopted a needs-based resource allocation mechanism for distributing financial resources across districts, instead relying on historical budgeting, which has contributed to entrenching inequalities in public health spending within provinces.

Another element of the availability dimension of health service access is the range of services provided. There have been improvements in this regard within the public health sector, with the most notable policies in this regard probably being the introduction of termination of pregnancy services and antiretroviral treatment (ART). The ART program has been one of the major successes within the public health system in recent years. Importantly, recent research found that the distribution of ART use is in line with the distribution of HIV-positive people, at least in urban settings, indicating that the ART program is being implemented in a way that promotes equity in access to this specific service³¹.

In relation to other aspects of service availability, household survey data routinely indicate that when asked about their experience of using a public health facility, the aspect most frequently commented on is the long waiting time within the facility, followed by lack of availability of drugs and finally inconvenient opening times³². This ordering is consistent across socio-economic groups. Interestingly a recent study, using what is known as discrete choice experiment methods to determine what the public see as the most important aspects of health service access, found that the availability of necessary medicines within a facility was the most highly valued aspect. The emphasis placed on this aspect of access to care far exceeded issues such as waiting time and whether care was provided by a nurse or a doctor (i.e. skills mix within a facility)³³.

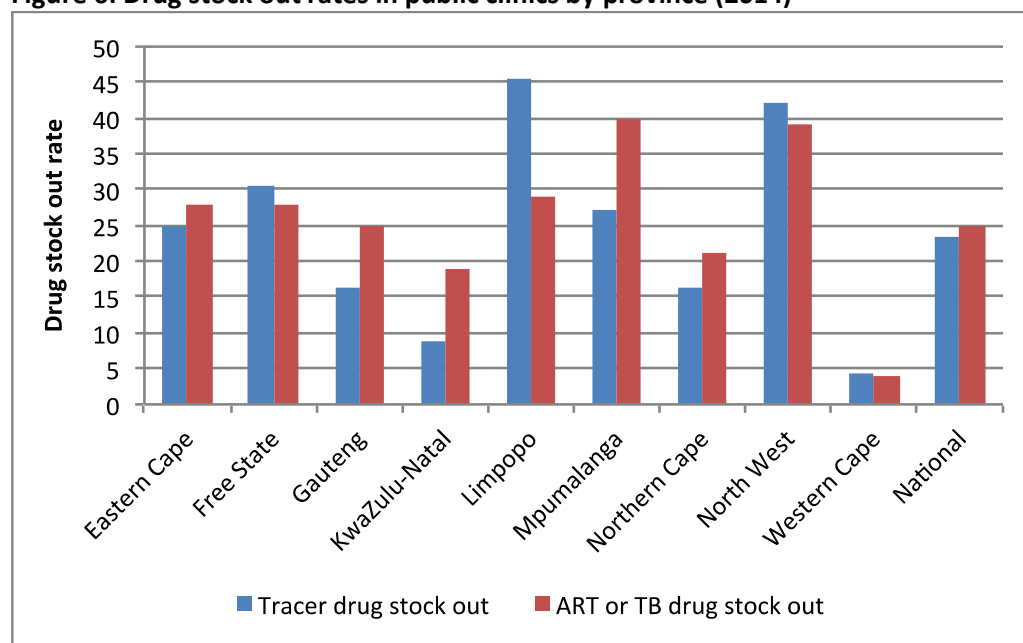
Figure 6 shows the extent of the problem of lack of availability of medicines in public clinics and community health centres, and differences across provinces. Improving the routine availability of medicines in public health facilities, particularly in provinces that currently face the biggest drug stock out rates would contribute substantially to promoting equitable access to quality health care and is seen as a priority by the national Department of Health.

³¹ Cleary S, Silal S, Birch S, Carrara H, Pillay-van Wyk V, Rehle T, Schneider H (2011). Equity in use of antiretroviral treatment in the public health care system in urban South Africa. *Health Policy* 99: 261-266.

³² Christian (2014) *op cit*.

³³ Honda A, Ryan M, van Niekerk R, McIntyre D (2015). Improving the public health sector in South Africa: Eliciting public preferences using a discrete choice experiment. *Health Policy and Planning* 30(5): 600-611.

Figure 6: Drug stock out rates in public clinics by province (2014) ³⁴



There have been some innovations to improve access to medicines, particularly the Chronic Dispensing Unit (CDU) initiative in the Western Cape. The Department of Health has outsourced the preparation of pre-packed patient medicine parcels (PMP) for stable patients with chronic conditions. These PMPs are prepared centrally and delivered to participating clinics; some PMPs are collected by patients from the clinic while others are collected at decentralised collection points such as mobile clinics, community clubs and old age homes. The aim of the CDU initiative is not only to reduce the workload of pharmacists within public facilities but also to decongest health care facilities and reduce patient waiting times³⁵. Innovations such as this can improve various aspects of health service availability simultaneously, and are being adopted on a more widespread basis.

All of the above evidence relates to the public health sector. Accurate data on the number of health care professionals working within the private health sector are not available, nor is it feasible to calculate accurate private provider to population ratios due to lack of data and repeated stakeholder contestation of estimates. It is critical that a comprehensive audit of all health professionals working in the public and private health sectors in South Africa is undertaken and that such data is maintained on ongoing basis.

The only data available is the total number of health professionals registered with their respective councils; these include those working in the public sector, those working in the private sector *as well as those no longer practicing in South Africa*. There were 15,008 medical specialists registered with the Health Professions Council (HPCSA) in 2015; 4,986 worked in the public health sector, some are retired or working outside of South Africa and the remainder work in the private sector. Other examples are 13,479 pharmacists registered with the Pharmacy Council and 4,970 working in the public sector in 2015; 6,035 dental practitioners registered with HPCSA and 1,137 working in the public sector; and 136,854 professional nurses registered with the SA Nursing Council and 68,105 working in

³⁴ Day and Gray (2016) *op cit*.

³⁵ Magadzire BP, Marchal B, Ward K (2015). Improving access to medicines through centralised dispensing in the public sector: a case study of the chronic dispensing unit in the Western Cape Province, South Africa. *BMC Health Services Research* 15: 513

the public sector in 2015³⁶. Even without precise figures on private sector health workers, the above information indicates that there is a large pool of health professionals in the private sector who could be drawn on to promote equitable access to quality health care.

The greatest challenge in realising this potential is the distribution of private health professionals, many of whom are based in urban areas, particularly metropolitan areas. For example, the density of community (private retail) pharmacies was far greater in urban provinces than rural provinces, ranging from 0.27 community pharmacies per 10,000 population in Limpopo and 0.34 in the Eastern Cape to 0.85 and 0.99 in the Western Cape and Gauteng respectively in 2012. There are also major differences in the distribution of community pharmacies within provinces; for example, the density of such pharmacies is 0.11 per 10,000 population in OR Tambo, one of the most deprived districts of the Eastern Cape, which is far lower than the average of 0.34 in that province. The density of these pharmacies was eight times higher in the least deprived districts than in the most deprived ones. Licensing regulations introduced under the Medicines and Related Substances Control Act and the Pharmacy Act, including the extension of pharmacy ownership to non-pharmacists under the 1997 Pharmacy Amendment Act which was seen as an important measure to ensure adequate distribution of pharmacies in rural and other underserved areas³⁷, have had some impact. For example, the density of these pharmacies has improved in some rural provinces such as Limpopo, increasing from 0.15 per 10,000 population in 1994 to 0.27 per 10,000 in 2012 and decreased in Gauteng and the Western Cape³⁸. Nevertheless, the remaining disparities in distribution of these pharmacies makes it difficult to draw on private sector health professional resources to improve access in areas that are most under-served currently.

5.2.2 Information on the affordability of health services

The affordability of health services is influenced by the costs of health care on the one hand and household resources to cover these costs on the other hand. The way in which health services are financed is critical to affordability, particularly whether this takes the form of out-of-pocket payments (i.e. direct payments by a patient to a health care provider, usually at the time of using a health service) or on a pre-payment basis (i.e. either through tax payments, some of which are then allocated to funding health care, or contributions to a voluntary or mandatory health insurance scheme).

Out-of-pocket (OOP) payments are the most concerning from an affordability perspective given that there is considerable uncertainty about when a person may fall ill and what financial resources they may have available at that particular point in time. Internationally, millions of people are impoverished, i.e. pulled below the poverty line, by paying for health services on an OOP basis³⁹. Figure 7 shows that although levels of impoverishment due to OOP payments for health care are relatively low in South Africa, they are far greater in the poorer than richer provinces.

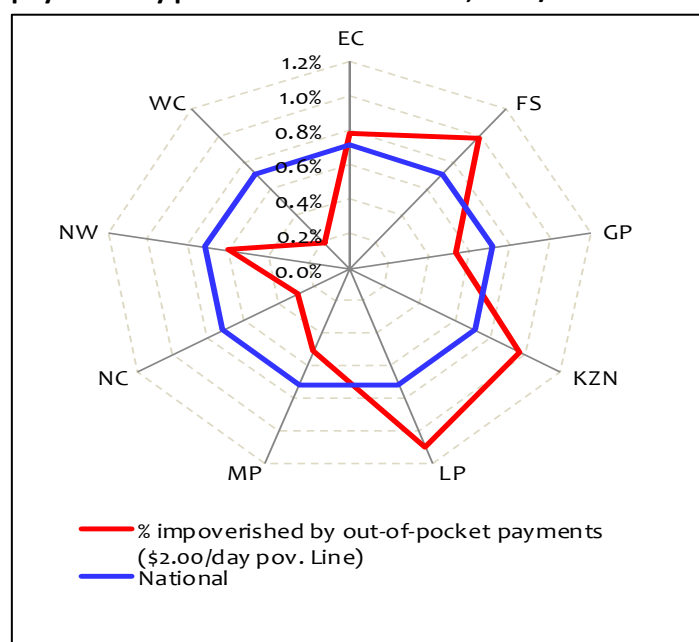
³⁶ Day and Gray (2016) *op cit*.

³⁷ Harrison S, Qose M (1998). Health Legislation. In: Ntuli A (Ed). *South African Health Review 1998*. Durban: Health Systems Trust.

³⁸ Ward K, Sanders D, Leng H, Pollock AM (2014) Assessing equity in the geographical distribution of community pharmacies in South Africa in preparation for a national health insurance scheme. *Bulletin of the World Health Organisation*, 92: 482-489.

³⁹ World Health Organisation (2000). 2000 World Health Report. Geneva: WHO.

Figure 7: Impoverishment associated with out-of-pocket payments by province in South Africa, 2005/06 ⁴⁰



Note: Eastern Cape (EC), Free State (FS), Gauteng (GP), KwaZulu-Natal (KZN), Limpopo (LP), Mpumalanga (MP), Northern Cape (NC), North West (NW) and Western Cape (WC).

It is unquestionable that the introduction of the ‘free care’ policies, first the 1994 introduction of care at any public sector facility free of any charge to pregnant women and children under 6 years and in 1996 free services at all public sector primary health care facilities, both of which were formalised in the National Health Act of 2003, has contributed to improving affordability of health services in South Africa. While there was a substantial increase in utilisation of services immediately after the first free care policy was introduced in 1994, this appears to have been largely related to addressing previously unmet need as levels of use declined over time and that increases in use arising from the free care policies overall were not statistically significant ⁴¹. These findings are important as it indicates that the concern about abuse or overuse of free health services is not well founded. What the policy did was to improve the affordability of services for the poorest, with OOP payments for a public health service declining as a percentage of household income between 1993 and 1995 ⁴².

However, these policies have not been fully implemented in some areas ⁴³; for example, public hospitals in some provinces continue to charge pregnant women a ‘registration fee’⁴⁴. In addition, user fees remain in place at public hospitals; although the poorest can apply to

⁴⁰ Ataguba, Day and McIntyre (2014) *op cit*.

⁴¹ McCoy D, Khosa S (1996). Free health care policies. In: Harrison D, Barron P, Edwards J (Eds.) *South African Health Review 1996*. Durban: Health Systems Trust.

Brink AS, Koch SF (2015). Did primary healthcare user fee abolition matter? Reconsidering South Africa’s experience. *Development Southern Africa* 32(2): 170-192.

⁴² Burger et al. (2012) *op cit*.

⁴³ Goudge J, Russell S, Gilson L, Gumede T, Tollman S, Mills A (2009). Illness related impoverishment in rural South Africa: why does social protection work for some households but not others? *Journal of International Development*, 21, 231-251

⁴⁴ Cleary S, Birch S, Chimbindi N, Silal S, McIntyre D (2013). Investigating the affordability of key health services in South Africa. *Social Science and Medicine*. 80: 37-46.

be exempted from these fees, once again there is variable implementation. Patients who are employed in the formal sector but are not medical scheme members are liable to pay user fees that are near cost-recovery level at public hospitals. These fees can impose a substantial burden on households in the case of inpatient care and for high-cost procedures.

There is growing international consensus that user fees at public sector health facilities are not an advisable way of financing health services. As noted by the WHO Director-General Dr Chan in her address to the World Health Assembly last year: "User fees punish the poor. User fees discourage people from seeking care until a condition is severe and far more difficult and costly to manage. User fees waste resources as well as human lives." The World Bank president, Jim Kim, has also supported this position.

It is also important to recognise that fees paid to health care providers are not the only direct cost of using health services. Depending on the availability of health facilities, relatively high transport costs are incurred, particularly in rural areas and for services requiring frequent clinic visits, such as tuberculosis ⁴⁵. A household survey found that over 20% of those in the poorest quintile who delayed seeking care when ill indicated that this was due to unaffordable transport costs. This survey also found that 19% of the poorest quintile who did use an outpatient service (e.g. a clinic) when in need incurred transport costs for that visit that exceeded 10% of their total household monthly expenditure ⁴⁶.

There are also high levels of OOP payments in the private health sector. Some of this relates to use of private providers, particularly general practitioners and retail pharmacies, by those who are not medical scheme members. In general, this reflects an explicit choice on the part of the patient, e.g. an employed person who cannot take time off work to use a health service and nearby public facilities are not open after-hours and do not operate appointment systems. In some instances, such use relates to availability problems such as a public facility not having the necessary medicines and patients having to purchase these medicines at a private pharmacy.

The largest share of OOP payments (over 60%)⁴⁷ are in fact made by medical scheme members, either in the form of co-payments or for services not covered by their scheme or when their annual scheme benefits have been exhausted. These payments are not insignificant, amounting to over R27 billion in 2015, which is over 18% of health care expenditure by medical scheme members ⁴⁸. This is in reality an underestimate of the OOP payments by scheme members as it is based only on the difference between claims submitted to schemes and scheme payments; members often do not submit claims for services that they know their scheme will not cover. A third of these OOP payments by scheme members are made to specialists (indicating the wide gap between fees charged by specialists and reimbursement levels by schemes), a quarter is spent on medicines (either in the form of co-payments or for over-the-counter medicines), 12% for hospital services (which is relatively low due to the prescribed minimum benefits requiring schemes to cover most inpatient care) and 11% for allied health professional services ⁴⁹.

⁴⁵ Cleary et al (2013) *op cit*.

⁴⁶ Harris B, Goudge J, Ataguba JE, McIntyre D, Nxumalo N, Govender V, Jikwana S, Chersich M (2011). Inequities in access to health care in South Africa. *Journal of Public Health Policy* 31 (S1): S102-123.

⁴⁷ McIntyre D (2010). *Private sector involvement in funding and providing health services in South Africa: Implications for equity and access to health care*. EQUINET Discussion Paper 84. Harare: Regional Network for Equity in Health in Southern Africa.

⁴⁸ Council for Medical Schemes (2016). *Annual report 2015/16*. Hatfield: CMS.

⁴⁹ Council for Medical Schemes (2015). *Out of pocket payments by medical scheme members*. Hatfield: CMS.

A key objective of medical scheme cover, as with health insurance schemes around the world, is to reduce OOP payments for health care through using a prepayment mechanism (i.e. contributing to the scheme on a regular basis and in advance of using a health service, with the scheme then covering the costs when a service is used). In an analysis that compared health service use and OOP payments by individuals who are medical scheme members with non-members, where these two groups have the same characteristics in other respects, found higher OOP payments by medical scheme than non-scheme members⁵⁰. From this perspective, there are limits in the extent to which medical schemes provide financial protection from paying for health services on an OOP basis. An important aspect of legislation introduced since 1994 is the introduction of prescribed minimum benefits (PMBs) as part of the Medical Schemes Act of 1998. Schemes are required to cover the full cost of services that are part of the PMBs, thus limiting OOP payments by scheme members for a range of chronic illnesses and inpatient services.

The affordability of medical scheme contributions also requires consideration. Household survey data shows that for those who are not medical scheme members, “do not have money” (or lack of affordability of medical scheme contributions) was by far the major reason provided for not joining a medical scheme⁵¹. Medical scheme contributions account for a greater share of household income for lower income medical scheme members than for the highest income scheme members, being about 14% and less than 6% of household income respectively in 2005/06⁵². Even though lower income individuals are likely to select lower cost medical scheme benefit options, the difference in contribution rates between benefit packages does not adequately coincide with differences in income across scheme members. What is of considerable concern is that some claim that “Virtually all open schemes deliberately overprice their low-cover options to cross-subsidise their comprehensive options”⁵³. Others claim that middle-income scheme members tend to cross-subsidise those with lower cost and those with comprehensive benefit options⁵⁴. Regressivity in scheme contributions across medical scheme members is exacerbated by explicit design in the case of open schemes.

Medical scheme expenditure, and hence contributions, have been increasing at relatively high rates on an annual basis, consistently exceeding general inflation. With little or no real increase in wages in recent years, this means that medical scheme contributions account for an increasing share of income for households whose income is from wages or salaries alone, as opposed to also from investments, posing growing medical scheme affordability challenges over time for such households. While there has been considerable debate about the underlying causes of well above inflation increases in medical schemes’ expenditure and contributions, there is agreement that these increases are of considerable concern. It is for this reason that the Competition Commission’s Health Market Inquiry (HMI) was instituted. Efforts to regulate fees of private sector providers, including where these have been to provide guidelines without mandatory implementation such as the National Health Reference Price List, have been met with legal action by the private health sector. Often this has taken the form of challenging the process of arriving at recommended prices, including what data and stakeholder views were taken into consideration.

⁵⁰ Ataguba and Goudge (2012) *op cit.*

⁵¹ Christian (2014) *op cit.*

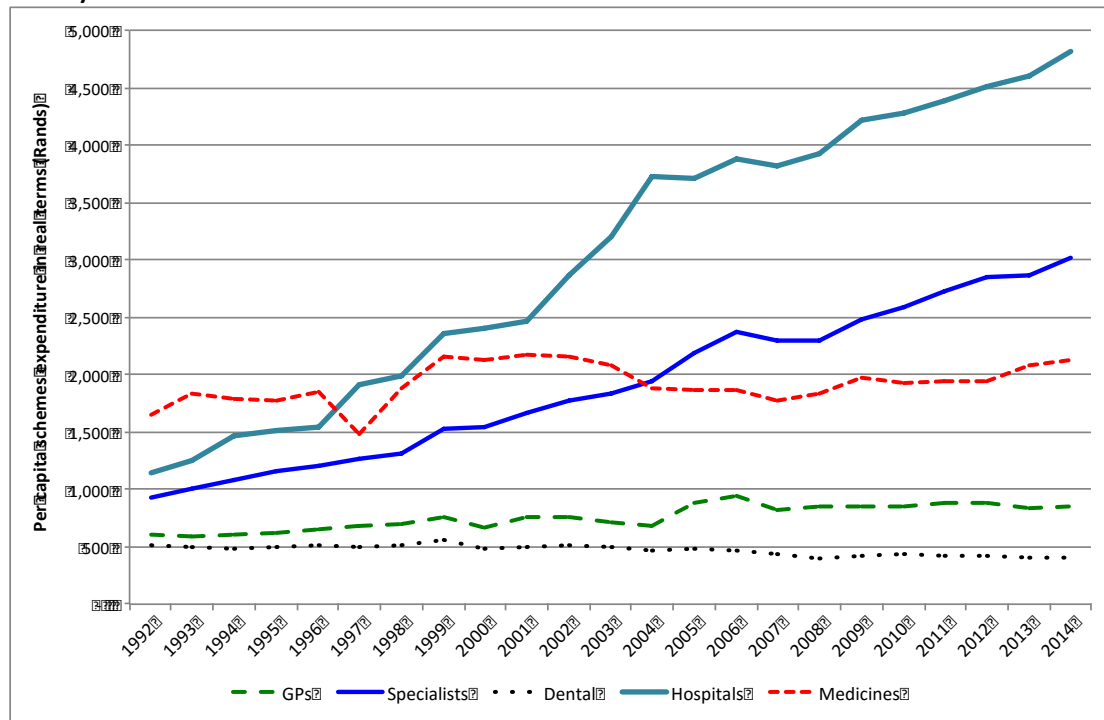
⁵² McIntyre (2010) *op cit.*

⁵³ van den Heever AM (2012). The role of insurance in the achievement of universal coverage within a developing country context: South Africa as a case study. *BMC Public Health*, 12 (Suppl 1): S5 (page 11)

⁵⁴ Participants from medical scheme administrators in High Level Panel “Workshop on the impact of the National Health Insurance policy on access to equitable, quality healthcare” held on 28 June 2017.

Figure 8 provides an overview of those aspects of expenditure by medical schemes that have increased above general inflation (measured by the consumer price index) since 1992. As this information is presented on a per beneficiary basis, these expenditure increases are not due to changes in the number of medical scheme beneficiaries.

Figure 8: Trends in real medical scheme expenditure per medical scheme beneficiary (2012 terms)



Source: Authors' own analysis of data from the Council for Medical Schemes' Annual report data

There have been limited changes in expenditure on general practitioners, dental services and medicines. Until 1992, expenditure on medicines experienced the greatest annual increases⁵⁵. Several policy interventions, through the Medicines and Related Substances Control Act of 1997, have limited the rate of these increases since then. These interventions include the introduction of generic substitution, whereby pharmacists are required to offer patients a generic equivalent for prescribed medicines, and the establishment of the Medicine Pricing Committee and subsequent introduction of a transparent pricing system and a 'single exit price', which requires manufacturers to sell a medicine at the same price to all providers.

Figure 8 shows that the two areas of particularly rapid increase in real expenditure per medical scheme beneficiary relate to private hospitals and specialists, whose services are strongly linked with hospitals. Although there has been a relative ageing of the medical scheme population, various studies have repeatedly found that this does not fully explain cost increases in hospitals or other aspects of medical scheme expenditure, nor do changes in the disease profile of medical scheme members. A report by the Council for Medical Schemes clearly stated that the results of their analysis "show clearly that the aging medical scheme population cannot explain the changes in costs and utilisation"⁵⁶. Recently, the

⁵⁵ McIntyre D, Valentine N, Cornell J (1995). Private sector health care expenditure in South Africa. *South African Medical Journal*; 85(3): 133-135.

⁵⁶ Council for Medical Schemes (2008). *Evaluation of medical schemes' cost increases: Findings and recommendations*. Pretoria: CMS.

Competition Commission's HMI has released a report that has attempted "to identify the 'unavoidable drivers' of cost escalation in the private sector, thus isolating a residual segment of increased costs that are amenable to intervention". They note that their analysis of schemes' data "does suggest that South Africa has a problem with cost escalation". After adjusting for cost increases due to inflation, age of beneficiaries, changes in members' benefit options, gender and disease profile, there remains an unexplained increase in expenditure of approximately R3 billion per year (in 2014 terms). The HMI found that this is largely attributable to in-hospital services, and note that "this stands in sharp contrast to flat or declining hospital-based spending in many countries, once risk factors are adjusted for." While there is some 'explainable' increase in utilisation, much of the increase in utilisation of hospital services is unexplained and the average cost per admission has increased significantly. The HMI is investigating these issues more closely and have indicated that "the results of these analyses do not point to immediate policy solutions"⁵⁷.

5.2.3 Information on the acceptability of health services

Most household surveys collect 'general satisfaction' information. Although general satisfaction with private sector services tends to be higher than for public sector services, there are relatively high levels of respondents reporting being very or somewhat satisfied with health services at public health facilities (around 80%). There has been an increase over time in the percentage of recent users of public sector health services indicating that they were very satisfied with the service, increasing from 58% in 2002 to 62% in 2012⁵⁸. There are differences across socio-economic groups, with higher-income groups expressing more dissatisfaction than lower-income groups.

The major source of dissatisfaction relates to the length of waiting time before receiving care (38% in the case of public sector outpatient services and 18% in the private sector). The next most important sources of dissatisfaction were: not being treated with respect and dignity (20% in public and 10% in private sectors respectively); perceptions of lack of effectiveness of drugs received (18% in public and 9% in private sector); lack of privacy in consultations (14% and 8%); and lack of confidentiality (10% and 7%). Lack of respectful treatment, privacy in consultations and confidentiality were seen as more problematic in inpatient than outpatient services in public sector facilities⁵⁹. Stigma and judgemental behaviour of health care providers, which pose acceptability barriers to health service access, are particularly a problem in relation to certain services such as HIV, tuberculosis, pregnancy related services for teenagers and termination of pregnancy⁶⁰.

Many of the 'acceptability' barriers within public health facilities are seen as relating to low staff morale or motivation. There are many factors that have contributed to this situation, including: a sense of exclusion and disempowerment among front-line health workers due to top-down implementation of policy on which they are not consulted or well-informed although they bear the consequences of these decisions; the impact of the HIV epidemic which increased patient numbers and during the period of AIDS-denialism consigned health workers to providing palliative care instead of life-saving drugs; challenges in the work environment such as availability of functional equipment and medical supplies; and

⁵⁷ Competition Commission Health Market Inquiry (2016). *Report on analysis of claims data – initial cost attribution analysis*. Pretoria: Competition Commission.

⁵⁸ Christian (2014) *op cit*.

⁵⁹ Harris *et al.* (2011) *op cit*.

