planning, monitoring & evaluation

Department:
Planning, Monitoring and Evaluation
REPUBLIC OF SOUTH AFRICA

SOCIO-ECONOMIC IMPACT ASSESSMENT SYSTEM (SEIAS)

INITIAL IMPACT ASSESSMENT: National Health Insurance Fund

JULY 2017

1. The problem/ Theory of Change

1.1. What is the social or economic problem that you are trying to solve?

The South African Government is committed to the goal of universal health coverage (UHC); however, to date, progress toward this goal has been limited by the existing health financing system structure. In particular, the high degree of fragmentation in funding undermines efforts towards improved efficiency in the management of available resources, reinforces inequality in their distribution, and prevents the provision of financial risk protection. The problem is therefore a socio-economic one.

The continued existence of this national heath financing system has resulted in the failure to achieve Constitutional imperatives contained in Section 27 of the Bill of Rights, and runs contrary to the values of equity and solidarity underlying the United Nations 2012 Declaration on UHC to which South Africa is a signatory. In addition, the evidence shows that compared to other countries of similar economic development, the level of expenditure channelled through this system is not translating into the expected health outcomes.

1.2. What are the main causes of the problem? That is why the problem arise and why does it persist?

At the national level, the current health system in South Africa is comprised of two tiers: Public and Private. This system is the legacy of the pre-1994 Apartheid period in South Africa in which the private sector was highly resourced and benefitted the white minority, while the public sector was systematically under-resourced and served the black majority. Significant improvements in services coverage and service delivery have been made since 1994; however, attempts to transform the underlying health financing system in both the 1990's and early 2000's were unsuccessful. As a result, despite the tremendous investment made into the public health system to date, the two-tiered system has become further entrenched with access to quality health services now more than ever based on socio-economic status. Therefore, while there are multiple dimensions to and determinants of access to health care, the primary one of concern in the South African context is financial.

The level of per capita spending South Africa is highly unequal. Currently, 8.9% of GDP is spent on health and of which 51% is spent on 16% of the population in the private sector, which serves a minority wealthy and urban population who also benefit from pre-existing infrastructure. By contrast, the remaining 49% is spent on 84% of the population that is dependent on the public health sector. This includes the majority poor, including key vulnerable populations, who continue to be served with a limited financial resources that are both disproportionate to the size of the population served and the burden of disease; and insufficient to address the historical imbalance in infrastructure. This is despite clear evidence that lower socio-economic

groups in South Africa represent a disproportionate burden of health needs and yet have lower health service utilisation rates and derive fewer benefits from using health care, either public or private.

Financial access is further limited within both the public and private sector due to the structure of their respective health financing system. In the public sector, there is no mechanism for prepayment thereby increasing the level of out-of-pocket (OOP) expenditure at the time of service delivery. There is also no mechanism for pooling of resources (outside of general revenues allocated to the health sector) thereby preventing cross-subsidisation that would otherwise provide risk protection to those that would suffer catastrophic expenditure or forgo access altogether. Finally, a fragmentation of funding – equitable share, conditional grant, public sector medical scheme contributions – limits the opportunity to leverage the benefits of strategic purchasing in the public sector and ensure that the payment of services is directly linked to defined health outcomes. Within the private sector, members of medical schemes also often have to make substantial out-of-pocket payments in cases where the scheme only covers part of the cost of services, where a service is not covered at all by the medical scheme (e.g. outside the scheme's service benefits), or where scheme benefits have run out. In addition, the existence of multiple medical schemes and benefit options within each further fragments the risk pool and prevents cross-subsidisation across the populations covered by these schemes. There are currently approximately 270 options or risk pools available across the existing medical schemes.

The current structure of the health financing system in South African health system limit the capacity for cross-subsidisation that would otherwise allow for the subsidisation of the poor by the rich, the sick by the healthy, and the elderly by the young. It also decreases the efficiency with which available resources can be spent, and undermines efforts to address existing inequalities. The continued existence of a separate public and private sectors has persisted to date due to lack of an alternative health financing legal framework or associated regulatory environment; a private sector vested interests in maintaining the status quo; and and a historical silo'd approach to funding in the public sector that has typically been disease-focussed but not linked to the burden of disease and reinforced by donor funding mechanisms.

