To NHI or not? And if so, what, when, why and how?

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It has been almost four years since the Green Paper on the proposed National Health Insurance (NHI) was gazetted. With no White Paper in sight, many are questioning whether the NHI policy will be taken forward or whether there has been a change of heart. There remains considerable confusion about the nature of the proposed reforms and I believe that it will not be possible to overcome the inevitable contestation around a policy of this magnitude until a clear vision is presented. This 'thought-piece' outlines my own understanding of the proposed health system reforms.

What are the proposed NHI reforms all about?

The term National Health Insurance is an unfortunate one. It immediately makes people think that what is being proposed is the creation of an insurance scheme, in the mould of private medical schemes. One of the connotations that goes along with this misconception is that government will need to pay for everyone to become a member of this 'mega-medical scheme', which is patently unaffordable given that medical schemes account for nearly half of all health care expenditure in South Africa yet cover less than a fifth of the population. An associated misconception is that the proposed NHI is all (and only) about how to raise more money for health services.

The Minister of Health has said on a number of occasions that the NHI is about moving towards Universal Health Coverage (UHC), which is a global health policy priority and is also an element of the post-2015 sustainable development agenda. UHC is commonly accepted to mean that *all people* within a country should have access to the health services they need, that these services should be of adequate quality to be effective, and that no one should face financial difficulties in accessing these services.

Although many people face financial difficulties related to health care, within the South African context the major challenge relates to the 'access to quality services' component of UHC goals. There are two key implications stemming from this:

- Firstly, in order to move towards UHC in South Africa, considerable attention needs to be paid to improving the availability and quality of health services. UHC reforms are not only about health care financing, but also about the delivery, management and governance of health services.
- Secondly, reforms related to health financing are not only about raising (more) money for health care, but also about how these funds are pooled (so that people can truly benefit according to their need and not their ability-to-pay) and most importantly about strategic purchasing. Purchasing is the least well understood function of a health financing system (see textbox), yet in my view, the primary reason for creating a NHI Fund (NHIF) is to ensure that there is strategic purchasing of health services.

"Purchasing is the critical link between resources mobilised for universal coverage and the effective delivery of quality services" (1).

"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." (2)

When might we see the NHI reforms being implemented?

There is considerable frustration at the seeming lack of progress with the NHI reforms. The only 'implementation' appears to be the NHI pilot districts and many do not see this as 'real NHI' reform (due to the misconception that NHI is only about health financing). However, as indicated earlier, efforts to improve service delivery and management are a key part of UHC reforms. Many countries (e.g. Thailand and Turkey) initiated their very successful UHC reforms by focusing on improving the availability and quality of services. So, the reality is that the NHI reforms are already being implemented. The term 'pilot district' is probably a misnomer, as the core reforms (such as district clinical specialist teams, school health services, contracting with general practicioners (GPs), etc.) are being implemented country-wide and not only in pilot districts. Indeed, many initiatives to improve public sector health services, particularly at the primary health care level, are being implemented.

However, there has been absolutely no movement on the creation of a NHIF, an autonomous public entity that would undertake strategic purchasing. Before a NHIF can be established, the White Paper needs to be released and relevant legislation brought before parliament. These legislative processes are lengthy, and considerable planning and institutional development is required before we have a fully functioning NHIF. It is this lack of progress in moving forward with these preliminary steps for a NHIF that is of the greatest concern.

Do we need a NHIF and if so, why and how?

Strategic purchasing actions can ensure that resources are used efficiently and equitably, and are translated into accessible, quality health services that meet the health needs of the population (see reference 1 for more details). While 'supply-side' efforts to improve quality, efficiency and equity are important (such as improving infrastructure, upgrading staff skills and sending teams into facilities to identify problems and address them), they are unlikely to have long-term effects – there is considerable staff turnover in facilities and as soon as the 'once-off pressure' of external teams visiting facilities is removed, things may revert to 'business as usual'. It is the creation of consistent and constant 'demand-side pressure' (from a strategic purchaser) and empowering facility managers (through delegating decision-making authority) that will translate into lasting improvements in quality, efficiency and equity. So, strategic purchasing is a 'non-negotiable' for a well-functioning health system.

But do we need a NHIF to undertake strategic purchasing? Can't existing government departments do this? Certainly some strategic purchasing actions could be undertaken within existing structures, but we are largely failing to do that at present. We could be doing better in assessing population health needs and ensuring that services that meet these needs are available; we could be doing more to allocate financial, human and other resources equitably; we could be establishing service agreements with all public providers to make performance

expectations explicit and doing more to monitor performance and to take action on poor performance. But many strategic purchasing actions require vastly different skills to what exists within government health departments at present and the public finance management environment limits the extent to which strategic purchasing actions, particularly in terms of changing provider payment mechanisms, can be undertaken.

It is also important to recognise that the health system challenges we face in South Africa are not restricted to the public sector. We also face massive challenges in the private sector, particularly in terms of rapid increases in private service providers' fees, with medical schemes being too fragmented to provide sufficient countervailing pressure. Once again, a NHIF as a single, large strategic purchaser is likely to be the most effective strategy for addressing these challenges in the private sector.

So, creating an autonomous public NHIF would be the first prize. However, merely creating an organisation like the NHIF will not automatically translate into improved, and truly strategic, purchasing of health services. Strategic purchasing requires a substantial investment in information systems, skilled personnel, strong leadership and most importantly impeccable governance arrangements. Because the NHIF would sit with an enormous pool of money, mismanagement or corruption within the NHIF could destroy the entire health system. With this in mind, the establishment of a NHIF would only be first prize if it is able to operate completely free of political interference and if it has rock solid accountability and governance structures. The groundwork for such an institution needs to be laid urgently – the details of the institutional and governance structures should be made public and the investment in information systems and other capacity requirements should be initiated sooner rather than later.

One final comment on the 'how' of moving towards UHC; although the NHI reforms are not only or even primarily about generating more funds for health services, in my mind, it is clear that we do require additional funds to provide quality, accessible public sector health services. While some are of the view that all that is required is to improve efficiency to 'free up funds', there is little clarity on the nature of existing inefficiencies in the public health sector or on the extent of the efficiency gains that could be achieved. There seems to be widespread agreement that staffing levels need to be increased in public sector health facilities. However, this cannot be done without budgetary increases; personnel is the single largest expenditure item in the health sector and efficiency improvements (e.g. in use of drugs) will not be of sufficient magnitude to meet the financial requirements for improved staffing levels. The need for additional funds is urgent. Training institutions have been under enormous pressure in recent years to increase the number of health professionals trained and they have responded. Yet, a number of recent graduates have not been able to find employment in public health facilities; some have not even been able to find a placement to undertake their compulsory community service and so cannot register as health professionals. In order to make the necessary progress in improving public sector health service delivery, which, as indicated previously, is a critical first phase of UHC reforms, additional resources are required.

References:

1. RESYST Consortium. What is strategic purchasing for health? London: RESYST; 2014.
2. World Health Organisation. World Health Report 2000. Geneva: WHO; 2000.