⁶⁰ Silal SP, Penn-Kekana L, Harris B, Birch S, McIntyre D (2012). Exploring inequalities in access to and use of maternal health services in South Africa. *BMC Health Services Research*; 12: 120

corruption⁶¹. While some of these factors relate to national level policies and their implementation, institutional factors that can be addressed by improved management and leadership at the facility level are equally important. However, management improvements have to be enabled by public sector health facility managers having the authority to make decisions that will allow them to create a conducive working environment.

5.3 Quality of health services in South Africa

As indicated in the conceptual overview in Annex 2, there is a strong link between quality and access, particularly the availability and acceptability dimensions. A key problem in the South African context is that there are almost no data to assess quality in a comprehensive way; instead, there is only anecdotal evidence and media coverage of the worst consequences of poor quality care. The extent of litigation is also seen as an indicator of poor quality of care. There has been a dramatic increase in medical malpractice litigation against health care providers in both the public and private health sectors. Medical litigation costs in the public health sector increased from around R191 million in 2011/12 to R389 million in 2014/15⁶². Settlement of claims by malpractice insurers on behalf of health care professionals run into billions of Rands, with claims against gynaecologists and obstetricians alone being over R4 billion. However, it should be noted that the increase of malpractice litigation does not necessarily represent declining quality of care, but is also driven by increased advertising around legal services for medical malpractice and patient knowledge of legal options, and the faultless liability regime created by section 61 of the Consumer Protection Act 68 of 2008⁶³. There are growing calls for moving to a system of mediation around medical malpractice to compensate those affected by poor quality of care while avoiding the large and rapidly growing litigation costs which are contributing to overall cost increases in the health sector⁶⁴.

Even though some surveys present information on patient satisfaction with health care, as presented in the acceptability section above, such data is generally not regarded as a good indicator of technical quality of care, or sometimes even interpersonal quality of care. Very high levels of patient satisfaction are often reported, which could be due to gratitude, limited previous alternative experiences against which to assess care received and low expectations of the health service, i.e. patients could express satisfaction with what is technically low quality care⁶⁵. Conversely, perceptions are influenced by factors such as negative media reports, with those who have never been admitted to a public hospital reporting higher levels of negative perceptions about quality of care in public hospitals than those who had been admitted to a public hospital in the previous year, and those without first-hand experience of public facilities listing media reports as the primary source of information on public facility quality of care⁶⁶.

⁶¹ Walker L, Gilson L (2004). 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social Science and Medicine* 59: 1251-1261.

Rispel LC, de Jager P, Fonn S (2016). Exploring corruption in the South African health sector. *Health Policy and Planning*, 31(2): 239-249.

Ibeziako OJ, Chabikuli ON, Olorunju S (2013). Hospital reform and staff morale in South Africa: a case study of Dr Yusuf Dadoo hospital. *South African Family Practice*, 55(2): 180-185.

⁶² National Assembly Question No. 443 to Minister of Health, 27 February 2015.

⁶³ MS Pepper and MN Slabbert (2011). 'Is South Africa on the verge of a medical malpractice litigation storm?' *South African Journal of Bioethics and Law* 4: 29

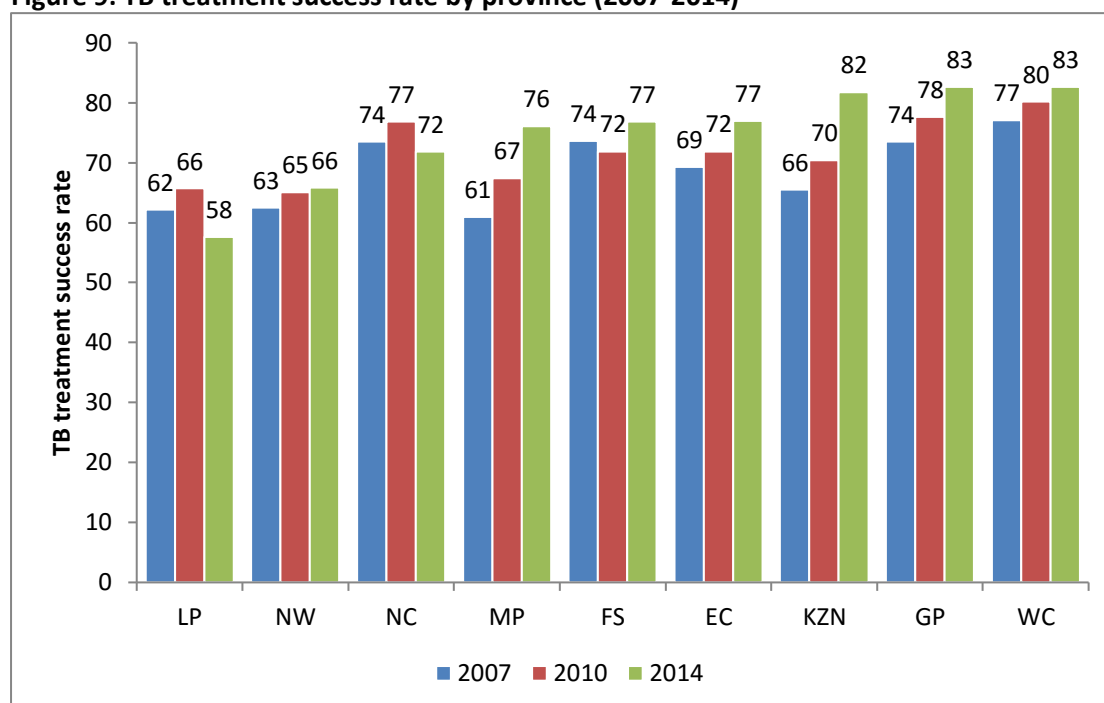
⁶⁴ Botes M (2015). Mediation: A perfect solution to health care disputes. Southern African Legal Information Institute, De Rebus; 67.

⁶⁵ Schneider H, Palmer N (2002). Getting to the truth? Researching user views of primary health care. *Health Policy and Planning*; 17(1):32-41.

⁶⁶ Harris *et al.* (2011) *op cit.*

Nevertheless, there are concerns about interpersonal service quality, as highlighted in the previous discussion about respectful treatment and staff morale issues, and structural quality of care as highlighted in terms of drug stock-outs and other service availability challenges. In relation to technical or clinical quality of care, there are limited available data. One indicator available for public sector facilities is the TB treatment success rates. While still somewhat low in some provinces (particularly Limpopo), it is higher in provinces with the greatest TB burden (such as the Western Cape) and has increased over the past decade in all provinces except Limpopo and the Northern Cape (see Figure 9). This improvement in treatment success rates has been achieved within the context of the emergence of MDRTB and XDRTB (multi-drug and extensively drug resistant TB respectively). Even indicators such as treatment success rates are difficult to interpret from the perspective of clinical quality of care, given that this outcome reflects not only aspects of service delivery but also patient factors such as treatment adherence.

Figure 9: TB treatment success rate by province (2007-2014)⁶⁷



Note: Limpopo (LP), North West (NW), Northern Cape (NC), Mpumalanga (MP), Free State (FS), Eastern Cape (EC), KwaZulu-Natal (KZN), Gauteng (GP) and Western Cape (WC).

Improving quality of care in public sector facilities is seen as an absolute priority by the national Department of Health. Much of the legislation introduced since 1994, particularly those Acts relating to councils for various health professionals and the Medicines and Related Substances Control Amendment Act, includes aspects intended to ensure the quality of professional services and medicines. Two key initiatives introduced by the Department to promote quality of care improvements are the introduction of the Office of Health Standards Compliance (OHSC), through the 2013 National Health Amendment Act, and the ideal clinic initiative. As part of the OHSC development, a set of national core standards were developed, against which all health facilities in South Africa are to be assessed. Although there is no publicly available information, it appears that the initial rounds of ‘mock

⁶⁷ Health Systems Trust (2015). *District Health Barometer 2015*. Durban: Health Systems Trust. Available from: https://public.tableau.com/views/DHB2015/ZA_table?%3Aembed=y&%3Adisplay_count=yes&%3AshowTabs=y&%3AshowVizHome=no

inspections' found that a relatively high proportion of the public facilities that were inspected were non-compliant with the core standards. The National Department of Health introduced Facility Improvement Teams (FITs) to support selected facilities in NHI pilot districts in an attempt to move facilities closer to compliance with the national core standards. Subsequently, the ideal clinic initiative was launched, which provides detailed benchmarks for what is regarded as a well-functioning clinic ⁶⁸.

While enormous efforts have been devoted to these initiatives, various criticisms and concerns have been raised. In particular both the core standards of the OHSC and the ideal clinic initiative's indicators focus almost exclusively on structural measures of quality of care, such as the availability of physical, administrative and other infrastructure in facilities. Even indicators relating to clinical governance are measured by the availability of written clinical protocols in the facility rather than the actual use or implementation of these protocols ⁶⁹. The second area of concern is that some health facility managers and frontline health workers experience the OHSC inspections as demotivating and not necessarily engendering quality improvement in that the inspections do not provide an educational opportunity to gain insights into how to improve quality ⁷⁰. The potential for public sector facilities to improve and sustain quality of care is limited within the context of the very limited decision-making authority of facility managers.

There is no publicly available information on the quality of care within the private health sector. Many years ago, Discovery Health posted information on its website on key outcomes measures (such as mortality rates and hospital-acquired infections) of individual private hospitals that were used by their members and, thus, on which they had data. However, this data was quickly removed after vociferous opposition from private hospital groups. More recently, Discovery Health began making available, but only to its members, the results of its patient experience survey.

One of the greatest concerns from a quality perspective in the private health sector relates to potential overprovision of diagnostic and therapeutic interventions; this is not only inefficient but can be harmful when interventions are undertaken that are unlikely to be beneficial. Although, once again, there are extremely limited data, it has been noted that there are very high levels of diagnostic equipment capitalisation in private hospitals, with MRI and CT scanners per million population that exceed levels in most high-income countries, only being higher in a few countries such as Japan, the United States and Iceland. There are also high levels of private hospital inpatient admissions in South Africa, being more than double those in countries such as the United States; private hospital inpatient admissions in South Africa have increased substantially over time in contrast to declining levels of inpatient admissions in high-income countries ⁷¹. The issue of potential overprovision of health care interventions in the private health sector is an issue that is being investigated by the Competition Commission's Health Market Inquiry.

⁶⁸ Moleko W, Msibi EB, Marshall C (2014). Recent developments in ensuring quality of care in health establishments in South Africa. In: Padarath A, English R (Eds). *South African Health Review 2013/14*. Durban: Health Systems Trust.

⁶⁹ Burger R, Ranchod S, Rossouw L, Smith A (2016). Strengthening the measurement of quality of care. In: Padarath A, King J, Mackie E, Casciola J (Eds). *South African Health Review 2016*. Durban: Health Systems Trust.

⁷⁰ Mabaso KJ (2017). *External Quality Assessment of Health Facilities in South Africa: Strengths appraised and gaps identified*. PhD thesis. Oxford: University of Oxford.

⁷¹ Council for Medical Schemes (2008). *Evaluation of medical schemes' cost increases: Findings and recommendations*. Pretoria: CMS.

5.4 Overview of key issues in terms of equitable access to quality health services

A wide range of issues is raised in the preceding sections that highlight inequalities in access to quality health services in South Africa. Some of the most important findings include:

- There are substantial differences in utilisation of health services across socio-economic groups and geographic areas. Although the greatest burden of ill health in the full range of disease categories is on the lowest socio-economic groups, utilisation of health services is lowest among the poorest. Utilisation of specialist referral services is particularly inequitable. Utilisation of health services is not in line with the need for health care; access inequalities contribute to this utilisation pattern.
- There are substantial inequalities in the availability of health services across socio-economic groups and geographic areas, whether one is looking at the distribution of facilities, human resources, the routine availability of essential medicines or other service availability indicators. The lowest socio-economic groups and poorest provinces have the worst access in the availability dimension.
- Affordability problems are in some ways less of a challenge, particularly given the removal of user fees at public sector primary health care facilities, but:
 - Some of the poorest continue to face cost barriers, particularly in terms of the costs of transport to facilities.
 - Those who are employed but are not medical scheme members sometimes face relatively high levels of out-of-pocket payments for inpatient care in public sector hospitals.
 - The greatest share of out-of-pocket payments is borne by medical scheme members in the form of co-payments as well as to pay for services not covered by their medical scheme. Also, lower income medical scheme members face medical scheme contributions that are a far greater share of their income than higher income scheme members, posing affordability challenges. These issues have been exacerbated by on-going increases well above inflation in the fees of some private providers, medical scheme expenditure and contribution rates.
- There is a range of acceptability challenges, particularly in public health sector facilities, and particularly in terms of staff morale and attitudes.
- There is very little available information to assess technical quality of health care in both the public and private health sectors. While the establishment of the OHSC provides the basis for routine assessment of quality of health services in public and private health facilities, there remains a lack of mechanisms for improving and sustaining quality of services.

There have been various legislative and policy efforts since 1994 to address some of these challenges, but progress has been slow in some areas. While some of these challenges point to very specific recommendations, such as removing user fees at public hospital for those not covered by medical schemes and improving patient transport, particularly for referral service, many analysts point to the need to introduce *fundamental institutional reform* to

achieve extensive and sustained improvements in access to quality health care. Some of the reforms that have received considerable support among a wide range of stakeholders⁷² are:

- Dramatic improvements in the management of public sector health facilities, particularly through decentralising management authority to individual public sector hospitals and health district or sub-district level for primary health care services, along with appropriate governance mechanisms.
- Centralised allocation of health care resources.
- Establishing public agencies outside of the Department of Health for strategic purchasing, quality assurance and other functions.

6. Reform options and their potential to address inequitable access to quality health services in South Africa

Various reform options have been put forward since 1994, with the National Health Insurance (NHI) proposals having dominated policy discussions for the last decade. This section provides a brief overview of reform proposals since 1994. This is followed by detailed consideration of the current government proposals for reform, namely the National Health Insurance (NHI) proposals. The reason for this focus is that the Terms of Reference for this report require consideration of legislation and policies related to the health system; the NHI is currently the official government policy on future health system reform with both a Green and White Paper having been published. It is, therefore, critical to gain a clear understanding of the proposed reforms and critically assess their potential to address inequitable access to quality health care. Thereafter, alternatives that have been put forward are considered from the same 'equitable access to quality health care' perspective.

6.1 Brief overview of key health sector reform proposals since 1994

There have been a range of committees established to make recommendations for health sector reform since 1994, including the Health Care Finance Committee (1994), the Committee of Inquiry into a National Health Insurance (1995), the Taylor Committee of Inquiry into Comprehensive Social Security (2002) and more recently the Ministerial Advisory Committee on National Health Insurance (2009-2010). During the 1990s and early 2000s, the emphasis was on what was termed Social Health Insurance (SHI). The core features of the SHI design during this time included:

- Mandatory membership for all formal sector employees above the income tax threshold;
- There could either be a single SHI scheme, or a number of smaller schemes as financial intermediaries for the SHI (generally existing medical schemes and some proposals included a state-sponsored scheme);
- A *uniform* prescribed minimum benefit (PMB) package that all members are entitled to and all schemes must provide;
- A uniform set of community-rated contribution rates for the PMB package across all schemes, only being adjusted on the basis of income and number of dependents; and
- A risk-equalisation mechanism across individual schemes (all of the early proposals envisage risk-equalisation across all schemes, including the state-sponsored scheme).

⁷² See for example the Development Bank of South Africa's "Roadmap for the reform of the South African health system"

In terms of the benefit package, there were some variations across the different proposals, with some favouring a comprehensive package (PHC and hospital care) while others focused on hospital care. It was envisaged that individuals could pay extra to use private hospitals, with the cost of the PMB package being based on use of public hospitals. It was envisaged that this would provide substantial benefits for the overall health system in the following way. Health insurance coverage of the population would be substantially increased through compulsory SHI membership for all formal sector employees above the income tax threshold and their dependants. As many of those who would be newly insured under the SHI would be relatively low-income earners, and given that the SHI benefit package would be sufficient only to cover the costs of public sector hospitals, the majority of the newly insured would continue to use the public sector but the SHI scheme would be able to cover the cost of this use. This would bring additional revenue into public hospitals that could be used, in combination with existing tax funding of health services, to improve health services for all public sector users, including the non-insured population. The proposed SHI was also seen as a mechanism for improving overall health system sustainability through exercising purchasing power in negotiating provider payment mechanisms and rates.

The SHI proposals were never taken forward, although the Medical Schemes Act of 1998 re-introduced community rating, which had always been the practice of medical schemes until risk-rating was allowed during a period of 'de-regulation' introduced in 1989, and a PMB package. Instead, the policy direction shifted to introducing a universal health system in 2007; the NHI reforms are considered in some detail below.

6.2 What is the goal of current reform proposals?

The NHI Green and White Papers indicate that the explicit goal of the government's NHI reform proposals is to move South Africa towards Universal Health Coverage (UHC). Almost without exception, stakeholders state that they support this goal. However, there appear to be different understandings of the UHC goal. Therefore, a fundamental issue in considering the debates about the NHI and alternative reform options is the importance of reaching a common understanding of the meaning of UHC.

According to the World Health Organisation's 2010 World Health Report, UHC is defined as providing financial protection from the costs of using health services for all people of a country **as well as** enabling them to obtain the health services that they need, where these services should be of sufficient quality to be effective. Another important element of the global emphasis on UHC is that there should be a move away from financial protection and access to quality health care being linked to employment status towards a **universal entitlement** to financial protection and health service access based on citizenship.

Some have stated that South Africa already has UHC. For example, one commentator has stated that "South Africa technically complies with the goal of universal coverage as a comprehensive package of health services is available on a pre-paid basis either through the public sector or regulated health insurance (medical schemes)"⁷³. In another paper, the same commentator clarified that "Together, the two systems [tax funded and medical schemes' systems] achieve a high degree of financial-risk protection reflected by the moderate levels of out-of-pocket (OOP) expenditure"⁷⁴. While South Africa does have a relatively good level of financial risk protection, as highlighted in the evidence presented

⁷³ Van den Heever (2012) *op cit*.

⁷⁴ Van den Heever (2016). South Africa's universal health coverage reforms in the post-apartheid period. *Health Policy*, 120: 1420-1428.

above South Africa is very far from having universal access to and use of quality health services in line with need for health care. It is important in moving forward in the current debates for all to acknowledge that South Africa does not currently have what could be termed a universal health system.

The area of greatest difference in understanding relates to the term ‘universal’; to some it simply means that *everyone* should have some financial risk protection and access but that there could be differences in the extent and nature of financial protection and access, while to others it means that *everyone* should have financial risk protection and access to quality health services *on the same terms*. Our personal view is that in moving to UHC, the emphasis should be on moving to a situation where everyone is able to claim their entitlements to health services on a comparable basis, i.e. to have comparable access to services of a comparable range and quality on the basis of need for health care. In almost all countries, there are some differentials due to the rich buying what they perceive to be ‘better’ health care; in countries that are regarded as having a universal health system, these differentials are at the *margin*. In the South African context, this requires a movement towards narrowing the differentials in access to quality health services *over time*. It should be clarified that this is a long-term goal; achieving access to a comprehensive range of quality health services for everyone will not be achieved overnight. Nevertheless, it should be clearly stated as the long-term goal and active steps taken to move towards this goal rather than only guaranteeing access to a minimalistic ‘package of services’ and ignoring the substantial differentials across groups.

6.3 National Health Insurance (NHI) reform proposals

There is considerable confusion around the nature of the proposed National Health Insurance (NHI) reforms. Many have commented on a lack of detail in the Green Paper and subsequent White Paper on NHI, which has undoubtedly contributed to the confusion around what is being proposed.

What the White Paper on NHI does clearly indicate is that the intention is to establish a NHI Fund (NHIF) as a single funding pool, which would function as a *strategic purchaser* of health services for the South African population (e.g. sections 7, 8, 11, 30, 90, 273 and 275-278 of the 2017 White Paper). Indeed, establishing an organisation (the NHI Fund) to strategically purchase health services for all is the core of the NHI proposals. The idea and practice of strategic purchasing is very poorly understood, yet it is the means by which resources mobilised for universal health coverage are actually translated into the effective delivery of accessible, quality services⁷⁵, as has been demonstrated in many countries around the world who have developed purchasing agencies and where these agencies have used the full range of active or strategic purchasing tools (see information on international experience in Annex 6).

Possibly the simplest way to explain the concept of *strategic purchasing* is to contrast it with passive purchasing: “Passive purchasing implies following a predetermined budget or simply paying bills when presented. Strategic purchasing involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be

⁷⁵ RESYST (2014). *What is strategic purchasing for health?* London: Resilient and Responsive Health Systems (RESYST) Consortium.
<http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/Purchasing%20brief.pdf>

purchased, how, and from whom.”⁷⁶ Figure 10 highlights some of the key differences between passive and strategic purchasing and key actions that a strategic purchaser would take. Annex 7 provides a more detailed overview of strategic purchasing actions. In South Africa at present, both government health departments and medical schemes would fit more within the category of passive rather than strategic purchasers. From this perspective, the NHI reforms seek to address challenges in both the public and private health sectors.

Figure 10: Contrasting passive and strategic purchasing

Passive purchasing	Strategic purchasing
<ul style="list-style-type: none"> • Little or no selection of providers (‘anything goes’) 	<ul style="list-style-type: none"> • Selection of providers (quality, location, range of services) whenever feasible
<ul style="list-style-type: none"> • Little or no clarity on purchaser’s expectations of providers 	<ul style="list-style-type: none"> • Explicit service level agreement or contract
<ul style="list-style-type: none"> • Allocation of resources and provider payment mechanisms with limited incentives or which create perverse incentives 	<ul style="list-style-type: none"> • Allocation of resources and provider payment mechanisms that provide appropriate incentives for quality, efficiency and equity
<ul style="list-style-type: none"> • Price and quality taker 	<ul style="list-style-type: none"> • Price and quality maker
<ul style="list-style-type: none"> • Little or no monitoring 	<ul style="list-style-type: none"> • Monitoring of quality and other aspects of services

The following sections unpack in a bit more detail how it is envisaged that the NHIF would function as a strategic purchaser and critically assesses whether or not this would address existing inequalities in access to quality health services in South Africa.

6.3.1 Addressing inequalities in the allocation of public sector financial resources

As indicated in earlier sections, a key challenge in promoting an equitable distribution of quality health services is the continued inequalities in public health care budgets and expenditure across and within provinces. Two fundamental contributors to this are: firstly, the fiscal federal system whereby provinces receive an ‘equitable share’ allocation and have autonomy in deciding on the allocation of these funds to the health and other sectors; and secondly, the reliance on historical budgeting practices within provincial health departments.

Under the proposed NHI reforms, all general tax funds for personal health services would be allocated to the NHIF, which would in turn allocate these funds to individual service providers (or groups of providers in the case of Primary Health Care (PHC) services). This approach is feasible from a constitutional perspective and would overcome the existing equity challenges posed by the fiscal federal system. As emergency health services are the only services that are an exclusive responsibility of provinces, it is only necessary to direct funding for these services through the equitable shares allocation process.

⁷⁶ World Health Organization (2000). *The World Health Report 2000. Health systems: Improving performance*. Geneva: World Health Organization

Given that PHC services are the most pro-poor services, ensuring access to quality PHC services is of considerable importance. The Green and White Papers indicate that funding for PHC services would be allocated by the NHIF using risk-adjusted capitation. This would allow for funds to be allocated across the entire country on the basis of the relative need for health services in each area. This approach (alternatively called needs-based resource allocation or risk-adjusted capitation) has been widely used internationally with great success in reducing inequalities in health service access across geographic areas (e.g. the experience of England with the RAWP process).

6.3.2 Promoting efficient provision of quality services

6.3.2.1 *Delegation of decision-making authority to individual public sector providers*

A pre-requisite for strategic purchasing to be effective is creating what is often referred to as a 'purchaser-provider' split. What this means is that there should be a degree of separation between the purchaser on the one hand and the provider on the other; ideally, the purchaser should not also be directly managing health service provision. Instead, providers must have quite extensive decision-making authority. This is critical in the South African context as one of the key drivers of inefficiency, inadequate service quality, poor staff morale and other negative features of public sector health services is lack of decision-making authority at the provider level. Hospital and other health facility managers have very little authority to make key decisions; instead, they have to send requests up the chain of command to provincial health departments. Not only does this create long delays in responding to issues that often have serious implications for service delivery, it is inefficient and contributes to managers being seen as unresponsive to their staff and patients.

Therefore, a key part of the NHI reforms is that greater authority to make and implement decisions needs to be granted to managers within individual public hospitals and for a group of facilities or providers in the case of primary health care services. It is unlikely that there will be adequate management capacity for authority to be delegated to every public clinic in South Africa; therefore, there should be delegation to a structure at a sufficiently decentralised level, probably resembling the current sub-district level⁷⁷. A similar approach has been adopted in Thailand, where authority is delegated to what is termed a 'Contracting Unit for PHC' (CUP). A CUP would be the organisational unit with which the NHIF would contract for PHC services, and it would be responsible for the management and delivery of comprehensive, integrated PHC services within its geographic area. The CUP would consist of all public PHC providers within a specified geographic area and should generally include a district hospital (given that first level referral hospitals are internationally viewed as an integral part of the PHC system⁷⁸), several clinics and/or community health centres and the ward-based outreach teams (WBOTs) (i.e. community health workers). In addition, the CUP may include contracted private PHC providers where this will promote access to comprehensive, quality PHC services for all in the area served by the CUP.

⁷⁷ The Green and White Papers referred to a District Health Authority (DHA) as the manager of PHC provision. However, the size of current health districts is too large to allow for truly decentralised management authority to enable efficiency and quality in health service provision.