Identified Problem	**Main Causes of the Problem**	**Why the problem arises and why does it persist?**
South African Government is committed to the goal of universal health coverage (UHC); however, to date, progress toward this goal has been limited. The country is thus challenged by a high Burden of Disease that is managed predominantly in the public health sector namely: • High levels of communicable diseases	Fragmented funding and risk pools Separate public and private sector	Historical legacy; Subsequent lack of legal framework
	High number (approx. 270) of risk pools within the private sector	Historical legacy; Subsequent regulatory gaps combined with vested interests
	Multiple risk pools in the public sector (Equitable Share, Conditional Grants, Donor funding,	Silo approach to funding (typically by disease or by population) that is not linked to the burden of disease and

Identified Problem	Main Causes of the Problem	Why the problem arises and why does it persist?
• Increasing levels of non-communicable diseases • Relatively high maternal and child mortality rates and • Increasing levels of trauma and injuries	Public sector employee scheme contributions)	reinforced by donor funding structure

1.3. **Whose behaviours give rise to the problem, and why does that behaviour arise?**

The problem of limited progress to UHC, driven by a fragmented health financing system, is driven by behaviour across all stakeholders. This is due to the prevailing incentive structures, conditions that make it in the best interest of each individual to choose a particular behaviour, which are both context and stakeholder-specific. For example, in the private sector, a student who is young and healthy and not looking beyond the next three years is unlikely to prioritise expenditure on prepaid medical insurance because they expect the likelihood of needing healthcare to be low. If the student comes from a higher socio-economic group or know they will still have access to financial resources should they need them, they are even less likely to make such a contribution. However, this behaviour is not in the best long-term interests of the student, or of society in that it increases the cost of services for all those who do utilise them (including the student in the long run) and the risk on those who come from lower-socio-economic group. As another example, a doctor in private practise who knows a patient with private medical scheme cover will not have to consider the cost of diagnostic tests for a particular condition, may choose to include tests early on for conditions that are highly unlikely. Similarly, in the public sector, a programme manager that, in the absence of a transparent process that directly links expenditure (per program/disease or geographical area) to the burden of disease, may advocate for maximum and ring-fenced funding – either public or donor – that may or may not be in proportion to the need, and where unspent (and utilising supportive budget mechanisms), cannot be reallocated to other programs where they can be spent. Thus, what is required is an overhaul of the health financing system – collection, pooling, purchasing and definition of the benefits package that makes it in the best interests of all stakeholders to work towards universal access. In particular, the traditional passive relationship between purchasers (i.e. those who hold a pool of funds and transfer these funds to providers) and service providers including resources that responds to need in terms of the level and distribution of funding (e.g. geographical distribution of health workers that is aligned to the burden of disease), need to be replaced by active or strategic purchasing in which tailored budgeting and payment mechanisms incentivise efficiency and high service quality.

This structural overhaul can only be led by the government, and while regulation is required, the first and foremost issue must be the identification and creation of stakeholder and context-specific incentives to drive behaviour. This applies to both the public and private sector and includes key factors such as health care providers, individuals seeking health care services, health professionals, private medical aids, suppliers (e.g. pharmaceutical companies) etc. A few of these are presented in the table below.

Identified Problem	Behaviour giving rise to the identified problem	Groups whose behaviour give rise to the identified problem?	Why does the behaviour arise?
South African Government is committed to the goal of universal health coverage (UHC); however, to date, progress toward this goal has been limited. The country is thus challenged by a high Burden of Disease that is managed predominantly in the public health sector namely: • High levels of communicable diseases • Increasing levels of non-communicable diseases • Relatively high maternal and child mortality rates and • Increasing levels of trauma and injuries	The benefit of free care in public sector is seen to be outweighed by a real or perceived associated poor quality of care, leading to persons with disposable funds to join private medical schemes and access private health care;	High socio-economic groups (minority)	Lack of comparable, independent information on quality of care in the public and private sector; Actual poor quality of care
	An unwillingness to go through the public sector referral network leads people to access the private sector instead (through prepayment or OOP)	All	There is a high opportunity cost to go through the PHC level first and/or the choice is available (i.e. referral system not enforced)
	Do not want to use public facilities and prefer to take the chance that they will not get sick, i.e. believe there is a greater probability that they will not need healthcare services than not; and that if they do, it will cost less to pay OOP at the time and point of service than prepayment for private medical insurance.	High socio-economic groups	High income and/or good health makes this an available and optimal individual choice
	No alternative than to pay OOP	Low socio-economic groups	Cannot access public services due to supply-side constraints (e.g. stockouts, insufficient health care workers) and do not have sufficient disposable income to pay