⁷⁸ See for example: Sustainable Development Solutions Network Thematic Group on Health (2014). Health in the framework of sustainable development: Technical report for the post-2015 development agenda. New York: Sustainable Development Solutions Network (pages 10 & 43). <http://unsdsn.org/wp-content/uploads/2014/02/Health-For-All-Report.Pdf>; and Røttingen, JA, Ottersen, T, Ablo, A et al. (2014) Shared responsibilities for health: a coherent global framework for health financing. The Royal Institute of International Affairs. Final report of the Centre for Global Health Security Working Group on Health Financing

Clearly the decentralisation of management authority needs to be phased in as and when adequate management capacity exists within each hospital and CUP, and needs to be accompanied by the implementation of effective governance structures (such as functioning hospital boards) and processes to ensure local oversight and accountability. An important issue to note in terms of management capacity is that considerable human resource, financial and other management capacity already exists within the public health sector, but most of this currently sits within provincial health departments. As the role of provincial health departments will move away from being the managers of service provision (see later), this management capacity needs to be reassigned to individual hospitals and CUPs.

Hospital and CUP managers will ultimately be fully responsible for making and implementing decisions on how to use the financial resources they have to provide efficient, quality health services and for the day-to-day management of their facilities. For example, given that national tenders are established for medicines on the essential drug list, each hospital and CUP can order the medicines they need directly from the manufacturer who can deliver these directly to them through the manufacturer's designated private distributor. As indicated previously, lack of routine availability of medicines within many public sector facilities is one of the most persistent obstacles to equitable access to quality health services, which can be addressed very rapidly with management authority delegations and the use of private medicine distributors. Managers would also be able to make staffing decisions; although there would be national guidelines on the number and range of staff required to deliver services at different levels of the health system, managers should have authority to adjust their skills mix to meet their specific needs and to directly manage their human resources.

This delegation of management authority will allow providers to respond appropriately to the strategic purchasing actions the NHIF will use to *influence the behaviour of providers* in order to promote and sustain the efficient provision of quality health services. It will also be possible for the first time to truly hold managers accountable for the use of resources as the manager will now have real decision-making authority over how resources are used.

6.3.2.2 Selection of health care providers

Ideally, a strategic purchaser should be able to select the providers from whom it would like to purchase health services; this is often referred to as selective contracting. The considerations that a purchaser would take into account when selecting providers include:

- The provider's quality of care
- Their ability to provide the full range of services required by the purchaser
- The location of the provider relative to the population for which services are being purchased
- The provider's willingness to accept the purchaser's contractual specifications, including how and how much the provider is paid
- Within the South African context, there would also be BEE considerations

The reality, however, is that it is not always feasible to engage in selective contracting, particularly in rural areas where the supply of health care providers is generally inadequate. In these cases, the purchaser generally contracts with all available providers to ensure that the resident population has some access to health services. A key problem is that some of these facilities will not necessarily meet acceptable quality standards at present. The Green and White Papers indicate that the NHIF will contract with providers which have been certified by the OHSC as meeting quality standards. The experience of countries such as Thailand provide valuable insights into how quality certification can be used as a supportive

and empowering process to assist facilities to improve quality over time⁷⁹; the relevance of such experience for the OHSC requires urgent consideration. Delegating management authority to individual public hospitals and CUPs, along with adequate resourcing of these facilities, and holding managers accountable for their use of resources and services provided is critical in promoting quality improvement.

While service quality is a key element of selecting providers with whom to contract, there are other issues that need to be considered. An important way of improving access to quality health services for all South Africans is for the NHIF not only to contract with public health facilities, but also with private providers. A key challenge in this regard is the heavy concentration of private providers in large urban areas at present. The NHIF will not be able to establish contracts with every service provider in areas that currently have a relative over-supply of providers. The allocation of PHC resources by the NHIF on a needs or risk-adjusted capitation basis will provide an incentive for private providers to begin practicing in relatively under-served areas if they so desire; securing a contract with the NHIF is more feasible in these areas. Selective contracting can, therefore, also contribute to equity in access to health care.

6.3.2.3 Contracting with health care providers

A key strategic purchasing action is establishing service level agreements or more formal contracts with providers. The NHIF will establish contracts with each provider, public or private, from whom they will purchase health services. Contracts are a mechanism for making expectations of service providers clear, particularly the quantity and range of services to be provided and quality of care requirements, including using standard diagnostic and treatment guidelines which will be based on the best available scientific evidence. It also provides a basis for monitoring provider performance (e.g. through specifying information to be provided to the NHIF) and acting on poor performance⁸⁰.

6.3.2.4 Changing health care provider payment mechanisms

The NHIF would be in a position to introduce alternative provider payment mechanisms to those currently used in the public health system and by medical schemes. The way in which providers are paid (e.g. diagnosis-related group compared with fee-for-service payments) provides strong incentives for providers to deliver quality care efficiently. The public finance management environment constrains payment of public hospitals and primary health care providers to line-item budgets and in the medical scheme environment, fee-for-service payments are the dominant provider payment mechanism; neither of these mechanisms is internationally regarded as providing appropriate incentives for the efficient provision of quality health services.

The Green and White Papers have indicated that non-hospital PHC providers will be paid on a risk-adjusted capitation basis and that hospitals would be paid on a diagnosis-related group (DRG) basis. Both of these provider payment mechanisms are widely used internationally as a means of promoting efficient delivery of quality health services. It is not

⁷⁹ Tangcharoensathien V, Limwattananon S, Patcharanarumol W, Thammatacharee J, Jongudomsuk P, Sirilak S (2015). Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy and Planning*; 30(9): 1152-1161

⁸⁰ Duran A, Sheiman I, Schneider M, Øvretveit J (2005). Chapter 9: Purchasers, providers and contracts. Velasco-Garrido M, Borowitz M, Øvretveit J, Busse R (2005). Chapter 10: Purchasing for quality of care. Both in: Figueras J, Robinson R, Jakubowski E (Eds). *Purchasing to improve health systems performance*. European Observatory on Health Systems and Policy Series. Maidenhead: Open University Press.

feasible to introduce these payment mechanisms overnight as this would introduce too much uncertainty for individual providers on the resources that would be available to them. The first step in the transition for public sector providers is to move from a tightly specified line item budget to allocating a global budget, which would allow managers to exercise the decision-making authority delegated to them. Initially, the global budget would be allocated on the same basis as in previous years, such as historical budgeting, but managers would also be provided with a 'shadow budget' indicating what allocation they would have received under the new provider payment mechanism (e.g. DRG or risk-adjusted capitation). This would be done for the first year or two to allow managers time to adjust their service organisation and provision arrangements to the upcoming changes in their resource envelop. The change to the new provider payment mechanism can further be phased in, such as moving to 75% of the global budget being allocated on the historical basis and 25% on the new basis in one year, 50:50 allocation the year after, 25:75 the next year and finally 100% on the new basis. The experience of countries such as Kyrgyzstan, which used a phasing in approach when changing provider payment mechanisms, can be drawn on.

6.3.3 Organisational arrangements including the roles of existing health departments

The Green and White Papers indicate that the NHI would be established as an autonomous public entity. However, the respective roles of existing public sector health departments and related structures once the NHIF is introduced is another area where limited detail has been provided to date.

The National Department of Health (NDoH) would remain responsible for all key health system stewardship functions, not only the development of national policy and creating and maintaining the legislative and regulatory framework for the whole health system, but also establishing norms and standards to promote equitable access to quality services. This would include the development and routine updating of the essential drug list (EDL) and a full range of standard treatment guidelines (STGs). The NDoH would also lead the planning of health facility infrastructure development and the planning for health human resource requirements of the country, to ensure that there are adequate numbers of health professionals and public health facilities and that these are well distributed.

Delegation of management authority to individual public hospitals and organisational entities such as CUPs would mean that provincial health departments would no longer be required to undertake management of health service provision. As indicated previously, human resource, financial and other relevant management capacity would need to be redistributed to individual hospitals and CUPs. Provincial health departments would take on more of a monitoring and evaluation role and provide support in areas where it may not be feasible to have capacity within every facility, such as labour relations expertise. In addition, emergency health services are an exclusive function of provinces in terms of the Constitution, and would need to continue to be provided by provincial health departments.

If management authority is delegated to CUPs at sub-district level, the need for district offices should be reconsidered; it is unclear whether any role could be assigned to them.

Although these changes would clearly require careful labour relations negotiations, it is critical that they are implemented to ensure that resources are not wasted on multiple administrative layers.

6.3.4 Will the NHI be affordable and sustainable?

A major concern expressed by various stakeholders is that of the affordability and long-term sustainability of the NHI. A wide range of cost estimates have been put forward by different stakeholders, due to different methodological approaches being used and particularly due to whether unit costs are based on current costs of public sector provision with increased resourcing to improve access to health services and quality of care or on current medical schemes spending levels. Those that have concluded that NHI is unaffordable have relied heavily on medical schemes data as the starting point. The NHI White Paper cost estimates use improved resourcing of public sector services as the starting point and concludes that tax funding of the health sector would need to increase over time from 4% of GDP to around 6.2% of GDP. This is in line with international estimates of the public resource requirements for a universal health system⁸¹ and, as noted by the White Paper, “would be below the level of public spending (as a percentage of GDP) of many developed countries”.

The ultimate cost of a universal health system is dependent on the *design* of the health system, and what safeguards are put in place to control cost and service utilisation increases and total spending limits. There are several features of the NHI reforms that are critical in this regard and need to be recognised in order to assess affordability and sustainability issues.

Firstly, the NHIF will be funded through allocations from tax revenue, whether this is simply an allocation from general tax revenue or a combination of dedicated tax revenue and an allocation from general tax revenue. This means that the NHIF will have a clear and explicit budget envelope that it must operate within. The rate of increase in NHIF expenditure will be determined by National Treasury decisions on the allocation of tax revenue. What this means is that expanding the number of provider contracts, or the range of services which contracted providers are expected to provide, will be determined by the budget allocated to the NHIF. Many of the concerns raised about affordability refer to some of the earlier estimates of the quantum of resources that it would be ideal to allocate to the NHI to rapidly improve access to quality health care, which were based on predicted GDP growth rates at that time and which due to the global economic crisis have not materialised. Within this context, it would simply mean that improving the availability, range and quality of health services for South Africans would proceed at a slower pace. A hallmark of the NHIF would be meticulous financial management, including careful budgeting and monitoring of expenditure relative to the budget.

Secondly, the explicit contracts between the NHIF and providers combined with appropriate design of provider payment mechanisms would assist with containing expenditure. In particular, the ‘blank cheque’ approach of open-ended fee-for-service payments would not be used. Risk-adjusted capitation payments allow for considerable predictability in projected expenditure and although DRGs are effectively an activity-based payment mechanism, international best practice is to place a global budget cap on hospital expenditure as a mechanism to prevent supplier-induced demand and what is termed ‘DRG creep’ (where hospitals try to ‘game the system’ and allocate higher DRG codes). DRG payments are monitored on an on-going basis, and the monetary value assigned to the relative value unit in the DRG system is adjusted if service provision exceeds contracted amounts to ensure that payments are budget neutral.

⁸¹ McIntyre D, Meheus F, Røttingen JA (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law* 12: 125-137.

Thirdly, the monopsony purchasing power of the NHIF is of considerable importance in ensuring affordability and sustainability. The power of purchasers relative to providers has dramatic implications for efficiency, affordability and sustainability of the health system. The balance of power to exert influence over the rate of expenditure increases, limiting overuse and overprovision and many other factors, will be in favour of the NHIF. While there is often considerable discomfort about the issue of exercising monopsony purchasing power, in contrast to ‘leaving it to the market’ or promoting competition, the reality is that there is an imbalance in power within an unregulated health system, in favour of health care providers. In the words of Kenneth Arrow, winner of the 1972 Nobel Prize in Economic Science and the intellectual father of health economics: “The market won’t work – it doesn’t work well in the health context.”⁸² As highlighted in Figure 10, the hallmark of a strategic purchaser is that it is a ‘price maker’ rather than a ‘price taker’. The consequences of health care providers being the ‘price makers’ in the private health sector context in South Africa is precisely what the Competition Commissions’ Health Market Inquiry is grappling with at present. While some have argued that the solution is comprehensive regulation of the private health sector⁸³, both on the health care financing (medical schemes) and provider side (including price regulation), the recent history in South Africa of legal challenges to every effort to regulate this sector does not bode well for effective implementation of such regulations in the foreseeable future (see Annex 3 for examples of legal challenges to legislation). A monopsony strategic purchaser ‘holding the purse strings’ circumvents the need for regulations, which even if promulgated are notoriously difficult to enforce. Exerting monopsony purchasing power, particularly in regard to ‘price making’ does not mean that a strategic purchaser such as the NHIF would pay providers at unreasonably low levels. As the purpose of strategic purchasing is to promote equitable access to efficiently provided, quality health services, payment levels have to enable achievement of this objective.

Fourthly, there would be safeguards against unfettered increases in utilisation rates, particularly of referral services. In particular, there would be strict PHC gatekeeping for all health service use except in the case of life-threatening emergencies. Unlike the current medical scheme model where there is direct access to specialists, often for services that could and should be provided by general practitioners, or even professional nurses, the NHIF would require patients to go to a PHC provider in the first instance, with referral only where required. Combined with an emphasis on task-shifting, where each service is provided by the least specialised health worker with the necessary skills to perform that task (e.g. dispensing of routine chronic medicines by a pharmacy assistant rather than a pharmacist), PHC gatekeeping will not promote affordability of the NHI but also enable progress to equitable access to quality health services in the context of constraints on the availability of highly skilled health professionals. For example, specialist doctors would see only patients that require their expertise rather than also patients who could be seen by a generalist doctor, or in many cases a clinical nurse practitioner.

Finally, international experience has demonstrated that strategic purchasing agencies tend to have very low administrative costs, particularly with a large monopsony purchaser. For example, administration costs of the South Korean NHI are 3.6% of total health expenditure, while that for Thailand’s Universal Coverage scheme is an extraordinary 0.7% of total

⁸² Arrow K (1963). Uncertainty and the welfare economics of medical care. *American Economic Review*, 53(5), 941-73

⁸³ van den Heever (2012) *op cit*.

Development Bank of South Africa (2008). *A roadmap for the reform of the South African health system*.

expenditure⁸⁴. As highlighted above, appropriate design of the NHIF organisational structure, combined with restructuring of existing public health sector management structures within the different spheres of government, would contribute to administrative efficiency gains and overall health system affordability and sustainability.

6.3.5 Funding of the NHI

The NHI will be funded from tax revenue allocations. There has been some discussion about introducing additional taxes to assist in funding the NHI, with the NHI White Paper mentioning several possible taxes, namely:

- Payroll taxes – An advantage is that payroll taxes are currently low. Disadvantages include that it can have negative employment effects, has a regressive incidence and the highest income individuals often do not pay payroll taxes if they are not formally ‘employed’ (e.g. their income stems from investments, inherited wealth etc.)
- Surcharge on taxable personal income – An advantage of this approach is that it includes all who are liable for personal income tax, not just those in formal sector ‘employment’, and income from all sources; it also has a progressive incidence. It can have a negative effect on savings.
- The above forms of taxes can also be applied to companies (and not just individuals). For example, individual employees and their employers can be required to pay a percentage of the payroll in the form of a social security tax. A surcharge could also be levied on taxable company income.
- Value-added tax – The key advantage of a ‘surcharge’ on VAT (or an increase in the VAT rate with the additional revenue dedicated to funding the NHI) is that it draws on a very broad base (everyone pays VAT). The main disadvantage is its regressive incidence.

These would be regarded as ‘dedicated taxes’, i.e. the revenue generated from the payroll taxes, surcharges on taxable income or additional VAT would be explicitly earmarked for funding the NHI. Such dedicated taxes are sometimes regarded as promoting tax compliance in the sense that individuals may be more willing to pay taxes that are to be used for improving access to quality health services than general taxes, particularly in the context of widespread corruption in government. However, it must be recognised that dedicated or earmarked taxes do not necessarily translate into increased tax revenue allocations to the sector for whom these specific taxes are earmarked. The reason for this is that the dedicated taxes would not fully fund the NHI; the NHI would also require allocations from general tax revenue. International evidence indicates that the ‘additional’ revenue from dedicated taxes is frequently partially or fully offset by reductions in allocations from general tax revenue. Ultimately, adequate funding of the NHI requires an increase in tax rates, whether in the form of introducing ‘dedicated’ taxes or increasing the rates of existing tax rates, and for improved access to quality health care to be seen as a sufficiently important for the NHIF to be awarded an overall increase in allocation from tax revenue in the budgeting process.

It is recognised that many other social sectors are in desperate need of additional funding, and that spending on these sectors can also contribute to improving South Africans’ health status through the social determinants of health mechanism. Gradual increases in tax funding to enable equitable access to quality health care for all South Africans should, therefore, not come at the expense of adequate funding of other social services. It is likely that increases in tax rates will be required; it should be borne in mind that personal income

⁸⁴ Mabaso K (2012). *Single purchaser vs. multiple purchaser health financing systems*. Masters thesis, Oxford University.

tax rates were reduced (from 45% to 40% for the highest income tax bracket between 1996 and 2008), as were corporate income tax rates (from 35% to 28%). There is also potential for increasing revenue through taxing the wealthiest more effectively and addressing tax avoidance practices of multinational corporations. The former Minister of Finance, Pravin Gordhan noted that “Aggressive tax avoidance is a serious cancer eating into the fiscal base of many countries”. Addressing this issue does require global action. In this regard, it is encouraging that the Addis Ababa Action Agenda, the global agreement reached for funding the Sustainable Development Goals, includes the following: “We recognize that significant additional domestic public resources ... will be critical to realizing sustainable development and achieving the sustainable development goals. ... We will redouble efforts to substantially reduce illicit financial flows by 2030, with a view to eventually eliminating them, including by combating tax evasion and corruption through strengthened national regulation and increased international cooperation. ... We will make sure that all companies, including multinationals, pay taxes to the Governments of countries where economic activity occurs and value is created, in accordance with national and international laws and policies.”⁸⁵

6.3.6 NHIF organisational and governance imperatives

Potentially one of the greatest concerns of stakeholders relates to governance of the NHIF. There is considerable risk in a large proportion of the financial resources available for health services being located in a single institution in the absence of strong risk management and good governance or without appropriately skilled staff. Concerns about governance are well founded within the current political context. However, the question is whether to maintain the status quo with all the likely adverse consequences for continued inequality in access to quality health care for the majority of South Africans, or whether to pursue reforms and use every available means to ensure good governance in public health facilities and the NHIF and appropriate staffing of the NHIF. Some point to the failures of existing institutions such as the Road Accident Fund (RAF). However, it must be recognised that RAF does *not* operate as a strategic purchaser and that it is important to learn from the failures of existing institutions and avoid evident problems in the governance and operational structures of these institutions, as well as drawing on international best practice on how to promote effective functioning and good governance.

The ways in which effective functioning and good governance can be promoted include:

- As an autonomous public entity, the NHIF will have greater flexibility than public sector health departments to attract staff with appropriate expertise. The establishment of the Council for Medical Schemes’ office is an example of how this can be achieved. The skills set required for strategic purchasing is different to that which exists in health departments and also in many respects within medical schemes, where a large focus is on processing literally millions of fee-for-service based claims; given that the NHIF will pay for health services using capitation and DRG payment mechanisms, the large infrastructure required by medical schemes to process the millions of fee-for-service claims will not be required. There are many international examples of effective strategic purchasing organisations that will inform the design of the NHIF organisation. There must be a rigorous and transparent process of recruiting and hiring staff for the NHIF.
- International experience indicates that where there is a single purchaser, it is essential that there be “external oversight mechanisms that make the fund accountable for

⁸⁵ UN (2015). *Report of the third International Conference on Financing for Development*. New York: United Nations. http://www.un.org/ga/search/view_doc.asp?symbol=A/CONF.227/20

integrity, quality and productivity”⁸⁶. The emphasis should be on ensuring that the interests of the general public are taken into account and that there is accountability to the general public. International experience also highlights that it is important to achieve a “balance between making these institutions accountable to governments and protecting against undue interference from those same governments”. This is generally achieved by government appointing members of the oversight body (such as a Supervisory Board), but not being involved in the day-to-day activities of the autonomous institution.

- In line with international best practice, the NHIF would have a Supervisory Board. In terms of South African legislation, cabinet would appoint Board members. This should be preceded by a call for public nominations of candidates to serve on the Board, followed by public interviews of shortlisted candidates under the auspices of the Parliamentary Portfolio Committee for Health, who will forward their recommendations to Cabinet for approval. Full transparency should be ensured throughout this process. For example, the details of all applicants or nominees should be made public, as should the reasons for shortlisting of specific candidates and the basis of the final recommendations to Cabinet. As the NHIF will be tax funded, it is not appropriate to appoint members representing specific interest groups⁸⁷. Instead, nominees will be shortlisted and Board members will be selected on the basis of their ability to *serve the interests of the general public* (the primary beneficiaries of the NHIF) and their technical expertise. The kinds of expertise that would be relevant include: public health law, health economics, actuarial sciences, monitoring and evaluation, labour, information technology and communication. Given the constraints on effective operation experienced in countries where Board members have had a vested interest in the decisions of the Board (e.g. accredited providers), no one with a conflict of interest in the functions of the NHIF may be appointed to the Supervisory Board.
- The CEO of the NHIF would be appointed through a transparent and competitive process and on the basis of their technical competence. The Supervisory Board will interview candidates for this position and the Minister of Health will appoint the CEO on the recommendation of the Supervisory Board. The Supervisory Board can also recommend the removal of the CEO on provision of appropriate substantiation of performance deficiencies. Once again, there should be transparency in this process with public reporting on candidates and reasons for appointment and removal decisions.
- The CEO and other members of the senior NHIF management team would report on at least a quarterly basis to the Supervisory Board, and on an annual basis to Parliament. It would be important for Parliament to play a strong oversight role. They would also prepare and disseminate publicly an annual report, which will not only report on the financial performance of the NHIF, as audited by the Auditor General, but also on performance in relation to ensuring access to good quality health services in line with the health care needs of the population. Specific performance indicators would be developed against which the NHIF will be assessed routinely. The examples of other countries that have achieved excellence in transparent public reporting, such as Estonia,

⁸⁶ Savedoff W, Gottret P (eds) (2008). *Governing mandatory health insurance: Learning from experience*. Washington D.C.: The World Bank.

⁸⁷ International experience has found that having representation of specific interest groups has made these oversight Boards “incapable of making hard choices or serving as an adequate and timely forum for decisionmaking”. International experience also indicates that “rather than by [securing] the interests of specific economic groups, representation is increasingly shaped by the desire to incorporate a wider range of social actors, increase transparency, and involve professionals with technical expertise”. (Savedoff and Gottret 2008).

can be drawn on in establishing the reporting requirements. Through making information available and transparent, the NHIF will be held accountable by government as well as the general public.

6.3.7 NHI and the role of medical schemes

The preceding sections have focused largely on changes within the public health system and how the proposed NHI reforms would address inequalities in access to quality care, including through the NHIF purchasing health services from both public and private providers. One of the most contentious issues about the NHI reforms, and the focus of many of the submissions to the High Level Panel, relates to the role of medical schemes. The Green and White Papers indicate that medical schemes should only play a complementary role in covering health services not part of the universal entitlement that would be made available through the NHI.

It is important to note that the intention of the NHI reforms is to address some of the most pressing challenges in *both* the public and private health sectors and in the overall health system. In particular, the monopsony purchasing power and administrative efficiencies achieved in single purchaser systems internationally would improve affordability and sustainability in both the public and private health sectors. As highlighted previously, there are growing affordability challenges facing medical scheme members.

Nevertheless, there are legitimate concerns about the undoubtedly lengthy process required to implement many of the NHI reforms such as delegating management authority to all public hospitals and organisations such as CUPs for PHC services, to implement information systems necessary to effectively introduce alternative provider payment mechanisms such as DRGs and to establish a fully functioning NHIF. A strong case could be made that the NHI legislation should not *immediately* restrict medical scheme to complementary cover so as not to destabilise the health system and to allow for a focus on reforming the public health system. Recent media reports indicate that this is under consideration by the Department and Ministry of Health.

The longer-term role of medical schemes is a more complex issue. On the one hand, international evidence clearly demonstrates that the less fragmentation there is across different pools of funds for health care and across purchasing agencies, the more feasible it is to achieve the UHC goals of financial risk protection as well as equitable access to quality health services on the basis of need. On the other hand, some stakeholders argue that South Africans should be allowed to choose whether or not to belong to a medical scheme in addition to the entitlements that all South Africans will have under the NHI. If such a reform path is pursued, medical scheme members are likely to face the prospect of increased tax rates in addition to continuing to make medical scheme contributions. Legislation would be required to ensure that the current practice of many employers forcing their employees to belong to a medical scheme, and indeed a particular medical scheme of the employer's choosing, does not continue.

The key challenge in pursuing this approach is the sustainability of the medical scheme environment as a form of voluntary health insurance. Some of the submissions to the High Level panel make some suggestions that are argued would reduce the cost of medical scheme contributions. In particular, the submissions call for changing the flat 25% reserve level that all medical schemes are required to maintain to an approach that assesses the risk faced by each scheme and determines the capital reserves required to provide adequate protection from this risk. Some submissions also call for the introduction of a risk-

equalisation mechanism across medical schemes and a change in the HPCSA rules to allow private hospitals to employ doctors. Detailed data are not available to assess whether or not such changes would ensure the long-term sustainability of medical schemes on a voluntary basis given that there are a range of factors contributing to ongoing cost increases well above the consumer price index. Rather than speculate, it would be advisable to await the outcome of the Competition Commission’s Health Market Inquiry, given that this process is considering these issues in considerable detail, with access to data that are not in the public domain.

6.4 The multi-payer mandatory medical scheme membership/SHI alternative to the NHI reforms

An alternative approach to the NHI reforms put forward by some stakeholders is to pursue mandatory medical scheme membership for formal sector workers, or what could be termed a multi-payer Social Health Insurance (SHI) system. What is being proposed is similar, yet differs in fundamental respects, to the SHI reform approach considered in the 1990s. Those who favour this approach explain it as follows⁸⁸:

- An equal amount of tax subsidy should be paid for all South Africans, either in the form of subsidising mandatory medical scheme membership for the employed or funding public sector services for others.
- This would ensure that those with the financial means are able to contribute to their own health care and not become a financial liability for the public sector.
- Over time, the economy would grow and employment rates would increase allowing more people to move into the SHI environment and it is hoped that there could be some convergence in the benefits offered by the parallel private and public systems.

There have been various submissions to the High Level Panel (HLP) which relate to expanded medical scheme membership, which are summarised in the table below.

	Higher-income employed	Lower-income employed	Rest of the population
Initial submissions to HLP			
Discovery	Mandatory medical scheme membership	Mandatory LIMS membership – private PHC	No reference to this group. Presumably remain as is.
Institute of Race Relations	Mandatory membership of schemes or health insurance with choice of benefit package	Mandatory membership of medical schemes or health insurance with choice of benefit package, including LIMS	Public-private partnerships in provision; government funded vouchers; “would ensure that every household would be able to gain access to a medical scheme”
Free Market Foundation	Voluntary deregulated medical schemes (no PMBs)	Voluntary deregulated medical schemes (no PMBs)	Government funded vouchers & people choose what to do with them
Submissions after workshop			
SA Private Practitioners’ Forum	Mandatory medical scheme membership and mandatory gap cover	Mandatory LIMS membership for private PHC (and mandatory gap cover - unclear)	‘Revised NHIF’ funded through levy on medical schemes for private PHC; integrate RAF & WCF
Harris & Price	Mandatory membership of schemes with choice of benefit package but at least ‘NHI PMB’; GEMS for civil servants, private schemes for the rest	Mandatory membership of schemes with choice of benefit package but at least ‘NHI PMB’; GEMS for civil servants, private schemes for the rest	NHIF administered by private sector and funded by government

⁸⁸ Van den Heever (2016) *op cit.*

With the exception of the Free Market Foundation, all of the submissions propose mandatory membership for those employed in the formal sector. The various submissions either call for the removal of the current PMBs to allow complete flexibility in scheme benefit package design or at least for the introduction of a LIMS (Low-Income Medical Scheme) package to be offered to the employed who can't currently afford medical scheme cover. The Harris and Price submission proposes that there should be a "NHI PMB", which would cover a common, minimum range of services that is affordable to all; the benefits under the NHI PMB are not spelt out but are unlikely to be comprehensive and may be comparable to the proposed LIMS package.

The LIMS proposal is most explicitly outlined in the Discovery submission to the HLP, which argues that it is necessary to "develop a differentiated minimum package of benefits for people in the lower income brackets" which provides cover only for some primary health care services⁸⁹. This approach is understandable in the context of the current cost of contributions for the existing PMBs; the Discovery submission explains that it is necessary to introduce the "primary healthcare package of benefits which is more affordable for lower income households". While some of the other submissions do not explicitly propose a more comprehensive mandatory medical scheme benefit package for higher-income groups and a basic PHC package for lower-income employees, they all point to differentiation in benefit packages according to ability-to-pay.

It is important to note that the form of multi-payer SHI that is now being proposed is very different to the 1990s SHI proposals in some fundamental respects. In particular, the 1990s SHI proposals were intended to make available to all formal sector employees above the income tax threshold the *same* prescribed minimum benefit package and that this PMB package would either just cover hospital care or would be a comprehensive package. It was envisaged that with contributions differentiated on an income basis and a risk-equalisation mechanism in place, there would be effective income and risk cross-subsidies across individual medical schemes acting as intermediaries for the SHI and this would make access to the same PMB for all SHI beneficiaries feasible. Instead, the proposals now argue for differentiated packages across socio-economic groups.

The following argument has been put forward as the benefit of formalising differentiated benefit packages, particularly a PHC only LIMS package: "Allowing medical schemes to offer packages based on the lower set of minimum benefits would allow low income households to benefit from the risk pooling impact of medical schemes. This would provide these households with richer benefits and better protection against the negative financial effects of out-of-pocket payments. It would also reduce the burden on the current public sector and the future National Health Insurance system."⁹⁰ This argument recognises that those who would be covered under a PHC PMB package are already using private providers for PHC services, such as general practitioners and retail pharmacies, for acute illness episodes on an out-of-pocket basis. So, having these services paid through a risk-pooling organisation such as a medical scheme would have some advantages, in the sense that a person does not need to worry about access to ready cash at the time of use. However, paying for the occasional use of PHC services for acute illness on an out-of-pocket basis is not the key financial risk protection issue. Instead it is the costs of diagnosis, treatment and monitoring of chronic illness and specialist and inpatient care that are of importance; this group of people currently use public sector health facilities for these services. As these costs would not be

⁸⁹ Discovery Health. Submission to the High Level Panel on the Assessment of key legislation.

⁹⁰ Discovery Health. Submission to the High Level Panel on the Assessment of key legislation.

covered under the proposed LIMS PHC PMB⁹¹, it is unclear how the argued reduction of “burden on the current public sector” would be achieved or what the benefit to the South African health system would be.

Whether a ‘three tier’ system of existing PMBs for the rich, LIMS for lower-income employees and something else for those outside the formal employment sector or a system with a range of medical scheme benefit packages for the formally employed is pursued, there will be considerable variation in access to health services across different socio-economic groups. It is, therefore, very unclear how mandatory medical scheme membership would promote equitable access to quality health services; none of the submissions have explicitly mapped out how this could be achieved. Instead, these proposals are at odds with a core goal of UHC, which is to move away from health service benefits being linked to employment status and instead move to a universal entitlement to access quality health services and financial protection on the basis of citizenship⁹². Importantly, international experience has shown that moving towards convergence of benefit packages over time, particularly between those employed in the formal sector and those outside the formal sector, has proved impossible when differential benefits are mandated in early phases of reform⁹³ (see Annex 6 for more information). The clear lesson for South Africa (and indeed other low- and middle-income countries with relatively low formal employment levels and growth rates) from international experience is that membership of health insurance for formal sector employees should not be made mandatory, unless South Africans as a whole are satisfied with entrenched disparities in access to quality health care, and specifically more privileged access for formal sector workers.

Some of the submissions to the HLP explicitly motivate for a multi-payer model, with medical schemes being the payers and purchasers of health services, as opposed to the single strategic purchaser system proposed in the NHI White Paper. It is simply stated that such a system is more likely to be successful than a single purchaser system and there is no explicit explanation of how a multi-payer model in the South African context would move the health system towards UHC. Ironically, while some of the submissions⁹⁴ claim that the NHI proposals are based on high-income countries such as Canada and Sweden and are therefore unrealistic, despite the fact that there are a growing number of examples of low- and middle-income countries effectively implementing single strategic purchaser health systems, the only multi-payer systems which could be described as UHC systems are found in high-income countries (e.g. the Netherlands, Switzerland, Japan). In order to achieve UHC through a multi-payer system, these countries have extensive regulatory frameworks in place that specify: the minimum benefit package, which in all cases is very comprehensive; community-rated, income-related contributions; provider payment mechanisms and rates; and other aspects that tightly control every aspect of payments to and by each scheme. The extent of any additional benefits offered to members on an ability-to-pay basis are truly marginal in these countries. Multi-payer systems that achieve UHC can only be found in high-income countries with very high levels of formal sector employment. The form of multi-payer system being proposed in the submissions is very far from a UHC model but instead would simply represent fragmented pooling and purchasing with considerable differentials in health service benefits across the population.

⁹¹ The Discovery and related submissions do not provide any details of what would be included in the PHC PMB package. It would need to be determined whether the costs of chronic care would be covered, but it is clear that specialist and inpatient services would not be covered.

⁹² World Health Organization (2010). *World Health Report 2010*. Geneva: WHO

⁹³ There are particularly striking examples from Latin America.

⁹⁴ Particularly the Harris and Price submission

The main rationale for mandatory medical scheme membership put forward in submissions to the HLP is to improve the affordability of medical schemes. However, even with a once-off reduction in scheme contribution rates, which the submissions claim would be of the order of 20%-25%, would not make scheme cover for a *comprehensive* package of services affordable for the vast majority of South Africans. In the absence of any clear explanation of how the proposed multi-payer system, with mandatory medical scheme membership for formal sector employees, would move the overall South African health system towards UHC, where every South African has financial risk protection and has comparable access to services of a comparable range and quality on the basis of need for health care, with differences in such protection and service access between groups ultimately becoming *marginal*, there is no justification for making medical scheme membership mandatory for any group.

6.5 Have any alternatives to NHI or SHI been put forward?

It is of interest that none of the submissions to the HLP consider how the challenges facing the public health sector can be addressed⁹⁵. While there are some suggestions on how medical schemes potentially could be made more sustainable and some preferences expressed for 'leaving it to the market', no submission put forward any suggestions on how to reform the part of the health system on which the vast majority of South Africans rely. As indicated earlier, the public sector is the main provider of health care services in South Africa and is used by the full range of socio-economic groups; even the highest income quintile uses public sector services, albeit largely at the central hospital level. Ensuring quality health services within the public health sector should therefore be a policy priority.

The only alternative proposal for public sector reform that has been put forward, is by one commentator who has suggested that it may not be necessary to introduce an NHI institution, although he supports the urgent need for delegation of authority to individual public sector providers and the need for there to be strategic purchasing. He suggests that provincial health departments could become strategic purchasers of services within the public health sector⁹⁶. While such an approach would require less dramatic institutional restructuring, there are three clear drawbacks of adopting such an approach:

- This would not address the inter-provincial differences in health care funding as the fiscal federal mechanism of distributing equitable shares to provinces with provincial autonomy in deciding on the allocation to the health sector would continue to prevail.
- Provincial health departments are structured and staffed to be managers of service provision; the skills required for strategic purchasing are very different to those for the management of service provision. Given the considerable autonomy that provincial health departments have in their operations, it is unlikely that all provinces would transform their health departments into strategic purchasers.
- Having nine strategic purchasing organisations would result in higher than necessary administrative costs; the efficiency gains from economies of scale in a single strategic purchaser would be lost.

One of the most comprehensive assessments of the challenges facing the South African health sector, which included an extensive process of consultation with a wide range of stakeholders, was the Development Bank of South Africa (DBSA) "Roadmap for the reform of

⁹⁵ The Harris and Price submission indicates support for decentralisation of management to individual public hospitals, but makes no explicit suggestions on how to address challenges in the public health sector.

⁹⁶ Van den Heever (2016) *op cit*.

the South African health system” process⁹⁷. This consultative process noted that “Provincial governments have not performed well in planning and rendering health services over the past fourteen years.” It is nearly a decade since this statement was made, and the conclusion today would be the same as it was then. Persistent inequalities in access to quality health services, and complete lack of access to quality health care for millions of South Africans, are in no small part due to this lack of performance.

It was on this basis that the ‘Roadmap’ process concluded that there should be “a reconsideration of their [provincial health departments] role within the health system, moving them away from operational decision making on behalf of services and refocusing them on policy and oversight.” They also concluded that:

- “Consistent with the assessment of institutional reforms needed, consideration should be given to the centralized allocation of the funding for hospital services, health districts, emergency transport services, capital expenditure, and the training of health professionals. This would ensure that national priorities are properly funded and prioritized in every respect.”
- “The following functional areas could benefit from agencification:
 - Resource allocation and strategic purchasing;
 - A National Health Information System;
 - Quality assurance and enforcement;
 - Price regulation and cost effectiveness analysis; and
 - Certificates of need in relation to hospitals and expensive technology.Although the above are listed as specific functional areas, consideration could be given to the consolidation, where appropriate, of more than one of these functions into either existing agencies or into a single agency.”

The National Health Insurance proposals are consistent with the fundamental institutional reforms called for in the “Roadmap”.

With the exception of the one proposal to make provincial health departments strategic purchasers, no alternative approach for addressing the fundamental institutional reforms, that all agree are needed in the public health system, has been presented. However, this option would not address all of the issues that the NHI reforms would address (e.g. national level allocation of public sector health care financial resources). There is a strong case for moving forward with the NHI reforms to address the challenges in the public health system and to do this in a way that improves governance, transparency and accountability for the use of tax funding of health services relative to what exists currently.

7. Recommendations

On the basis of the information presented in this report, several suggestions are put forward for consideration by the Sub-Committee.

⁹⁷ This process was undertaken in 2008 during the period when Barbara Hogan was Minister of Health and included participants from the Department of Health, a range of private sector stakeholders including the Hospital Association of South Africa and individual private hospital groups, the Board of Healthcare Funders and some of the largest medical schemes, professional organisations such as SAMA, trade unions, civil society organisations and academic institutions. It is important to note that neither of the authors of this report were involved in the ‘Roadmap’ process, nor were any of their publications quoted in the report; it was thus a consultative process that was completely independent of the authors of the current report.

1. Improve health system information and make it publicly available

A key constraint to detailed evaluation of efficiency, equity and quality in the South African health system, and trends in these aspects of the health system over time, is the lack of publicly available comprehensive, accurate data on both the public and private health sectors.

Although the National Department of Health has been working with the Health Information Systems Program (HISP) to develop a National Health Information Repository and Data Warehouse (NHIRD) which collates information from various vital statistics and other health indicator datasets, the facility-based District Health Information System, the BAS public financial management system, PERSAL human resource system and a range of household survey datasets. Although it is necessary to improve facility information systems to capture data such as ICD diagnostic and procedure codes for all services provided in public sector facilities to enable effective strategic purchasing of these services, the NHIRD could already provide a relatively comprehensive set of data on resources and services in the public health sector. However, there is neither publicly available information on the status of the NHIRD nor does it seem likely that the data will be made publicly available; access to data is tightly controlled by the National Department of Health.

Data on the private health sector is even less accessible. While medical schemes are legally required to make considerable data available to the Council for Medical Schemes (CMS), which the CMS makes publicly available through its very detailed annual reports, there is a dearth of data on private health care provision. There is an urgent need for integrated and comprehensive data on resources and services in the public and private health sector that are routinely updated and is publicly available.

Equity analyses rely heavily on household survey data; while most household surveys containing health and health service related variables are placed in the public domain, many of the surveys conducted in South Africa have serious deficiencies particularly in relation to the measurement of health service utilisation. Again, there is an urgent need to address these deficiencies so that accurate analyses of the current situation can be undertaken and changes over time monitored.

All of these data are critical to enabling strategic purchasing.

Legislation or policy implication: Legislation should be introduced to make annual submission of a standard set of data compulsory for all health care providers in South Africa and to make comprehensive, disaggregated data on health care financing and provision publicly available.

2. Remove user fees at public hospitals

User fees for public hospital services should be removed, other than for medical scheme members. This will improve the affordability dimension of health service access and improve financial risk protection for formal sector workers who are not members of medical schemes; these individuals can face catastrophic health service out-of-pocket payments for major hospitalisation events. As most hospital-based services are part of the Prescribed Minimum Benefit (PMB), medical schemes can and should pay for public sector hospital services used by their members.

Legislation or policy implication: The National Health Act should be amended to remove user fees at public hospitals for everyone who is not a medical scheme member

3. Prioritise improvements in public sector health services, particularly at the primary health care level and formalise employment of CHWs

The public sector is the main provider of health care services in South Africa and is used by the majority of the population and by the full range of socio-economic groups. Ensuring quality health services within the public health sector should, therefore, be a policy priority. Services at public sector clinics, community health centres and district hospitals are most widely used by lower socio-economic groups and are the most 'pro-poor' health services available in South Africa. Promoting equitable access to quality health care therefore requires a particular emphasis on ensuring quality within these facilities.

Various initiatives have been introduced in the last few years, such as 'PHC re-engineering' and the 'Ideal Clinic' programs. However, there are aspects of these initiatives that require more attention, particularly institutionalising the Ward-based Outreach Teams (WBOTs; i.e. community health workers) and reaching agreement on their status within the public health system. Community health workers (CHWs) are critical in promoting equitable access to health care through their 'close to client' service provision; international evidence demonstrates that they make considerable contributions to improved health outcomes. Community health workers are also key providers of preventive and promotive health services. The long-term sustainability of a universal health system is closely linked to the effectiveness of preventive and promotive interventions, particularly in relation to the growing burden of morbidity related to non-communicable diseases.

There are over 40,000 CHWs in SA, but most are paid a small stipend and have very insecure and informal employment status, which in some cases contributes to high turnover and motivation problems. Formalising the employment of this important cadre of health workers will not only have major health benefits, but will also contribute to employment creation.

Legislation or policy implication: Introduce legislation to allow for CHWs to be formally employed within the public health system.

4. Pilot delegation of management authority to public hospitals and CUPs

There have been various initiatives to improve the management of public health facilities and quality of services within these facilities. However, many of these initiatives have been 'top-down', being driven by the National Department of Health and sometimes with limited ability at facility level to sustain these initiatives. A key constraint in this regard is the limited delegated authority to make and implement management decisions at facility level. Many of the persistent challenges that face public sector health facilities, such as poor staff morale, which impacts on the quality of services provided, and perceived lack of responsiveness to patients, can only be addressed in a comprehensive and sustainable way through increased management authority at facility level combined with strong governance and accountability structures. Decentralised authority is also a pre-requisite for the introduction of strategic purchasing of public and private health services.

Institutional change for decentralised management and delivery of comprehensive, integrated PHC services, of which first level referral hospitals (district hospitals) are an

integral part, should be pursued through piloting the establishment of Contracting Units for Primary Health Care (CUPs) at sub-district level as proposed in the latest White Paper on NHI. Private PHC providers could be included in CUPs where appropriate. Particular attention should be paid to the incorporation of WBOTs/CHWs in these CUPs. It is envisaged that the providers within the CUP would form a horizontal management network, operating as a cooperative with shared responsibility for ensuring good access to quality services and a strong focus on prevention and health promotion. It would *not* be a hierarchical structure dominated by the district hospital; this is critical to ensure that PHC services are not curative biased and hospi-centric.

The delegation of management authority, with appropriate governance structures, to selected public hospitals and CUPs should be piloted as a matter of urgency. These pilots must be supported to ensure adequate management capacity is available and that adequate funding is provided for the efficient provision of quality health services. Effective piloting cannot be expected in public health facilities that are relatively under-resourced at present. Monitoring and evaluation must be designed as a core element of these pilots from the outset, to ensure learning for future scale-up.

Legislation or policy implication: A policy to formalise the creation of CUPs should be developed. Piloting of delegated management authority can be initiated without legislative changes. It is likely that some legislative changes may be required in future to allow for the delegation of all relevant management authority to individual hospitals and CUPs; these would be identified during the piloting process. In addition, the National Health Act will need to be revised, when delegation of management authority is rolled out to all public hospitals and CUPs, to change the responsibilities of provincial health departments.

5. Initiate the establishment of a strategic purchasing organisation

Strategic purchasing is key to achieving an affordable and sustainable universal health system with access to quality care and financial risk protection. It will be important to ensure that care is taken to establish an effective and accountable strategic purchasing agency. It is, therefore, advisable to initiate the establishment of the autonomous public entity for strategic purchasing / National Health Insurance Fund (NHIF) and the necessary governance mechanisms in the near future. Phasing in of funding flows via the NHIF should be in line with the roll-out of delegation of management authority to public hospitals and CUPs and the reform of provincial health departments with redistribution of staff with financial and human resource management skills to hospitals and CUPs.

Legislation or policy implication: Legislation is required to establish an autonomous public entity for strategic purchasing of health services for all.

6. Amendments to the Medical Schemes Act

Various proposals have been put forward to revise the Medical Schemes Act, including changes to the PMBs and prescribed medical scheme reserve levels. Detailed data are not available in the public domain to assess the extent to which these efforts would make medical scheme cover more affordable, which is the stated objective of these proposals. It would be advisable to await the Competition Commission's Health Market Inquiry recommendations for an appropriate regulatory environment for medical schemes within a *voluntary* health insurance context.

Proposals have also been made for medical scheme membership to be made mandatory for all formal sector employees above the income tax threshold. However, no explanation or evidence has been provided on how this would facilitate progress to UHC or even promote equitable access to quality health care; instead, it is likely to entrench inequalities in health service access between the formally employed and the rest of the population. In this context, there is no justification for making medical scheme membership mandatory for any groups.

Legislation or policy implication: Proposed changes to the Medical Scheme Act in relation to the PMBs and prescribed medical scheme reserve levels should be considered after the Competition Commission's Health Market Inquiry has completed its work and submitted its report. Any changes to the Act should be within the context of a voluntary health insurance environment and medical scheme membership should **not** be made mandatory for any groups.

Annex 1: Glossary of relevant terms

Acceptability dimension of access	The 'degree of fit' between provider and patient attitudes and expectations of each other
Access to health care	Access refers to people's ability to obtain and appropriately use quality health services. It is the compatibility or 'degree of fit' between health services and those who need to use these services. There are several aspects or dimensions of access; while different terms are sometimes used, these dimensions can be categorised as: availability (physical access), affordability (financial access) and acceptability (cultural access) of health services
Allocative efficiency	The allocation of resources to achieve the appropriate mix of health care programs to maximise the health of a population, a core element of which is allocating funds to health services providing care for those aspects of ill-health for which effective interventions exist. Allocative efficiency is achieved when it is not possible to increase the overall benefits produced by the health system by reallocating resources between health programs.
Affordability dimension of access	The 'degree of fit' between the full costs of using health care services and individuals' ability-to-pay in the context of the household budget and other demands on that budget
Availability dimension of access	Whether the appropriate health services are available in the right place and at the right time to meet the needs of the population
Benefit incidence analysis	A technique that has traditionally been used to assess the distributional impact of government spending on health services. Analysis of which socioeconomic groups receive what benefit from using health services
Capitation	An amount of money paid per capita or per person, which may be adjusted for the relative risk of that person needing health care (see risk-adjusted capitation)
Capitation payment	A negotiated payment paid for an agreed period of time by a purchaser to a health care provider per person entitled to benefit under that purchasing arrangement and receiving health care from the provider
Community rating	Everyone within a particular insurance scheme (or benefit option of that scheme) must be charged the same standard rate, regardless of age or state of health
Co-payment	Out-of-pocket partial payment by a health insurance scheme member for health services used in addition to the amount paid by the insurance. This is generally seen as a way of discouraging scheme members from excessive use of health services through placing some direct cost burden on them
Cross-subsidies (income and risk)	Income cross-subsidy: whereby the wealthy contribute more to the funding of health care than the poor but all have access to the same range of health services Risk cross-subsidy: whereby people with a greater need for health care (i.e. high-risk individuals) are able to use more health services than those who are healthy (i.e. low risk individuals), irrespective of the contribution made by each group
Diagnosis-related group (DRG)	The grouping of patients according to such criteria as diagnosis, likely medical procedures required, age, sex, and the presence of complications or co-existing illness. Since each group is comprised of patients presenting similar clinical problems and likely to require the same level of hospital resources, a purchaser

	can estimate relatively easily how much it has to reimburse a hospital for services rendered to patients in each group
Effective health care / effectiveness	Effective care refers to health services that are of proven value and that have no significant risks associated with them. Effectiveness is the extent to which planned outcomes are achieved as a result of a health care intervention under ordinary circumstances (i.e. not in an 'ideal' clinical trial context).
Equity in a health system	Individuals contribute to covering the costs of health care according to their ability to pay (or their income) and benefit from health services according to their need for health care
Fee-for-service payment	A provider payment mechanism where a fee is paid for each service provided
Fund pooling	Accumulation of prepaid health care revenues, such as tax revenue or health insurance contributions, that can be used to benefit a population. The aim is to share risk across the population, so that unexpected health care expenditure does not fall solely on an individual or household, with sometimes catastrophic consequences
Inequality	Of health: differences in health status or in the distribution of health determinants between different individuals or population groups. Of health care: systematic differences in the distribution of health care resources or in access to quality health care across individuals or population groups.
Inequity	Differences in health status or in access to health services that are not only unnecessary and avoidable but are also considered to be unfair or unjust
Mandatory prepayment	A prepayment mechanism that is enforced by law, such as the payment of various taxes or contributions to a health insurance scheme to which certain population groups or the entire population are required to belong
Medical schemes	Voluntary private health insurance schemes. There are two main categories of schemes: open and restricted schemes. Open schemes must freely admit anyone who applies to join; schemes may choose to restrict their membership if they are attached to a large employer, union or other defined group.
Morbidity	Ill-health; how often a disease or illness occurs in a population
Mortality	Death; the number of people who have died within a population
Open enrolment	Health insurance schemes must accept anyone who wants to become a member at standard rates
Out-of-pocket payment	Payment made by an individual patient directly to a health care provider, as distinct from payments made by a health insurance scheme or taken from government revenue
Prepayment funding	Payments made by individuals via taxes or health insurance contributions before they need to use a health service; prepayment contributions are pooled (see fund pooling)
Prescribed Minimum Benefits (PMBs)	A minimum benefits package, regulated by the Council for Medical Schemes, which all medical schemes must offer. This includes nearly 300 diagnosis and treatment interventions that are largely offered in hospitals, and diagnosis and treatment of certain chronic diseases. Medical scheme beneficiaries must be

	covered in full for conditions specified in the PMBs with no financial limits or co-payments. Schemes may insist on the use of preferred providers for PMB conditions.
Progressive financing	A financing mechanism whereby high-income groups contribute a higher percentage of their income towards funding health care than do low-income groups
Proportional financing	A financing mechanism whereby everyone contributes the same percentage of income towards funding health care, irrespective of income level
Purchasing	Allocating financial resources to health care providers to obtain health services on behalf of the population
Quality of health care	Health care that is clinically effective, safe and patient-centered.
Regressive financing	A financing mechanism whereby low-income groups contribute a higher percentage of their income towards funding health care than high-income groups
Risk rating	A health insurance scheme charges individuals contributions that are based on the ill-health risk profile using indicators such as age, pre-existing conditions, previous claims experience, etc.
Risk-adjusted capitation	A per capita (or per person) amount of money paid to a health care provider that is based on a person's likelihood, or risk, of requiring health care (using indicators of risk such as age, gender, and the presence of chronic disease)
Social determinants of health	The conditions in which people are born, grow, live, work and age that influence a person's health status and the distribution of health status across individuals and groups
Strategic purchasing	A continuous search for the best ways to maximise health system performance by deciding which interventions should be purchased, how, and from which service providers
Technical efficiency	A measure of the maximum number of health services that can be provided with a specific amount of funds or a measure of the lowest cost needed for each health service to function without compromising quality of care
Universal health coverage (UHC)	Providing financial protection from the costs of using health services for all people of a country as well as enabling them to obtain the health services that they need, where these services should be of sufficient quality to be effective
User fee	A fee charged at the place and time of service use within a public health facility and paid on an out-of-pocket basis
Voluntary health insurance	A health insurance, to which an individual or group can belong without a legal requirement to do so

Annex 2: Further details on conceptual issues

A2.1 Access to health services

Seminal papers by Donabedian⁹⁸ and Penchansky⁹⁹ in the 1970s highlighted that access is fundamentally about the “degree of fit” or compatibility between the health system on the one hand and individuals who need to use these services on the other hand. Expressed differently, there are both supply- and demand-side aspects that need to be considered and access is concerned with the interaction between these supply and demand-side aspects.