Identified Problem	Behaviour giving rise to the identified problem	Groups whose behaviour give rise to the identified problem?	Why does the behaviour arise?
			for private medical insurance, thereby resorted to OOP
	Urgency to address political priorities in health with targeted funds; Often disease-specific but not linked to evidence on the relative burden of disease; can also be geographical or population-specific (Note: This is not necessarily a problem in itself if it is a reflection of the agreed societal values)	Political actors; Donors	To gain political or financial leverage
	Profit-driven development of multiple benefit plans for different income groups	Administrators and managed care organisations (with approval of medical schemes)	Insufficient regulation to prohibit this or to make the comparative benefits of different packages transparent
	Protracted regulatory processes for attracting and recruiting foreign medical professionals	Department of Home Affairs, South African Qualifications Authority, Department of Labour	Not understanding the socio-economic benefits of required skills

1.4. **Identify the major social and economic groups affected by the problem, and how are they affected. Who benefits and who loses from the current situation?**

All South Africans that seek health care services – in the public or private sector - will be affected by this restructuring of the health financing system; and many will be affected in their professional capacities too, such as providers or supporting industry. This restructuring will also be felt at the individual, community and national level. As the primary aim of the NHI Fund is to shift risk away from the historically disadvantaged, the groups described below and in the table are chosen because they reflect some of the most common dimensions of inequality in South Africa.

To date, publicly-funded health services have been primarily accessed by the poor majority with private health care accessible onto to the privileged few. The richest 40% of the population receives about 60% of the health care benefits, and the richest 20% of the population receives 36% of total benefits. This means that those with relatively greater financial means have had greater access to health care despite their need being less than 10%; and have wider choice to choose between the public and private sector. By contrast, the poorest 20% received only 13% of the benefits despite having a greater need for health care at 25%. Therefore, until now the poor have suffer at the expense of the non-poor; an imbalance that will begin to be rectified through the implementation of a National Health Insurance Fund.

Equally, the regulatory environment today has created a problem of moral hazard in which the healthy, who can reasonably expect not to require health services in the immediate future (in addition to the young and wealthy), can choose not to make any prepaid contributions to healthcare. There is also no risk equalisation measure to support schemes who take on higher risk members, thereby creating the incentive for schemes to select healthy (as well as young and wealthy) members. Over time, this creates a relatively higher risk profile amongst members (as well as old and poor), leading to an increase in contribution rates to maintain solvency; as well as exclusion of many people from schemes due to increases contribution rates or buy-downs to more limited options with lower premiums.

The dichotomous structure described above – public and private sector - has a similar impact on race to that observed during the years of segregation enforced by apartheid. For example, the majority of Africans (75.5 per cent) and slightly more than half of Coloureds (56.1 per cent) rely on public health sector services today. In contrast, the overwhelming majority of Whites (83.4 per cent) and a substantial percentage of Indians (65.5 per cent) have access to the well-resourced private health sector. Whites and Indians are also more likely to have medical scheme coverage which provides risk protection and guarantees better access to quality health care compared to Africans and Coloureds. Recent figures indicate that 71 per cent of Whites belonged to some medical scheme, followed by Indians at 47 per cent, Coloureds at 22 per cent and Africans at 10 per cent (Statistics South Africa, 2014). Thus, twenty years after democracy was installed, Africans and Coloureds continue to disproportionately suffer from the existing health system structure. Thus, inequality in access by race is a third imbalance that the prepayment and thereby risk protection through the National Health Insurance Fund will begin to address.

Socio-economic status can also be driven by geographical location and gender. Rural populations, which exhibit low population density, and therefore typically require higher per capita expenditure to reach, are typically under-resourced and thus underserved by the public sector as well as the private sector. For example, although 43.6 per cent of the population in South Africa live in rural areas, they are only served by the 12 per cent of doctors and 19 per cent of nurses in the public sector. Thus, residents of urban areas are the beneficiaries at the expense of those in rural areas. Similarly, it is reported that females (63.5 per cent) are

more likely than males (57.6 per cent) to use the public health sector and therefore suffer relatively more due to this limited access. The creation of the NHI Fund as a single purchaser is expected to be able to support the creation of an environment and incentives that will rectify this imbalance.