Access is generally seen as being multidimensional or having different elements. In the literature, although different terms are used to describe various dimensions of access, the same set of factors is included. In this paper, these dimensions are summarised as: the availability (or physical access), affordability (or financial access) and acceptability (or cultural access) of health services¹⁰⁰. The availability dimension of access deals with whether the appropriate health services are available in the right place and at the right time to meet the needs of the population. Affordability concerns the ‘degree of fit’ between the full costs of using health care services and individuals’ ability-to-pay in the context of the household budget and other demands on that budget. Acceptability is concerned with the fit between provider and patient attitudes towards and expectations of each other. Beliefs and perceptions also influence acceptability. The table below summarises some of the key issues affecting each dimension of access from both the health system and individual’s perspective.

	Health system	Individual
Availability	<ul style="list-style-type: none"> ○ Availability of information (e.g. on patient’s rights and entitlements, services provided, opening hours, etc.) ○ Physical location of facility, including proximity to public transport ○ Operating hours ○ Use of an appointment system ○ Range of services provided at facility ○ Physical infrastructure and equipment, including ability to undertake a range of diagnostic tests ○ Routine availability of drugs and other supplies ○ Number, skills mix and experience of staff ○ Scope of practice policies ○ Clearly defined pathways of care including referral between PHC and hospital services ○ Ambulances for emergencies ○ Outreach or close-to-client services 	<ul style="list-style-type: none"> ○ Burden of illness (extent and type of illness) in community ○ Awareness of symptoms and understanding of when to seek care ○ Awareness of service entitlements and knowledge of where facilities are located, which facilities provide which services, opening hours etc. ○ Distance to facility ○ Transport options (walking, public transport, private transport) ○ Severity of illness – ability to travel to facility ○ Work commitments and time frame for when care can be sought

⁹⁸ Donabedian A (1973). *Aspects of Medical Care Administration*. Cambridge, MA: Harvard University Press

⁹⁹ Penchansky R (1977). *The concept of access: a definition*. Hyattsville: National Health Planning Information Centre, Department of Health, Education and Welfare.

¹⁰⁰ McIntyre D, Thiede M, Birch S (2009). Access as a policy-relevant concept in low- and middle-income countries. *Health Economics, Policy and Law* 4: 179-193.

	Health system	Individual
	<ul style="list-style-type: none"> ○ Quality of care 	
Affordability	<ul style="list-style-type: none"> ○ Health care costs such as consultation fees, cost of diagnostic tests, cost of medicines, ward fees, theatre fees, pre-admission deposits, etc. ○ Form of payment (e.g. immediate payment or account) ○ Health insurance scheme contribution rates ○ Co-payment requirements of schemes ○ Fee exemptions (public hospitals) ○ Other direct costs (influenced by health system availability issues – transport, special diets) ○ Extent of indirect costs such as lost income or productivity (influenced by health system availability issues - time travelling to and from facility and waiting to be seen) 	<ul style="list-style-type: none"> ○ Eligibility to benefit from publicly funded health services, knowledge of entitlements and ability to secure entitlements (e.g. to a fee exemption) ○ Medical scheme membership ○ Amount, timing and frequency of income, including from social grants and ability of individual household members to access this income ○ Extent of savings ○ Household assets and whether these assets can be easily and rapidly translated into cash ○ Social support networks (including extended family) ○ Access to credit and conditions of loans (repayment period, interest rate) ○ Ability to incur indirect costs (paid sick leave benefits for employed, ability of informal worker to mobilise substitute labour)
Acceptability	<ul style="list-style-type: none"> ○ Privacy in consultation room, curtains around hospital bed, etc. ○ Maintenance of confidentiality ○ Awareness of and respect for cultural norms in local community ○ Provider attitudes to patient characteristics (e.g. age, gender, race) and ability to engage in a non-discriminatory way (e.g. not regarding some as ‘undeserving’ e.g. pregnant teenagers, substance abusers, commercial sex workers) ○ Provider expectations of patients and perceptions of extent to which patients fulfil these expectations (e.g. respect for professional status, compliance with prescribed treatment) ○ Providing services in a way that reduces stigma ○ Ability to communicate (e.g. language, use of local idioms) 	<ul style="list-style-type: none"> ○ Perceptions of effectiveness of services at facility (previous experiences, beliefs about different healing systems) ○ Acceptance of diagnosis and prescribed treatment and understanding of treatment compliance issues ○ Patient attitudes to provider characteristics (age, gender, race, etc.) ○ Patient expectations and perceptions of extent to which providers fulfilled these expectations, which include: <ul style="list-style-type: none"> ● Fairness ● Confidentiality (avoid stigma) ● Respectful treatment ● Listen to patient and explain illness and treatment ● Undertake thorough examination

A2.2 Quality of health services

As is the case with access, quality is a multi-dimensional concept with different perspectives on these dimensions in the literature. Donabedian¹⁰¹ was once again a pioneer in the field, suggesting that quality should be looked at in terms of:

- Structure (sometimes referred to as inputs) in relation to issues such as the adequacy of facilities, equipment and supplies, the number and qualifications of medical staff, etc.;

¹⁰¹ Donabedian A (1966). Evaluating the quality of medical care. *Milbank Memorial Fund Quart*, 44(3): 166-206.

- Process including issues such as whether a thorough clinical history and physical examination are undertaken, appropriate diagnostic tests carried out and appropriate treatment prescribed; and
- Outcomes in terms of recovery and survival as well as unintended outcomes or adverse effects.

Others have built on this foundation, with the most widely used definition of health care quality being that developed by the Institute of Medicine (IOM)¹⁰²: "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The IOM also outlines a number of domains, or properties of health care quality (see Box 1), which have also been adopted by the World Health Organisation (WHO)¹⁰³.

Box 1: Institute of Medicine's domains of health care quality

Effectiveness: Providing services that are based on the best available scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit (i.e. avoiding underuse and overuse respectively)

Efficiency: Delivering health care in a way that maximises outcomes from resource use and avoids waste

Equity: Delivering health care that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.

Patient centeredness: Providing care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions, and that patients are given the information and opportunity to exercise the degree of control they choose over health care decisions that affect them

Safety: Delivering health services that minimise risks and harm to service users from care that is intended to help them

Timeliness: Obtaining needed care while minimising delays

Many of the aspects of quality of care outlined above overlap considerably with the concept of access. For example, structural quality of care and timeliness are strongly related to the availability dimension of access, while patient-centeredness is associated with the acceptability dimension of access. There is also overlap between some of the domains. For example, timeliness could be seen as part of effectiveness as the effectiveness of a particular treatment could be reduced if there are considerable delays. Also, overuse or overprovision of services (part of effectiveness) is a form of wastage (part of efficiency).

For this reason, some, such as the UK National Health Service (NHS) have narrowed down the concept of quality of care into three areas: clinical effectiveness, patient safety and patient experience¹⁰⁴. As pointed out by the IOM¹⁰⁵, equity in health care quality should

¹⁰² Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academy Press.

¹⁰³ World Health Organization (2006). *Quality of care: a process for making strategic choices in health systems*. Geneva: WHO.

¹⁰⁴ Department of Health (2008). *High quality care for all: NHS next stage review final report*. London: The Stationery Office.

¹⁰⁵ Institute of Medicine (2001). *Envisioning the National Health Care Quality Report*. Washington, D.C.: National Academy Press.

actually be seen as a cross-cutting issue and that all the different elements of quality should be compared across different population groups and geographic areas. In this paper, we use the NHS categorisation, which could be further summarised as technical and interpersonal excellence.

A2.3 Inequality and inequity

Health inequalities can be defined as differences in health status between groups within a country. Inequalities across groups are most frequently considered in terms of socioeconomic position, race, ethnicity, place of residence/geographic location, gender and age.

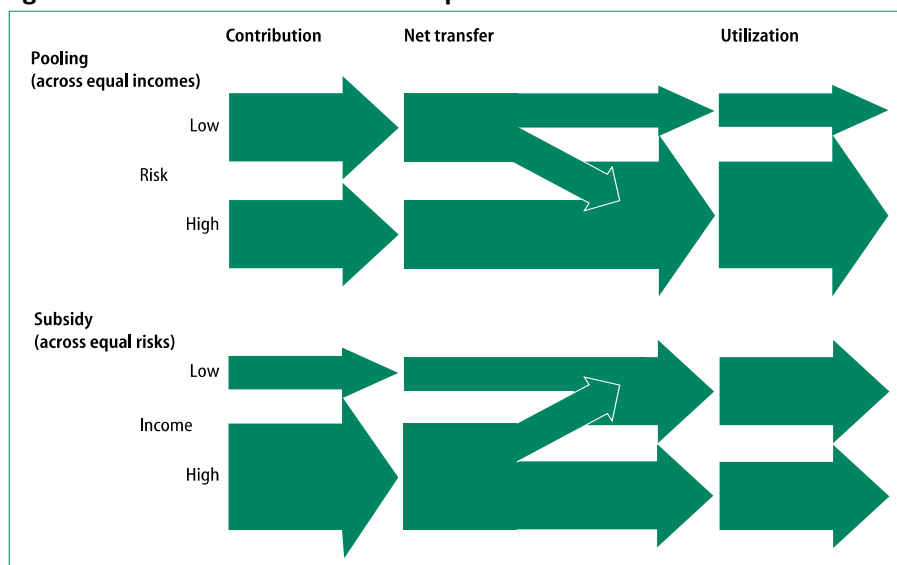
From a health system perspective, inequalities similarly refer to differences across groups such as in access to quality health care. Conceptually, inequalities are not the same as inequities. There is a moral or ethical dimension to the concept of equity (or inequity); equity implies fairness and justice. Differences or inequalities in, for example the use of health services does not necessarily imply inequities; an elderly person with a serious chronic illness using health services more frequently than a healthy teenager would not be considered unfair or inequitable.

The internationally accepted definitions of health system equity, in relation to financing and utilisation of health of services respectively, are:

- Payments towards funding of health services should be according to ability-to-pay (or income); and
- Use of health services should be according to need.

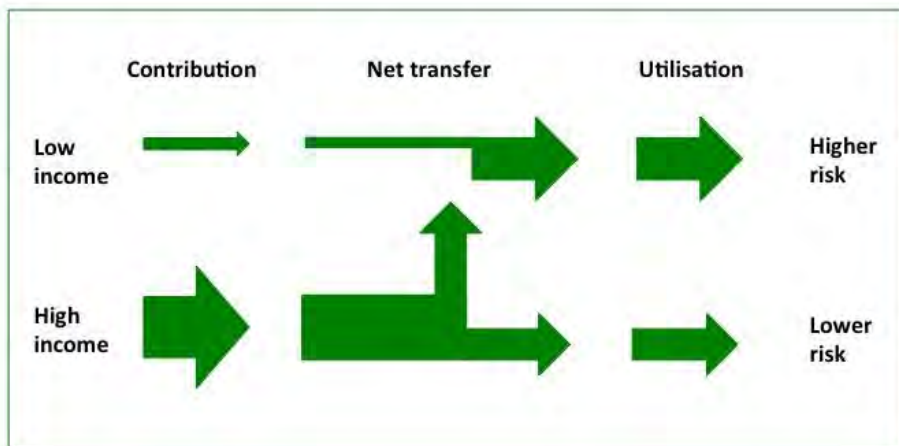
These definitions imply that there should be both income and risk cross-subsidies in the health system. The definitions and concept of cross-subsidies can best be illustrated graphically. The first set of arrows in Figure A2.1 indicate risk cross-subsidy between two individuals or groups with the same income level, but different ill-health risk profiles. The second set of arrows illustrates income cross-subsidies between two individuals or groups with different income levels but the same need for health services or the same illness risk profile.

Figure A2.1: Illustration of the concepts of risk and income cross-subsidies



It is more frequently the case that there are differences across individuals in both income levels and illness risks or need for health services. This is illustrated in Figure A2.2, where income and risk cross-subsidies are combined in the context of large differences in income levels.

Figure A2.2: Illustration of combined risk and income cross-subsidies



Annex 3: Summary of key health legislation since 1994

Fundamental Act / Framework legislation
<i>National Health Act 61 of 2003 and National Health Amendment Act 12 of 2013</i>
<p>This Act took many years to draft and to pass through the legislative process; it was passed by Parliament in late 2003 and signed by the President in July 2004. Most of the sections of the Act came into effect in May 2005. This Act provides a national legislative framework for the health system in South Africa. Some of the key elements of the Act include:</p> <ul style="list-style-type: none"> • defining municipal health services, clarifying the roles of national, provincial and local governments for health services and establishing mechanisms for engagement across the spheres of government such as the National Health Council and broader consultative forums at national and provincial level; • affirming free care for pregnant women and children under 6 years and for primary health care services; • addressing the rights and duties of health personnel and service users; • establishing a district health system; • categorising all health facilities/establishments and the types of services to be provided in different categories of facilities (and initially, a proposed certificate of need process to ensure the equitable distribution of services); • issues relating to health research and information systems including the establishment of a National Health Research Committee and a National Health Research Ethics Council; and • enabling the Minister of Health to introduce regulations on an essential drug list and medical and other assistive devices list and to introduce reference price lists. <p>An Amendment Act (12 of 2013) allowed for the creation of an independent Office of Health Standards Compliance (OHSC) and for an Ombud.</p>

Statutory bodies Acts
<i>Medical Schemes Act 131 of 1998</i>
<p>This Act represented a major change in the regulatory framework for medical schemes, and repealed the Medical Schemes Act of 1967. It reversed the amendments introduced in 1989, which allowed schemes to charge risk-rated contributions. This resulted in vulnerable groups, particularly older people and those with chronic diseases, being excluded and reductions in benefits. The key elements of the 1998 Act were to:</p> <ul style="list-style-type: none"> • Clearly demarcate medical schemes as the only vehicle that could provide indemnity cover, i.e. reimburse actual health care expenditure, from other health insurance, and ensure that medical schemes are appropriately regulated and monitored by the Council for Medical Schemes; • Promote risk pooling within schemes through open enrolment, community rating and introducing prescribed minimum benefits (PMBs) (see glossary for explanation of these terms); • Improve governance of schemes, through ensuring that each scheme is governed by a board of trustees, of which half are elected by members, and whose duties are codified by the Act; • Task the Council for Medical Schemes with the protection of beneficiaries, rather than with the protection of the industry, as was previously the case; and • Make the Council for Medical Schemes also responsible for accrediting organisations that provide services to medical schemes. <p>Business South Africa instituted court action to halt implementation of the Act in 1998, but this was dismissed by the Cape High Court. The new Medical Schemes Act became effective from 1 January 2000. Further amendments were introduced in 2001 (Act 55 of 2001) to further strengthen the governance of schemes, such as through improving the independence of scheme trustees, to strengthen complaints procedures and to improve oversight of re-insurance arrangements. A further amendment in 2002 (Act 62 of 2002) provided for the regulation of medical scheme brokers.</p>

<i>Council for Medical Schemes Levies Act 58 of 2000</i>
This Bill provides for the imposition of levies by the Medical Schemes Council, to be paid by medical schemes. These levies are used to meet the administrative costs of the Council and the Registrar of Medical Schemes. It also provides for assessment of the efficiency and effectiveness of the Council's management of the financial resources raised through these levies. While such assessments may be requested by the schemes, they are performed at least every 5 years and reported to both the Ministers of Health and Finance.
<i>Medical Schemes Amendment Bill 58 of 2008</i>
This Bill intended to establish a Risk Equalisation Fund (REF), to improve efficiency by allowing schemes to specify preferred providers, and to support the introduction of medical scheme products for low-income individuals. This Bill has never been passed.
<i>Medical, Dental and Supplementary Health Services Amendment Act 89 of 1997</i>
This Act established the Health Professions Council and increased the powers of the boards for each health profession, particularly disciplinary powers. It also introduced the requirement that new graduates would have to serve a year of remunerated community service before they could register as a health professional. Compulsory community service became effective on 1 July 1998.
<i>Health Professions Amendment Act 29 of 2007</i>
This Act addressed issues around membership of the Health Professions Council, including removal of Council members, tightening financial controls of the council, disciplinary action, the control of education and training and compliance with continuing professional development requirements.
<i>Allied Health Professions Act</i>
The Act established the Allied Health Professions Council, to regulate a wide range of allied and complementary practitioners (each with a professional board). In addition to the existing registers for chiropractors and homeopaths, the Act made provision to open registers for ayurvedic practitioners, naturopaths, osteopaths, phytotherapists (previously referred to as herbalists), Chinese medicine and acupuncture practitioners, therapeutic aromatherapists, therapeutic massage therapists and therapeutic reflexologists
<i>Nursing Amendment Act 19 of 1997 and Nursing Act 33 of 2005</i>
The Nursing Amendment Act of 1997 introduced a new Nursing Council. The 2005 Nursing Act completely replaced the old Nursing Act (50 of 1978). The Act gave the Minister of Health power to appoint all members of the Council after calling for nominations; previously, nurses could elect some of the members of the Council. The Act regulates the powers of the Nursing Council, including conducting an inquiry into charges of unprofessional conduct. The Act also regulates education, training, research and practice in the nursing profession, including prescribing and dispensing privileges of professional and staff nurses and midwives.
<i>Pharmacy Amendment Act 88 of 1997 and Pharmacy Amendment Act 1 of 2000</i>
The 1997 Act provided for the establishment of a permanent Pharmacy Council and contains provisions on the licensing of pharmacies, pharmacy training and the practice of providing pharmaceutical services. The Act allows for people other than pharmacists to own pharmacies, although they must be operated under the continuous personal supervision of a pharmacist; prior to this, only pharmacists could own a pharmacy. The 2000 Act introduced a year of remunerated community service in a public sector health facility before recent graduates could register with the Pharmacy Council, as was done for other health professionals in 1998.
<i>Dental Technicians Act 43 of 1997</i>
This Act formally recognised the profession of dental technologist and established a new South African Dental Technicians' Council.
<i>Traditional Health Practitioners Act 35 of 2004 and Act 22 of 2007</i>
The 2004 Act established the Interim Traditional Health Practitioners Council and provided a regulatory framework to ensure the efficiency, safety and quality of traditional health care services. The 2007 Act, operationalized the Traditional Health Practitioners Council, whose members are appointed by the Minister and must include traditional health practitioners from each province.
<i>National Health Laboratory Service Act 37 of 2000</i>
The Act introduced a significant change to the way laboratory services are provided in the public sector. It created a new service, as an autonomous body, bringing together the staff and assets of the SA Institute for Medical Research (SAIMR), the National Institute for Virology (NIV), the National

Centre for Occupational Health, the forensic chemistry laboratories owned by the State (with the exception of those operated by the police and military) and all provincial health laboratories. This was followed by an Amendment Act in 2001, which provided a framework for the amalgamation of the various public sector laboratories and research facilities into the NHLS, particularly in relation to pension arrangements for employees.

Acts related to specific policy areas

Medicines and related substances control Amendment Act 90 of 1997

A key focus of this Act was reducing the cost of medicines to improve affordability of health services. Relevant measures in the Act to achieve this objective were: international tendering and parallel importation of medicines; generic substitution; regulating the use of bonuses, rebates and sampling in the supply of medicines; and establishing a medicine pricing committee. The implementation of this Act was delayed due to court action taken by the Pharmaceutical Manufacturers' Association, who particularly objected to parallel importation. They ultimately withdrew their court action in April 2001. The Act was further amended in 2002 (Act 59 of 2002) to allow for regulations on the marketing of medicines, and strengthen controls on the manufacture, use and recording of some scheduled medicines. A further Amendment Act (72 of 2008) provided for the establishment of a South African Health Products Regulatory Authority (SAHPRA) which would not only replace the Medicines Control Council in regulating medicines but would also be responsible for the regulation of complementary medicines and medical devices.

Tobacco Products Control Amendment Act 12 of 1999

This Act allows the prohibition of smoking in designated public places and the advertisement and promotion of tobacco products. Court action by the Tobacco Institute to stall this legislation was unsuccessful. The Act came into effect in 2000. An amendment (Act 23 of 2007) extended the definition of a 'public place' to include "any area within a prescribed distance from a window of, ventilation inlet of, doorway to or entrance into a public place" and to outdoor public places.

Mental Health Care Act 17 of 2002

This Act repealed the Mental Health Act of 1973. It included a section on patient rights and introduced Mental Health Review Boards, which include a legal practitioner, a mental health care practitioner and a community member for committal/certification decisions; in the past this responsibility was borne by a magistrate. The Act also introduced a 72-hour assessment period prior to involuntary admission in a psychiatric hospital.

Choice of Termination of Pregnancy Act (Act 92 of 1996)

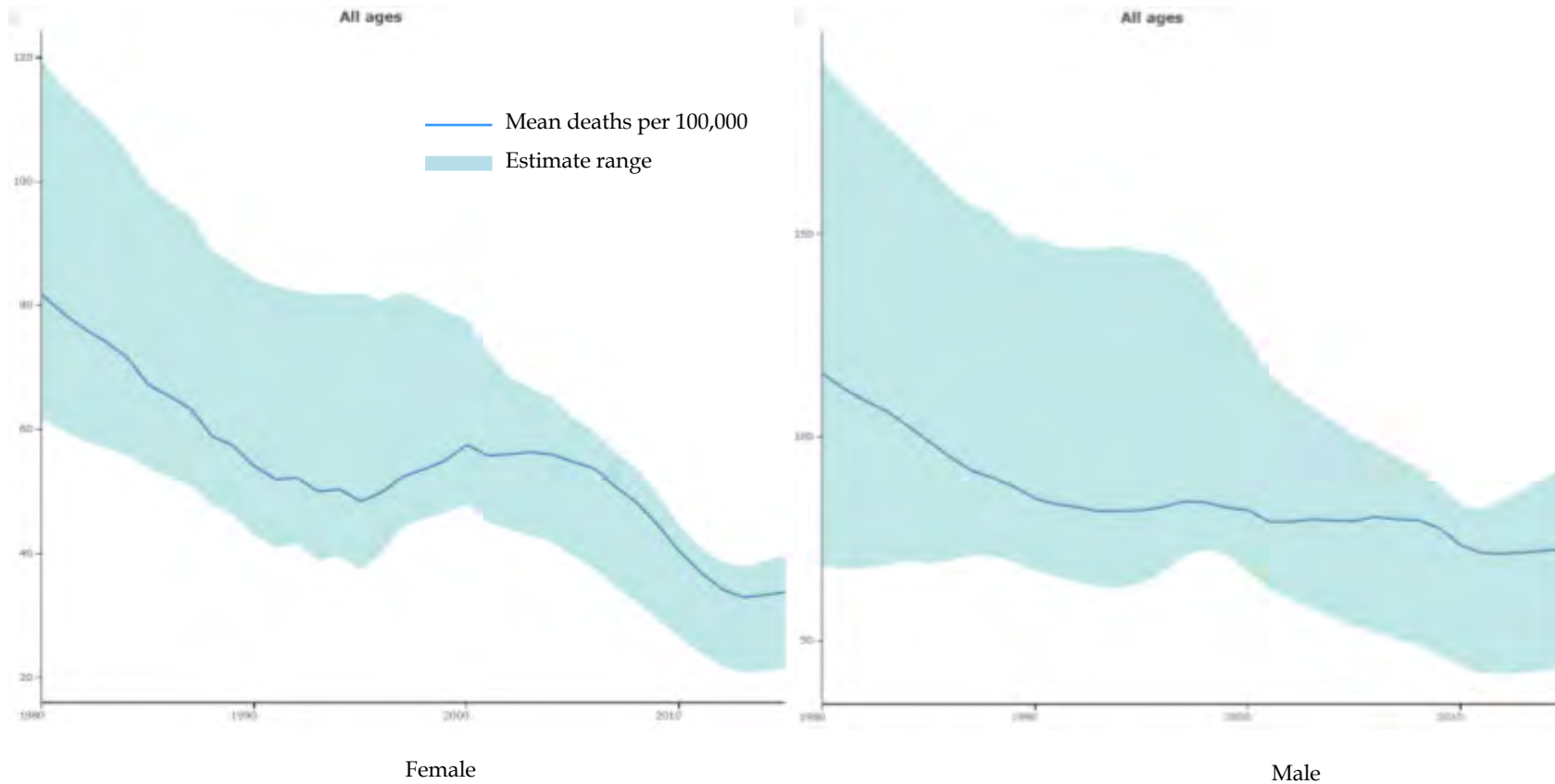
This Act provided for abortion on request up to twelve weeks gestational age, and under specified conditions after twenty weeks. Later amendments (Act 38 of 2004 and Act 1 of 2008) devolved the power to approve facilities where termination of pregnancy may be undertaken to the MECs for health in each province, exempted facilities offering a 24-hour maternity service from having to obtain approval for termination of pregnancy services and allowing registered nurses and midwives who have undergone training to perform pregnancy terminations. There were several court challenges to this Act in 1998 and 2001 by the Christian Lawyers Association, and in 2006 by Doctors for Life; none of these court actions were successful.

Occupational Diseases in Mines and Works Act 60 of 2002

This Act required mine owners to compensate workers who contract diseases while in their service for a period of not more than two years from the date of onset of the disease.

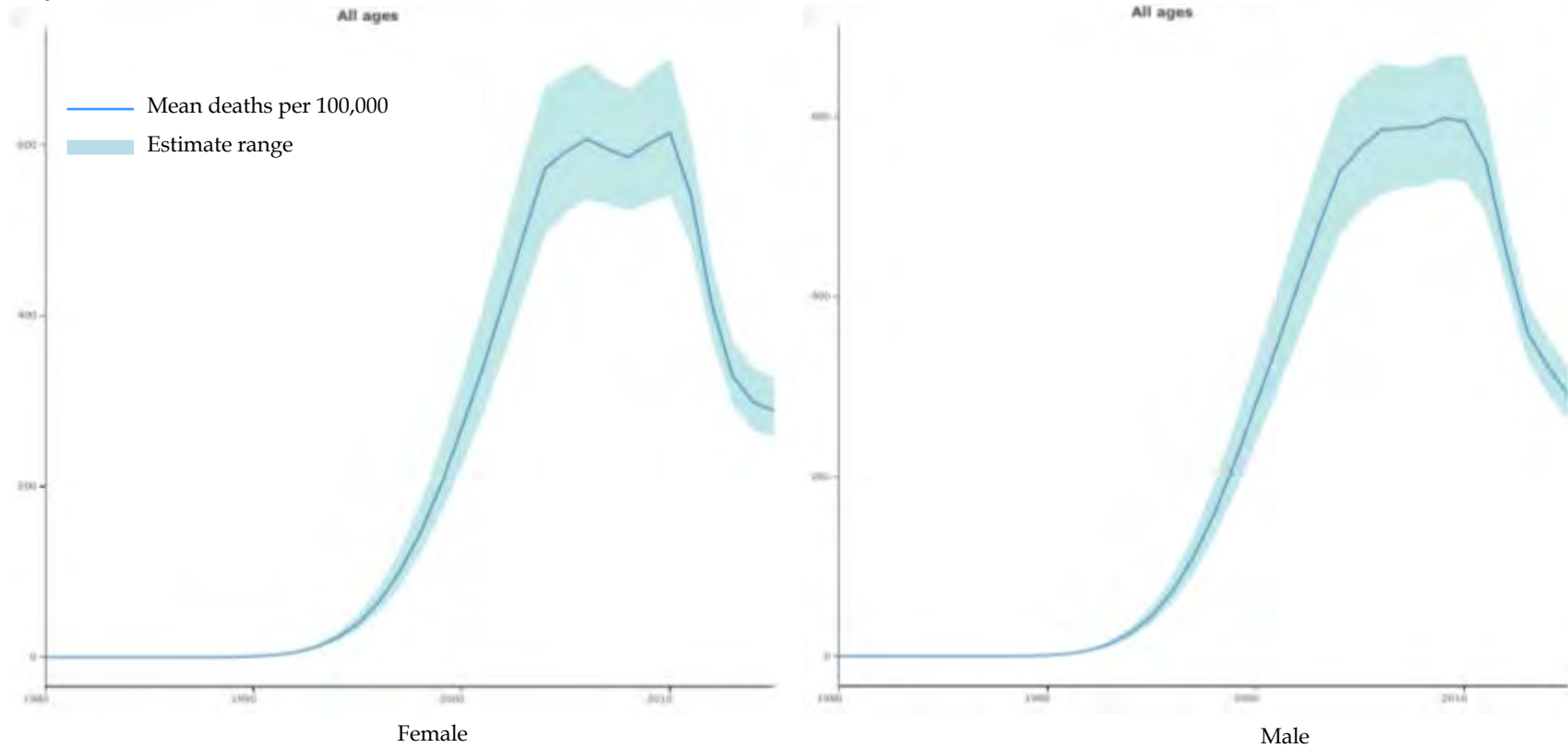
Annex 4: Trends in mortality rates for different causes of death 1980-2015

Tuberculosis



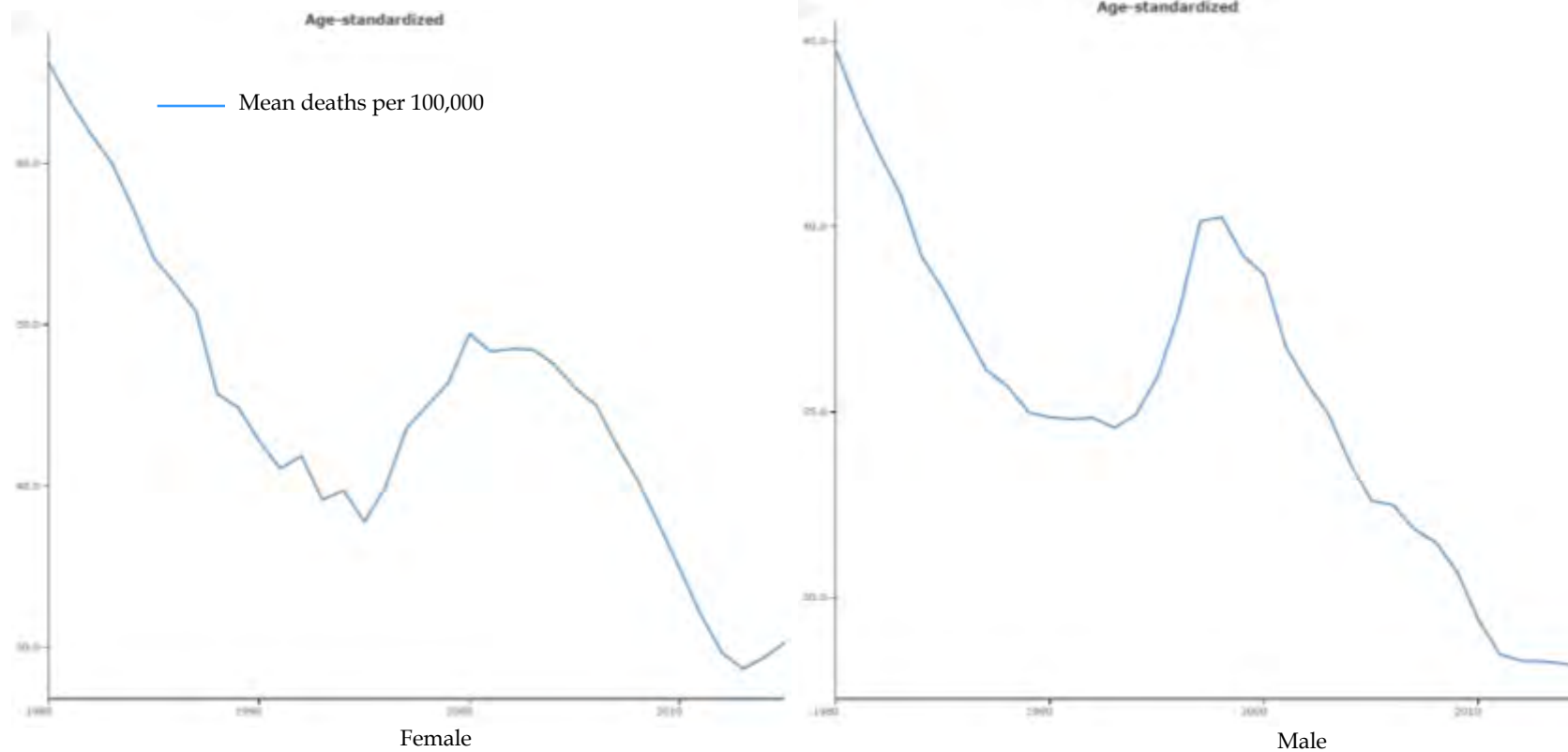
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

HIV/AIDS



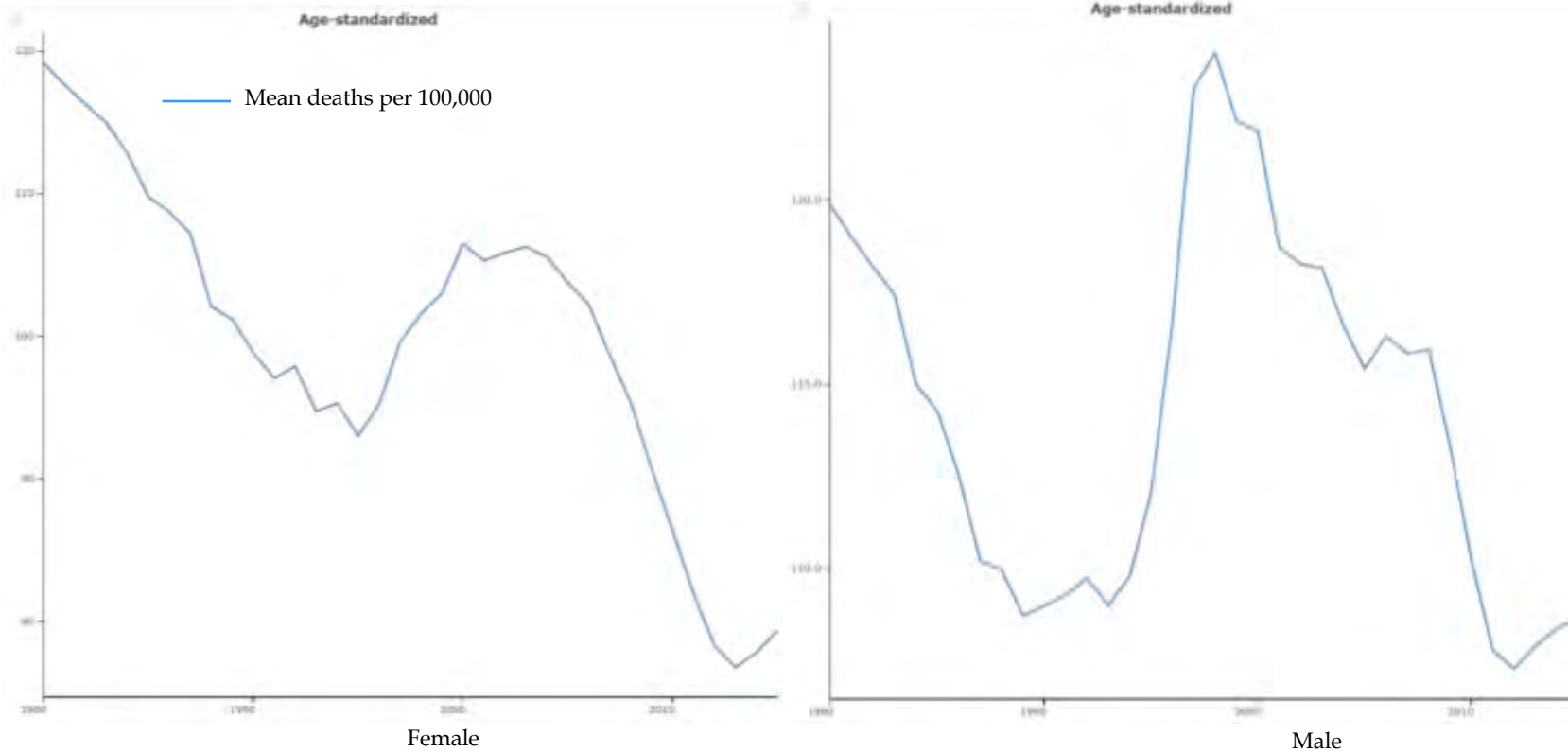
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Diarrhoeal diseases



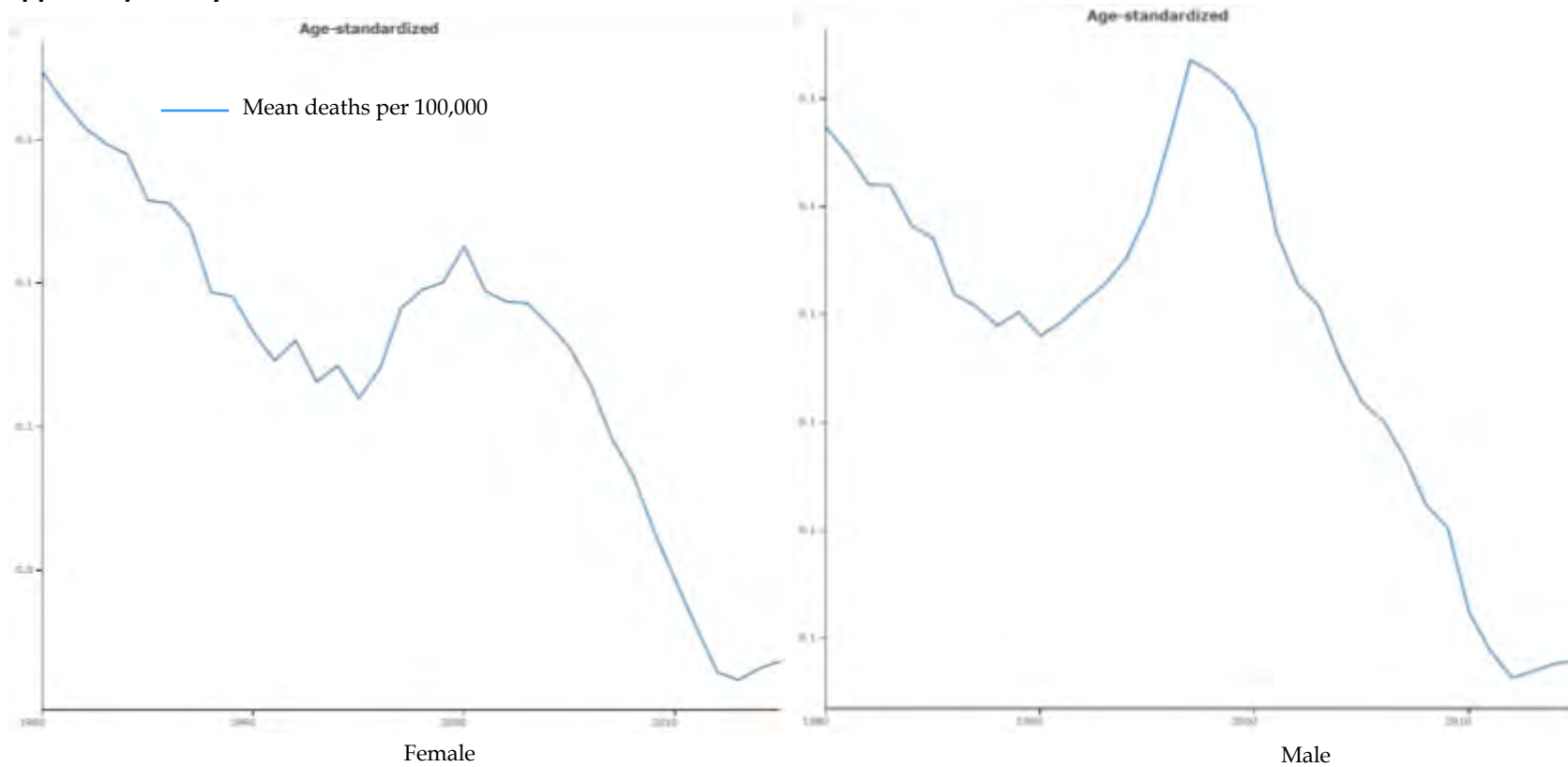
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Lower respiratory infections



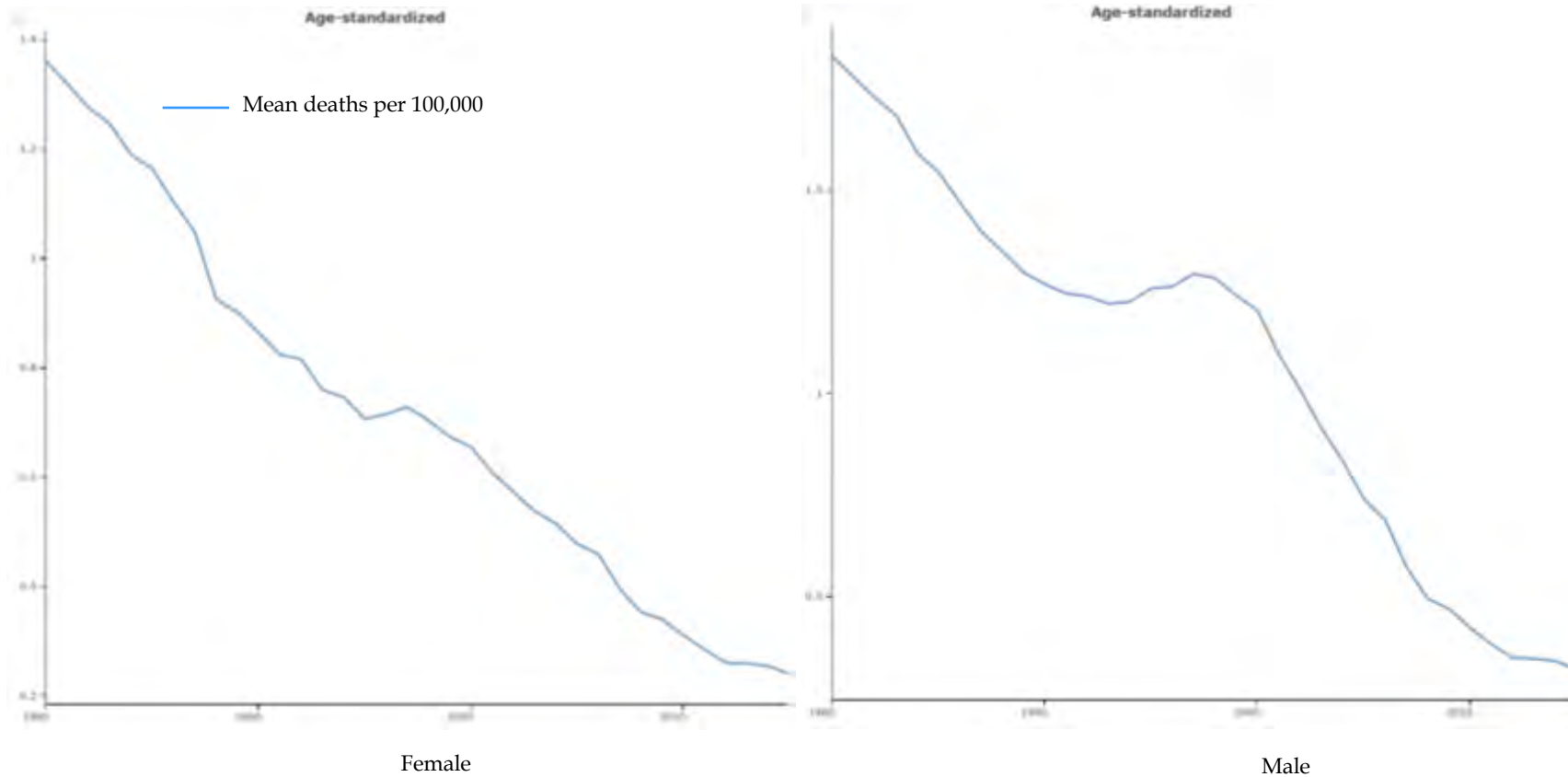
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Upper respiratory infections



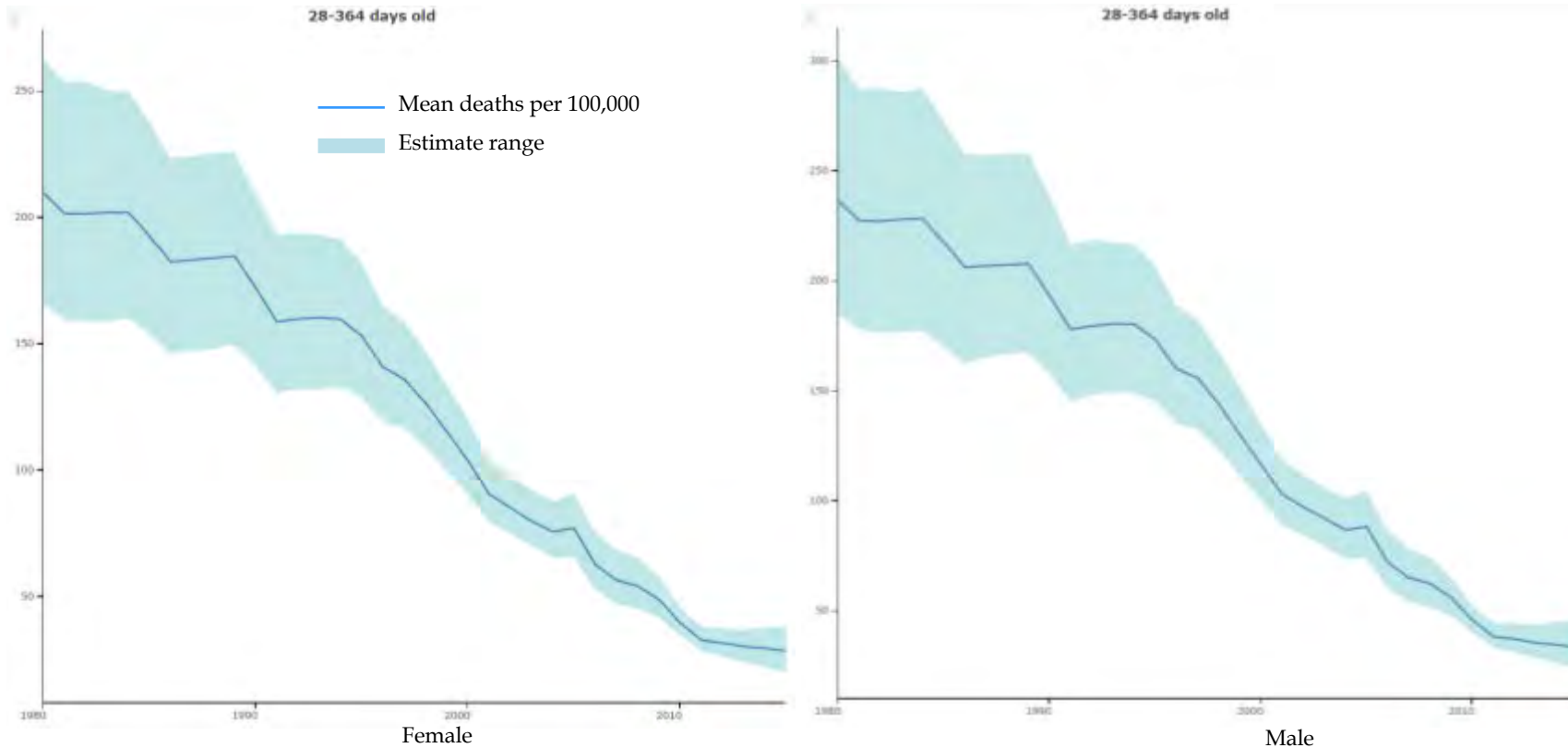
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Malaria



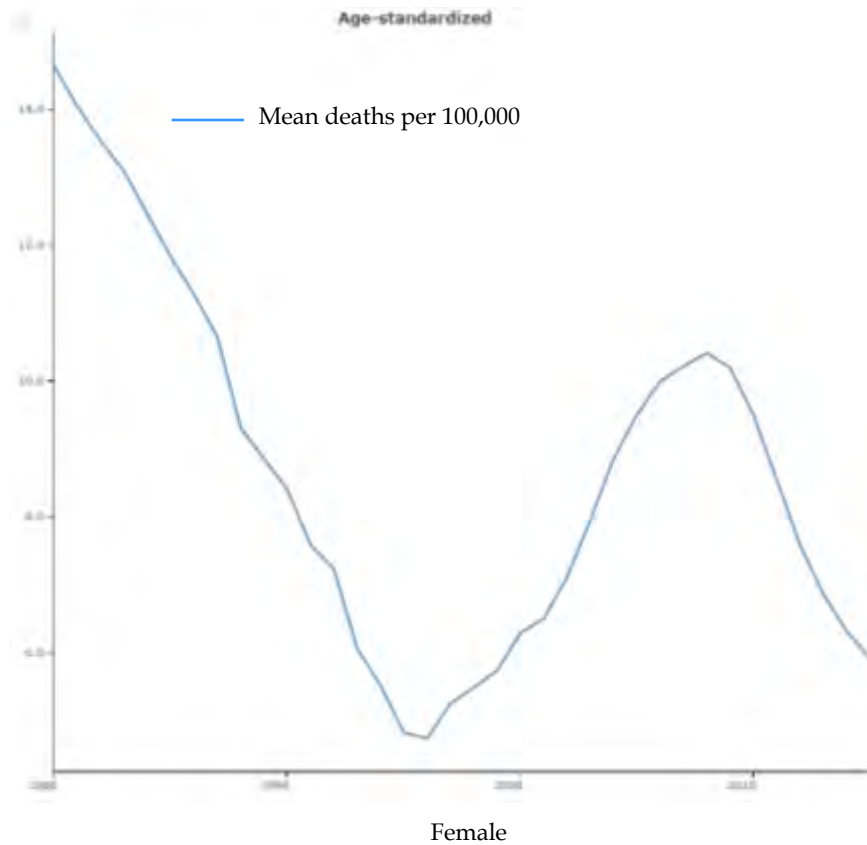
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Neonatal disorders



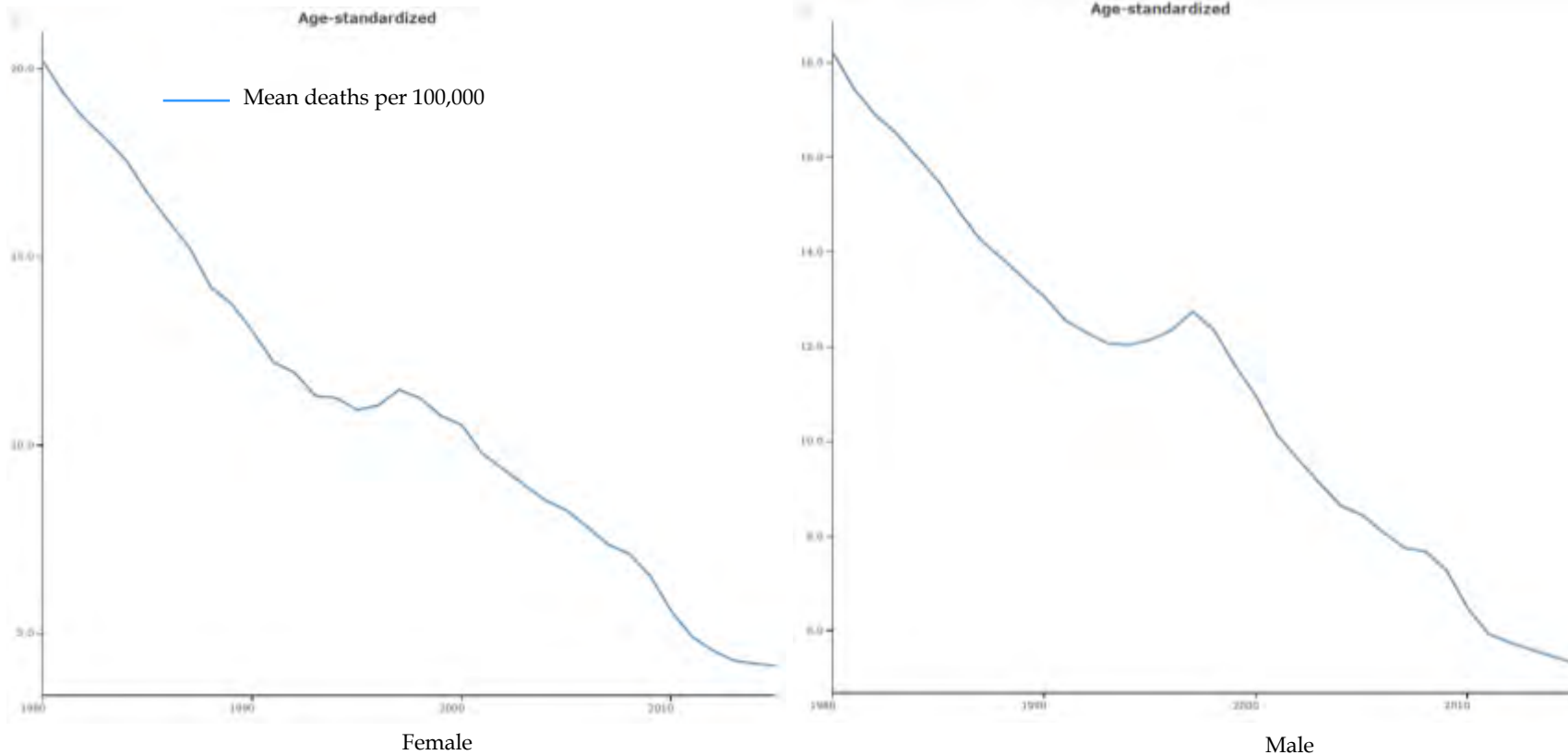
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Maternal disorders



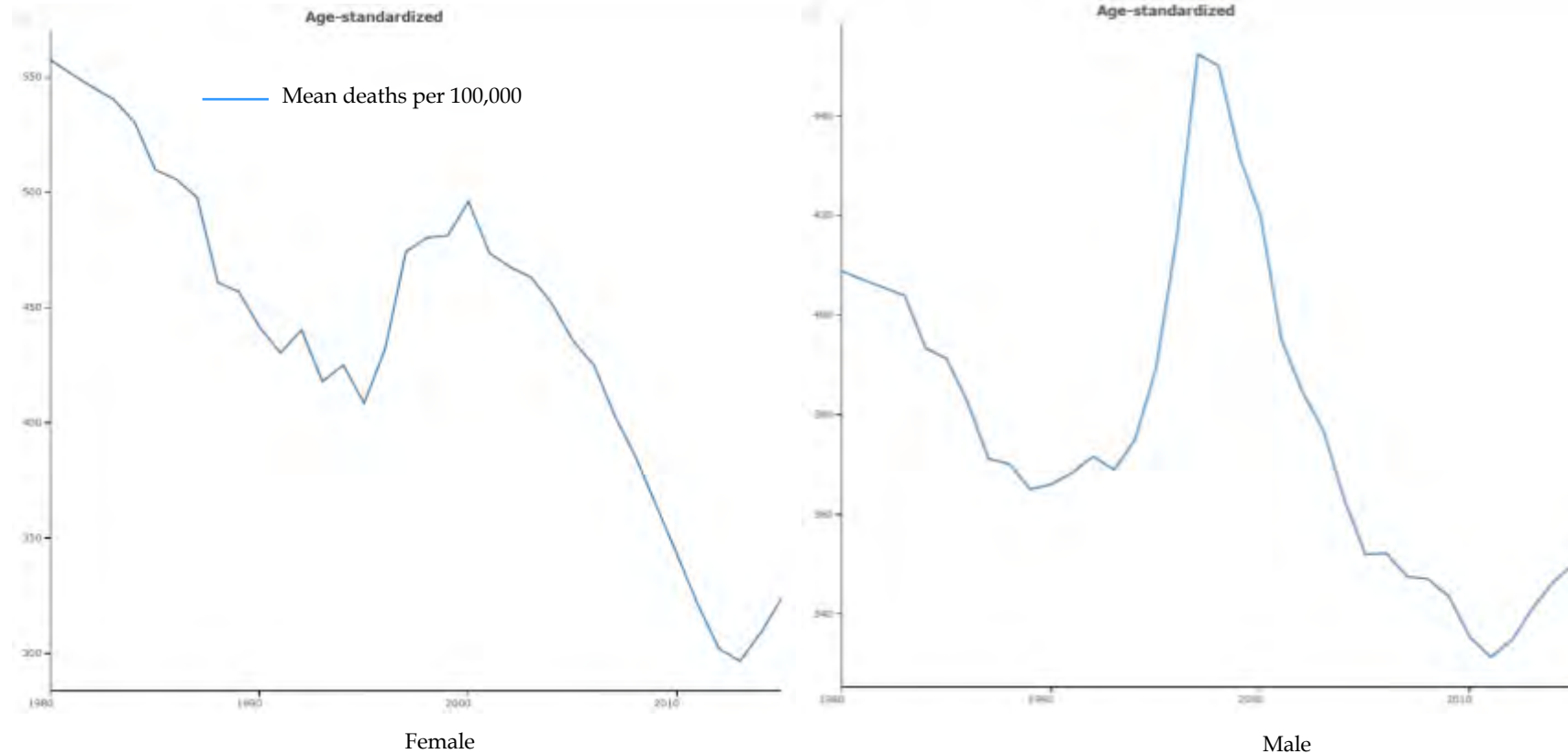
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Nutritional deficiencies



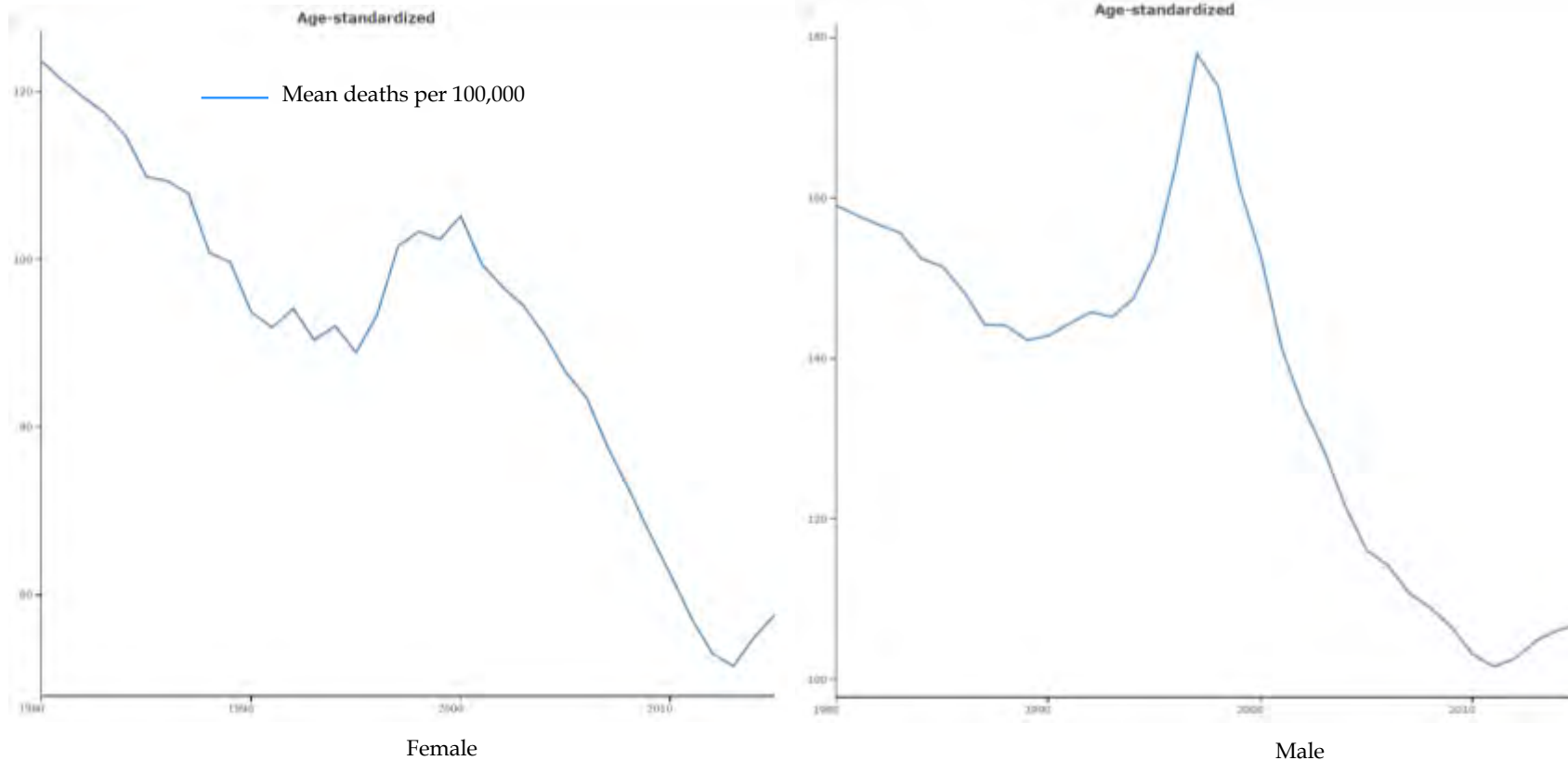
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Cardiovascular diseases



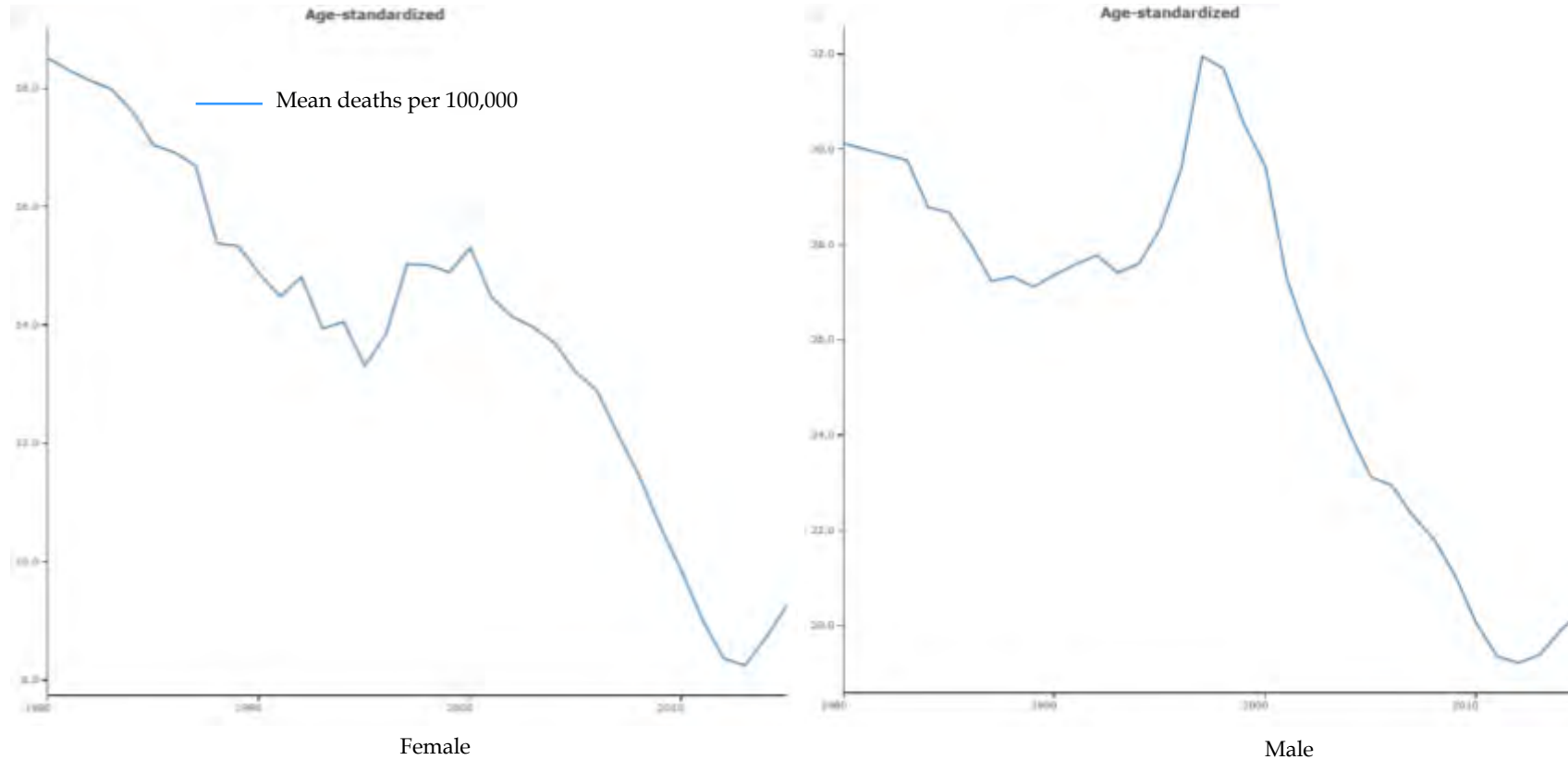
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Chronic respiratory diseases



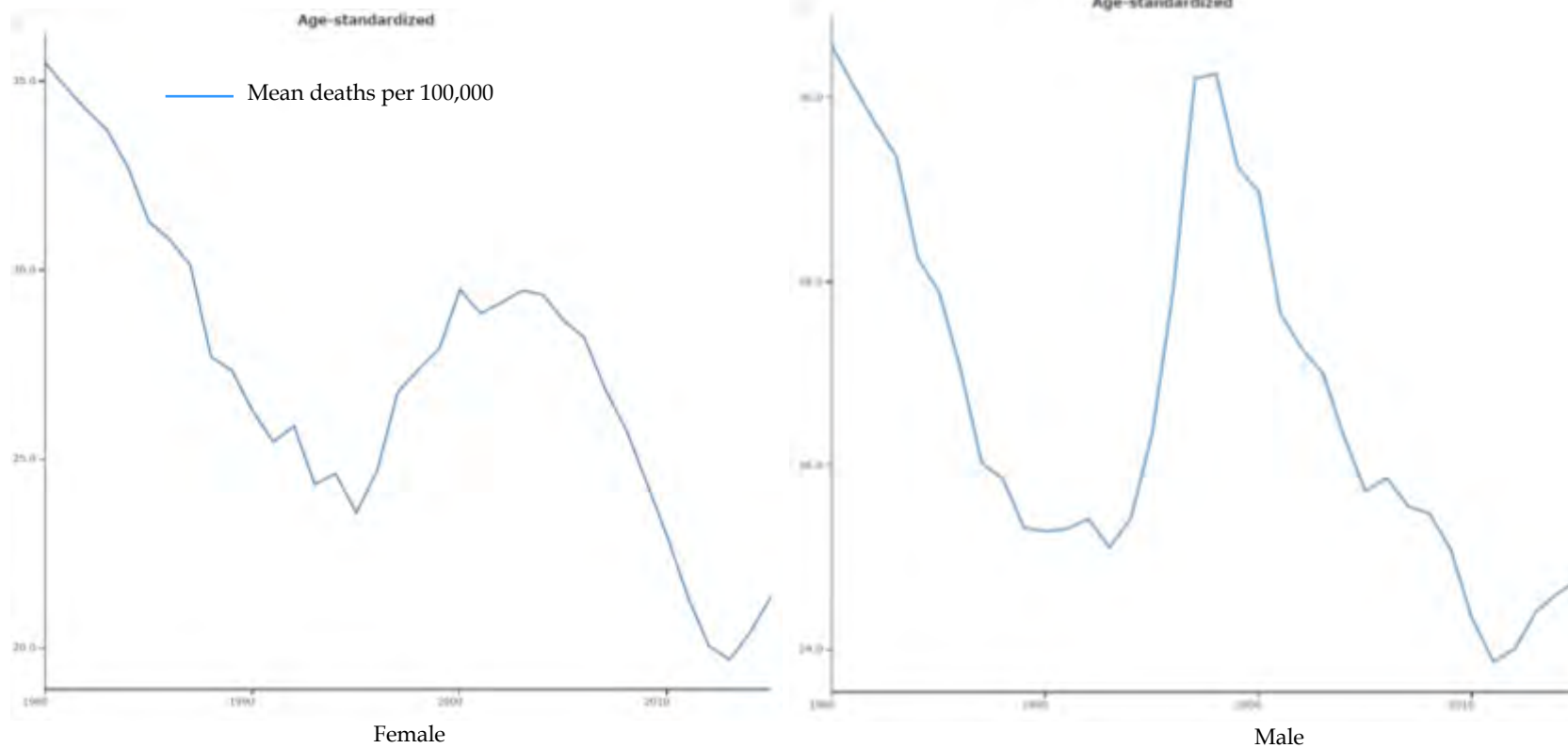
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Cirrhosis and other chronic liver diseases



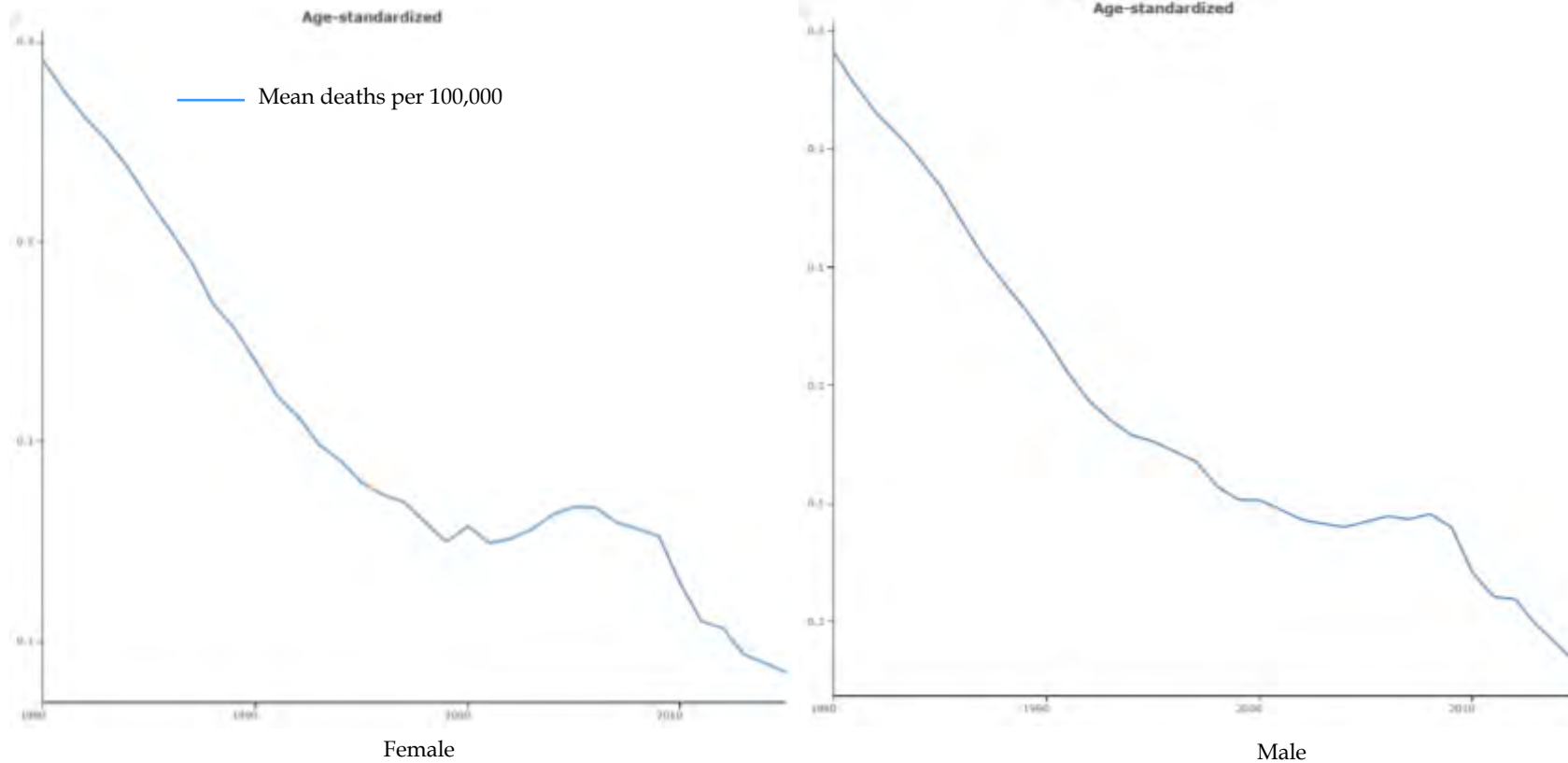
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Digestive diseases



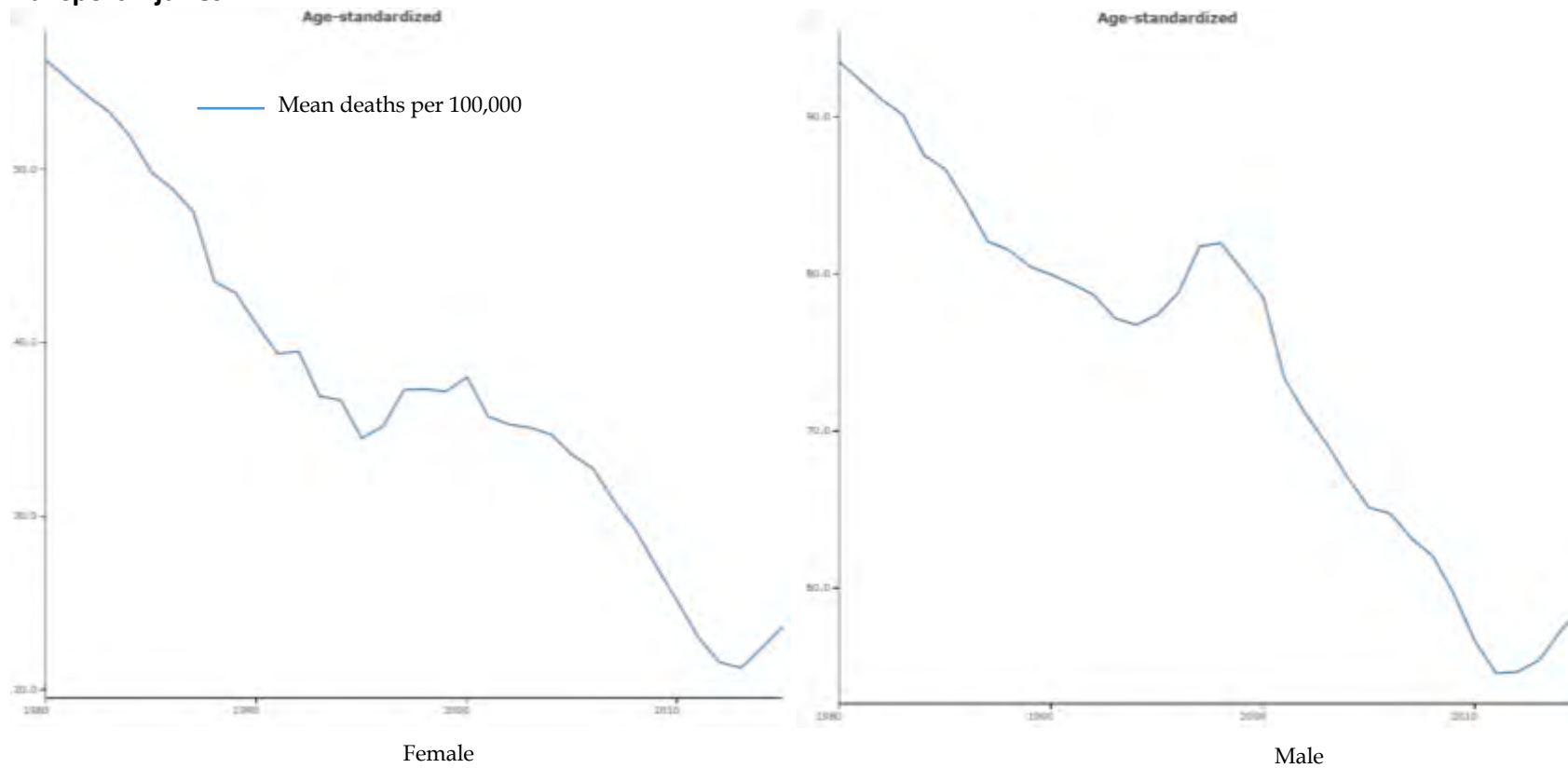
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Diabetes



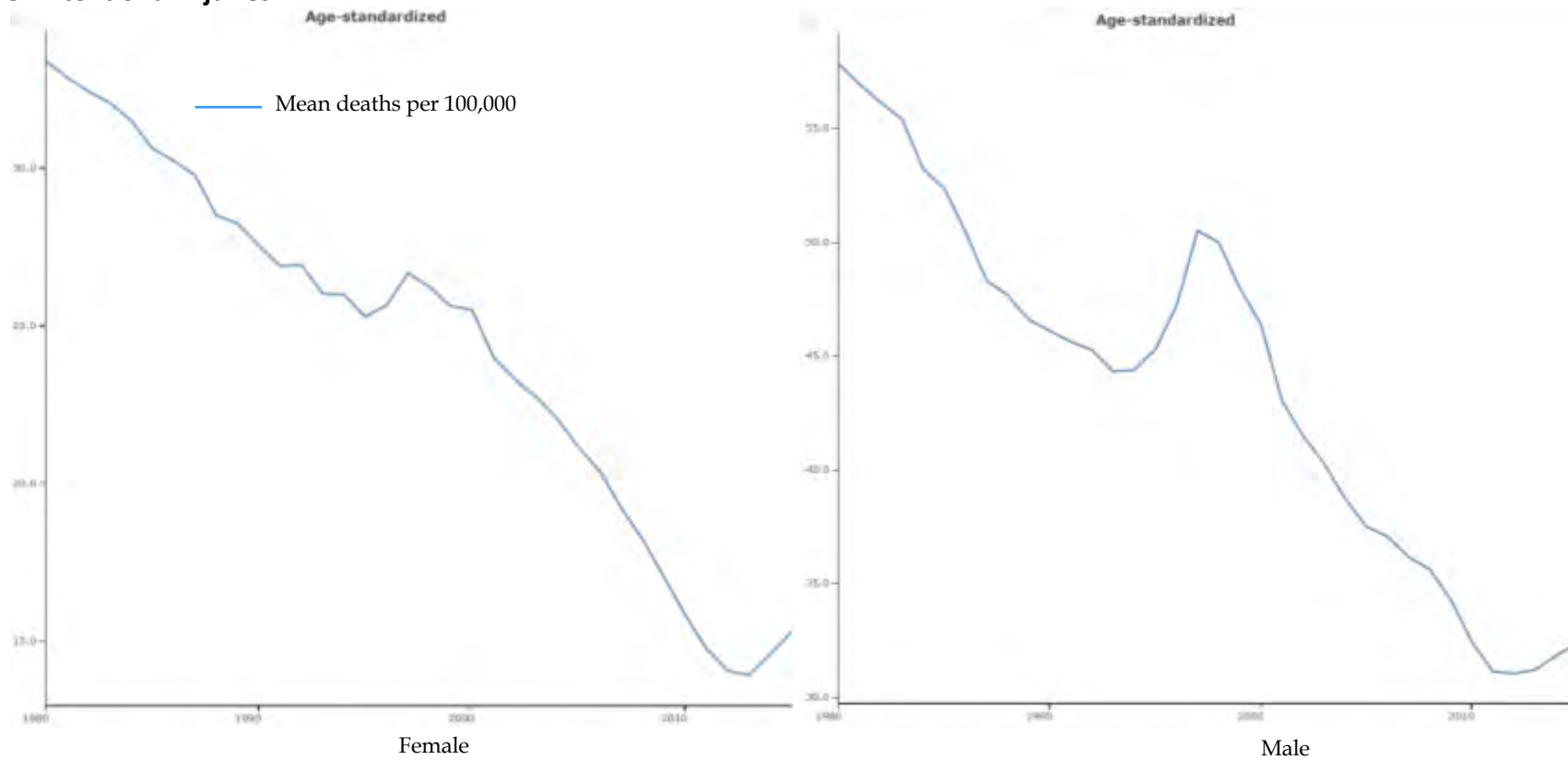
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Transport injuries



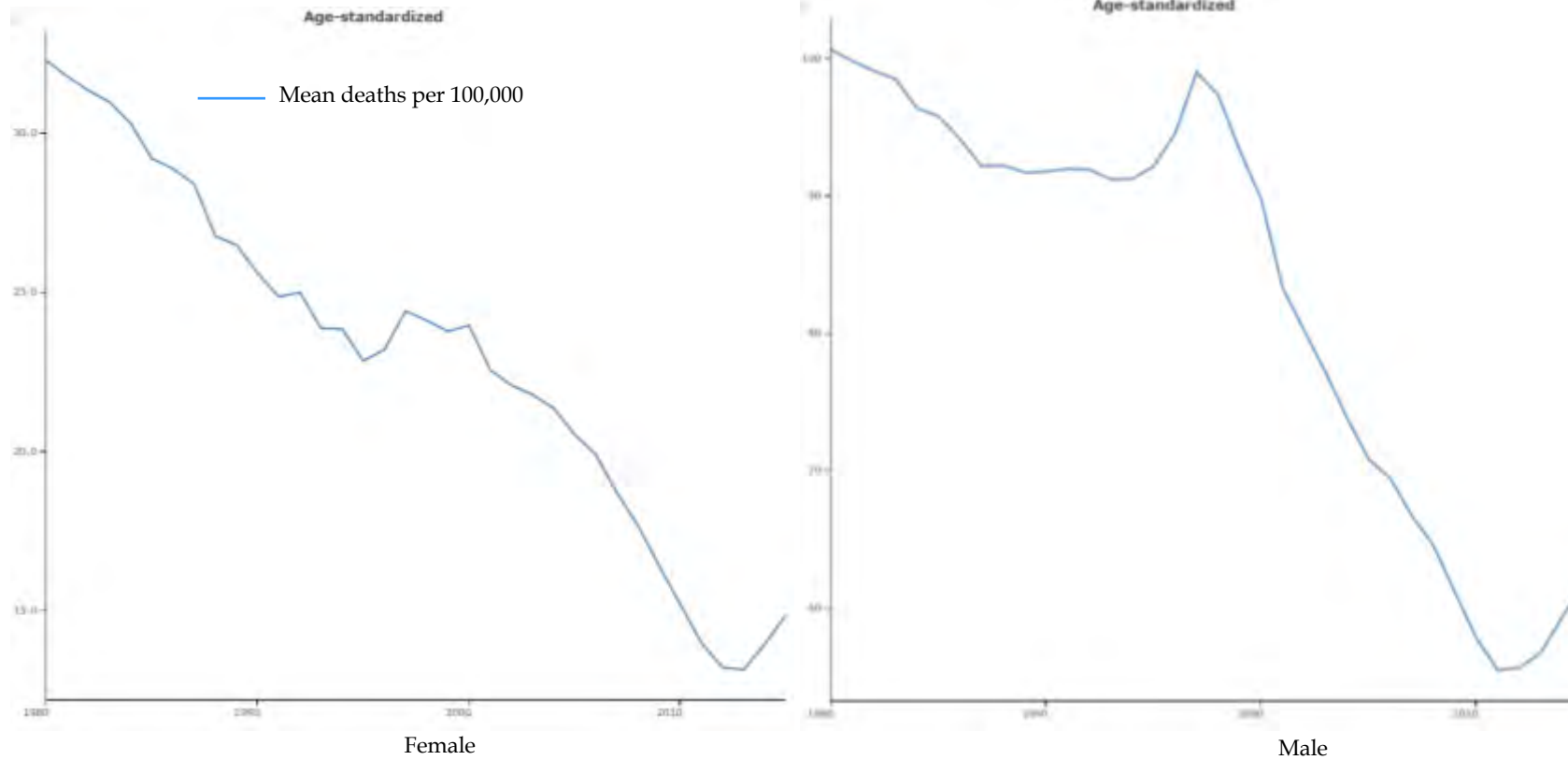
Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Unintentional injuries



Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Interpersonal violence



Source: Institute for Health Metrics and Evaluation (IHME). Causes of Death (COD) Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from <http://vizhub.healthdata.org/cod/>. (Accessed [10 May 2017])

Annex 5: Utilisation data and its limitations

The public sector collects and collates information on the number of outpatient visits and inpatient days in its facilities. Although data quality has improved over time, there are still deficiencies such as some facilities collating information on the basis of headcounts (i.e. total number of patients attending for outpatient services) while others collect information on visits (i.e. where a consultation with a nurse or doctor and receiving medicines in the pharmacy are counted as two separate visits). There are no comprehensive data on utilisation of private sector services; although the Council for Medical Schemes now publishes information on utilisation, this does not include visits by medical scheme members for services not covered by the scheme or use of private sector services by non-scheme members. Household surveys *can* provide a more comprehensive picture of utilisation and importantly, is the only data source that allows for analysis of utilisation across socio-economic groups. However, these surveys collect self-reported utilisation information and recall bias and other factors can lead to under-reporting of utilisation. In addition, all of the routine household surveys (such as the General Household Survey) in South Africa suffer from two design flaws that limit the usability of this data:

- Firstly, respondents are only asked about their use of health services if they report being ill or injured in the previous 2-4 weeks. This means that utilisation for preventive services (e.g. vaccinations or ante-natal care), to collect medicines for a chronic illness or other service use that is not related to acute illness is not captured. A once-off household survey (the SACBIA survey) that collected comprehensive utilisation data found that 38% of those who had used a health service in the previous month did not report being ill in that month¹⁰⁶. Another study, which used data from the 2009-2012 General Household Surveys, found that only half of those who have chronic diabetes or hypertension reported being ill in the previous month and so were asked about health service utilisation in the past month¹⁰⁷.
- Secondly, information is only collected on one visit, whereas there can be visits to more than one health care provider (e.g. a general practitioner and a retail pharmacist) or multiple visits to the same provider during an illness episode.

These deficiencies mean that it is not possible to use these surveys to estimate utilisation rates or accurately estimate the distribution of utilisation across different types of health care providers as both indicators require information on all health services used.

Importantly, given that the public health sector is the main provider of preventive services and chronic disease care, these data result in particularly large under-reporting of the use of public sector health services. Thus, comparing the General Household Survey (GHS) with the once-off comprehensive health service utilisation SACBIA survey, the GHS found that 61% of those who had reported an illness and reported using a health service had used a public provider while the SACBIA survey found that 71% of all health services used in the previous month had been to a public provider¹⁰⁸. Unfortunately the SACBIA survey was undertaken in 2008 and some aspects of utilisation patterns may have changed since then.

Nevertheless, it is the only comprehensive survey of health service utilisation and so is included along with analyses from other surveys that are not comprehensive.

¹⁰⁶ Alaba OA, McIntyre D (2012). What do we know about health service utilisation in South Africa? *Development Southern Africa*; 29(5): 704-724

¹⁰⁷ Christian CS (2014). Access in the South African public health system: Factors that influenced access to health care in the South African public sector during the last decade. Masters thesis. Bellville: University of the Western Cape

¹⁰⁸ Alaba and McIntyre (2012) *op cit*.

Annex 6: Key international experience relevant to current SA debates

Examples of a strong, effective strategic purchasing organisation

There are a growing number of countries, particularly in Europe but also in some middle-income countries, that provide examples of how an effective strategic purchasing organisation can promote efficiency, equity and quality health services. The country whose experience has been most extensively documented is that of Thailand¹⁰⁹. In 2002, Thailand introduced the “Universal Coverage Scheme” (UCS). Although it is termed a ‘scheme’, it is not an insurance scheme funded through member contributions. Instead, it is fully funded from tax revenue (through an annual budget allocation) which is used by the National Health Security Office (NHSO), an autonomous public entity, to purchase comprehensive health services for about 80% of the population (see later information on other schemes in Thailand). There is extensive literature on how the NHSO has been able to secure financial protection and access to quality health services according to need, promote equity, and use its purchasing power for efficiency gains. Services to which the Thai population are entitled under the UC scheme are very comprehensive, ranging from primary preventive, promotive, curative and rehabilitative services to highly specialised services in hospitals (e.g. organ transplantation and dialysis). This has been made possible within the context of a constrained budget envelop through extensive use of technology assessment to identify the most cost-effective interventions for different conditions and the NHSO using its purchasing power to reduce prices of medicines and control payments to providers. The health and health system achievements of the Thai UC scheme are dramatic and have been well-documented. Thailand acknowledges that it still faces challenges, particularly in relation to the impact of separate mandatory schemes for those in formal employment.

Challenges of focusing on mandatory insurance for the employed

Historically, countries choosing to pursue mandatory health insurance schemes have initially focused on making scheme membership mandatory for formal sector employees. This was generally gradually extended to ensure coverage through the same mechanism for other members of the population over many decades. An important feature to note about countries that have adopted such an approach and achieved universal coverage (e.g. Germany and other West European countries, South Korea, etc.) is that they are high-income countries and embarked on this strategy when there were already relatively high employment levels and employment growth rates.

Middle-income countries, particularly in Latin America (LA), which opted to focus initially on mandatory health insurance membership for those in formal employment have in most cases not been successful in extending coverage outside the formal employment sector through these schemes, and are characterised by fragmented health systems with wide disparities in access to quality health services between those in formal employment and those not. A notable exception is Costa Rica, which although beginning by making membership of their CCSS scheme mandatory for urban formal sector workers, had the stated intention from the outset of covering everyone through the CCSS and committed to paying for contributions of the poor from tax funds. Other countries in LA have struggled to expand coverage, in the context of relatively low formal employment levels and growth

¹⁰⁹ See for example: Viroj Tangcharoensathien, Supon Limwattananon, Walaiporn Patcharanarumol, Jadej Thammatacharee, Pongpisut Jongudomsuk, Supakit Sirilak (2015). Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health Policy and Planning* 30(9): 1152-1161.

rates, but importantly also because of vociferous resistance from formal sector workers protecting their superior health service benefits and opposed to cross-subsidising comparable service benefits for those outside the formal employment sector. There has been similar experience in low-income countries, such as Tanzania, which introduced mandatory insurance for civil servants through a NHIF. In 2008, it considered trying to 'harmonise' the district level community health funds (CHF) for those in the informal sector and integrate them with the NHIF to create a single scheme covering the whole population. This again was vociferously opposed by civil servants who did not want their NHIF contributions to cross-subsidise benefits for non-civil servants¹¹⁰.

Thailand had also started its journey to universal coverage by introducing a mandatory health insurance scheme for civil servants (CSMBS) and for private formal sector employees (SHI). There have been repeated attempts to 'harmonise' or integrate these two schemes with the UC scheme, but this has not been possible due to opposition from formal sector workers, particularly civil servants. The UCS and SHI have similar service benefits and methods of paying providers; while the CSMBS also has a similar range of service benefits to the two other schemes, the main difference is that the CSMBS pays providers on a fee-for-service basis. Not only has this contributed to the average spending per CSMBS beneficiary being four times greater than UCS per capita spending, it has introduced disparities in service access with providers giving preferential access to CSMBS members.

¹¹⁰ Borghi J, Maluka S, Kuwawenaruwa A, Makawia S, Tantau J, Mtei G, Ally M, Macha J (2013). Promoting universal financial protection: a case study of new management of community health insurance in Tanzania. *Health Research Policy and Systems*; 11: 21

Annex 7: Overview of strategic purchasing

TOPIC OVERVIEW 4 | Financing research theme

Ever since the publication of the 2000 World Health Report, there has been a growing awareness that health financing is not simply about raising money. Instead, there are three key functions of health financing: revenue generation, pooling and purchasing. Nevertheless, global debates tended to continue to focus on the revenue generation function.

More recently, the 2010 World Health Report on financing for universal coverage noted that: *“Raising sufficient money for health is imperative, but just having the money will not ensure universal coverage. Nor will removing financial barriers to access through prepayment and pooling. The final requirement is to ensure resources are used efficiently.”* This pointed to the importance of the purchasing function of health financing; purchasing is the critical link between resources mobilised for universal coverage and the effective delivery of quality services.

Although the key role of purchasing is being recognised gradually, there remains considerable confusion about what purchasing entails. There is an even greater lack of understanding of what is required for strategic or active purchasing.

This brief attempts to fill this gap by providing an overview of the key activities that a strategic purchaser should undertake. It draws on the limited literature on strategic purchasing, and RESYST (Resilient and Responsive Health Systems) consortium members’ experience and understanding from involvement in supporting the development of purchasers. This conceptual model of strategic purchasing underpins an ongoing analysis of purchasing arrangements in 10 countries across members of RESYST and the Asia Pacific Observatory on Health Systems and Policies.

Some initial concepts

Purchasing refers to the process by which funds are allocated to healthcare providers to obtain services on behalf of identified groups (e.g. insurance scheme members) or the entire population (Kutzin 2001).

Purchasing involves three sets of decisions (World Health Organisation 2000; Figueras, Robinson et al. 2005):

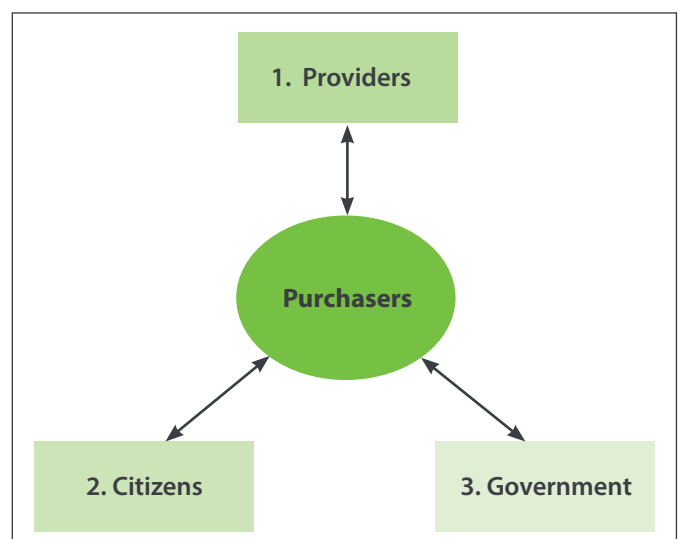
1. Identifying the interventions or services to be purchased, taking into account population needs, national health priorities and cost-effectiveness.
2. Choosing service providers, giving consideration to service quality, efficiency and equity.
3. Determining how services will be purchased, including contractual arrangements and provider payment mechanisms

It is undertaken by a purchasing organization which can be, for example, an insurance scheme, a Ministry of Health, or an autonomous agency. Purchasing should not be confused with procurement, which generally only refers to buying medicines and other medical supplies.

The 2000 World Health Report distinguished between passive and strategic purchasing:

“Passive purchasing implies following a predetermined budget or simply paying bills when presented. Strategic purchasing involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom.”

Strategic purchasing requires the purchaser to engage actively in 3 main relationships: with Government (Ministry of Health), with healthcare providers, and with citizens.



1. Key strategic purchasing actions in relation to providers

- Select (accredit) providers considering the range and quality of services, and their location
- Establish service agreements/contracts
- Develop formularies (of generic drugs, surgical supplies, prostheses etc.) and standard treatment guidelines
- Design, implement and modify provider payment methods to encourage efficiency and service quality
- Establish provider payment rates
- Secure information on services provided
- Monitor provider performance and act on poor performance
- Audit provider claims
- Protect against fraud and corruption
- Pay providers regularly
- Allocate resources equitably across areas
- Implement other strategies to promote equitable access to services
- Establish and monitor user payment policies
- Develop, manage and use information systems

2. Key strategic purchasing actions in relation to citizens or population served

- Assess the service needs, preferences and values of the population and use to specify service entitlements/benefits
- Inform the population of their entitlements and obligations
- Ensure population can access their entitlements
- Establish effective mechanisms to receive and respond to complaints and feedback from the population
- Publicly report on use of resources and other measures of performance

3. Key strategic purchasing actions by government to promote strategic purchasing

- Establish clear frameworks for purchaser(s) and providers
- Fill service delivery infrastructure gaps
- Ensure adequate resources mobilised to meet service entitlements
- Ensure accountability of purchaser(s)

Defining service entitlements and relationships with providers

One of the first actions that a strategic purchaser should undertake is to establish what services it should purchase for the population it serves. This could take the form of an itemised list of services (limited benefit package) or it may be an entitlement to a comprehensive range of health services with some limitations (e.g. excluding certain high cost or ineffective procedures).

Government may take the lead in deciding on service entitlements, but a strategic purchaser should engage actively in identifying the health needs of the population and understanding the preferences and values of citizens. The coverage of the benefit package or entitlements needs to be affordable within the resources available to the government or purchaser, and choices therefore need to be made about what services can be included. The service entitlement needs to be reviewed and updated regularly as the resources available expand, and as new interventions and technologies become available.

Strategic purchasers should also decide which providers to purchase services from. This may be limited to public sector providers, or may include private providers, and often involves an accreditation process. Being selective may not always be feasible, particularly where there is only one health care provider in a geographic area. But wherever possible, purchasers should make explicit decisions on which providers to accredit considering issues such as providers'

location relative to the population, their ability to provide an appropriate range of services and quality of care. Where selection is not possible, clear systems for performance and quality improvement are needed.

The purchaser should then establish some form of agreement with accredited providers, which may take the form of a formal contract. This is a means of making the purchaser's expectations clear to providers, such as the range of services to be provided; quality expectations; method, timing and level of payment; the information that providers are required to submit; and outlining action that will be taken for poor performance.



A strategic purchaser should actively identify the health needs, preferences and values of the population

Purchasing is the critical link between resources mobilised for universal coverage and the effective delivery of quality services

Promoting efficiency and service quality

A strategic purchaser also needs to provide guidance on service provision, particularly to promote efficiency and ensure affordability and sustainability of universal health systems. Most often, this will take the form of an essential drug list or formulary and associated standard treatment guidelines that accredited providers are obliged to follow. These should not focus only on the use of generic medicines but also diagnostic, surgical and other supplies and equipment. Capacity for technology assessment, which should consider cost-effectiveness and budget impact analysis, is important to support developing these lists and guidelines.

The population should also be provided with guidance on the appropriate means of accessing services. For example, presenting to a primary health care provider who will serve as a gatekeeper to higher levels of care, and following a specified referral pathway to ensure efficiency, are elements of good practice.

A key element of strategic purchasing is designing, implementing and modifying (if necessary) provider payment methods that will encourage providers to enhance and maintain service quality and efficiency. For example, rigid line-item budgets do not allow facility managers to adapt their mix of inputs or encourage other strategies to improve service delivery efficiency. Other ways of paying providers, often a mix of different payment methods, are more effective in promoting efficiency and quality.

Strategic purchasers have a responsibility to not simply rely on these strategies to influence the behaviour of providers. Instead, they should actively monitor provider performance, particularly in terms of service quality. Monitoring activities could include routine analysis of information submitted by providers (e.g. to ensure that standard treatment guidelines are being followed, or to pick up 'red flags' such as high levels of hospital acquired infections) and regular audits of health facilities. It is equally important to establish effective ways for the population served to provide feedback on their experience of health services, including complaints mechanisms but also pro-active ways of seeking input from

citizens. Monitoring needs to be backed up by taking action on poor performance (including responding to patient complaints), which could include de-accreditation (although this may not be feasible in relatively under-served areas) or instituting quality improvement plans.

Ensuring affordability and sustainability

Purchasers carry a heavy burden of responsibility to ensure that the services to which the population is entitled can be delivered with the funds available, and that the health system is sustainable in the long term. It has to ensure that expenditure and revenue are aligned. A strategic purchaser must, therefore, actively engage in establishing the payment rates for providers. The fewer and larger the purchasers, the greater the power they have to influence payment rates, and to exert their purchasing power such as through bulk purchasing of quality-assured drugs and supplies.

Strategic purchasers' financial responsibility also extends to auditing provider claims and taking steps to protect against fraud and corruption. The effective provision of services is also affected by purchasers' ability to pay providers regularly and in a timely fashion. Where government revenue funds the purchaser, government has a reciprocal responsibility to ensure that adequate resources are mobilised so that service entitlements can be met.



A strategic purchaser should take explicit steps to protect its members from catastrophic healthcare payments

Promoting equity and financial protection

While attention in purchasing is often directed to promoting efficiency and service quality, a strategic purchaser should also take explicit steps to promote equity and protect its members from catastrophic healthcare payments. It is insufficient to create an entitlement to services. Not only should the population served be made aware of their entitlements, services must be physically accessible to all those who have this entitlement, for which functioning primary health care and proper referral play a critical role. While government may bear much of the responsibility for building physical infrastructure where gaps exist, a strategic purchaser can influence the distribution of health workers. For example, purchasers can offer higher payment rates for services provided in under-served areas. The equitable allocation of financial resources across geographic areas can play an important role in promoting the availability of well staffed, equipped and supplied health services across the country. The availability of services is not the only equity concern; financial protection must also be assured through establishing and monitoring user payment policies (e.g. disallowing balance billing, setting co-payment limits).

Transparency, accountability and information

Strategic purchasers can wield considerable power; to ensure that this power is not abused, strong governance and accountability mechanisms are required. Government has a stewardship role in establishing clear policy and regulatory frameworks within which purchasers (and providers)



Strong governance and accountability mechanisms are required for purchasers and providers

will operate. These could include explicit expectations of purchasers (eg to ensure the availability of services to, and financial protection of, the population served), governance structures, reporting requirements and accountability mechanisms. Regular (e.g. annual) public reporting by the purchaser on its use of funds, services purchased and other issues is critical for ensuring transparency and accountability to government (particularly where public funds are used) and to citizens.

To effectively undertake all of these activities, a strategic purchaser is dependent on accurate and up to date information, such as information on population health needs, service utilisation patterns, aspects of provision (eg diagnosis and treatment, referral practices) and revenue and expenditure. Therefore, a final responsibility of the purchaser is to develop, manage and use information systems.

About the brief

This brief is an output of the multi-country purchasing project conducted through a collaboration between RESYST and the Asia-Pacific Observatory on Health Systems and Policies

The project aims to critically assess the performance of health care purchasers in a range of low and middle-income countries. The countries involved in the study are: China, India, Indonesia, Kenya, Nigeria, South Africa, Tanzania, Thailand, the Philippines and Vietnam.

Further information

Project webpage: <http://resyst.lshtm.ac.uk/research-projects/multi-country-purchasing-study>

Email: Ayako Honda ayako.honda@uct.ac.za

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