The inequitable access to quality health care contributes to poor health outcomes as a result of preventable communicable and non-communicable diseases. This contributes to premature deaths and high mortality and morbidity rates amongst the vulnerable and disadvantaged sections of the population who are affected by a system that perpetuates underfunded and deteriorating health care services. Viewed through a different lens, without complete structural change, the government elected by that public is limited in its capacity to address health inequalities and affect improved health outcomes that are associated with socio-economic issues of poverty, crime, and poorly educated/unskilled labour force.

Identified Problem	**Groups (Social/ Economic)**	**How are they affected by the identified problem?**	**Are they benefitting or losing from the current situation?**
South African Government is committed to the goal of universal health coverage (UHC); however, to date, progress toward this goal has been limited. The country is thus challenged by a high Burden of Disease that are managed predominantly in the public health sector namely: • High levels of communicable diseases • Increasing levels of non-communicable diseases • Relatively high maternal and child mortality rates and • Increasing levels of trauma and injuries	Low socio-economic groups	Have lower prepayment (scheme) coverage and those that do access low-end options with higher-risk profiles and therefore higher contributions rates relative to the benefits; face a relatively high risk if they become ill and do not have coverage; have fewer choices	Lose
	High socio-economic group	Have higher prepayment (scheme) coverage and those that do can access high-end options with lower-risk profiles and therefore lower contributions rates relative to the benefits; therefore face a relatively low risk if they become ill; greater choice; But face strong upward pressure of private health care costs	Benefit (short term) and lose (long term)
	Sick/Morbid	Face relatively higher costs and less choice	Lose
	Well/Healthy	Face relatively lower costs and greater choice	Benefit
	Previously disadvantaged	Have lower prepayment (scheme)	Lose

Identified Problem	Groups (Social/ Economic)	How are they affected by the identified problem?	Are they benefitting or losing from the current situation?
	groups	coverage and those that do access low-end options with higher-risk profiles and therefore higher contributions rates relative to the benefits; face a relatively high risk if they become ill and do not have coverage; have fewer choices	
	Rural	Have lower prepayment (scheme) coverage and those that do access low-end options with higher-risk profiles and therefore higher contributions rates relative to the benefits; face a relatively high risk if they become ill and do not have coverage; have fewer choices	Lose
	Urban	Have higher prepayment (scheme) coverage and those that do can access high-end options with lower-risk profiles and therefore lower contributions rates relative to the benefits; therefore face a relatively low risk if they become ill; greater choice; But face strong upward pressure of private health care costs	Benefit (short term) and lose (long term)

1.5. **Which of the five top priorities of the State- that is , Social Cohesion, Security, Economic Growth, Economic Inclusion (Job Creation and Equality) and a Sustainable Environment is/ are negatively affected by the identified problem?**

The implementation of NHI in South Africa is based on the following eight principles:

i. Right to access health (Bill of Rights, Section 27 of the Constitution)
ii. Equity
iii. Social Solidarity
iv. Health as a public good
v. Affordability

vi. Appropriateness

vii. Efficiency

viii. Effectiveness

Within this context, there is the possibility that the following state priorities could be negatively affected:

National Priority	How is the priority negatively affected by the identified problem?
1. Social Cohesion	Inequality in health services- among race, location and various income groups – and therefore the universal health coverage goal, is compromised Health is a public good and the health system is a social institution. National Health Insurance (NHI) is the vehicle through which South Africa will strive towards the attainment of universal health coverage (UHC). The associated structural reform including the creation of mechanisms for a common financial and risk pool ensures that values such as equity and solidarity become a reality. The effects of decreased health inequalities and improved national health outcomes will also have positive spill overs that support improvement in other social sectors, driving a reduction in poverty and crime, and an improvement in education outcomes and the skill level of the labour force. Implementation of NHI will improve the capacity of the State to progressively deliver good quality and effective health services, giving all South Africans the best chance of enjoying a long and healthy life and thereby strengthen social cohesion.
2. Security (Safety, Financial, Food, Energy and etc.)	High cost of health care services by private sector with no choice of lower costs. High burden of disease increase the government health Progressively delivery of good quality and effective health services will decrease the risk of service delivery protest and strengthen.
3. Economic Growth	The nexus between health-poverty-income suggests that per capita income and health status are strongly associated. A poorly performing health system affects the economy through the labour market through multiple channels. Where the existing work force is without access to health services, they are less productive and generate a lower level of output due to decreased efficiency, effectiveness, and devoting less time to productive activities (i.e. more days off work, a shorter work life span). Decreased life expectancy also narrows the knowledge base in the economy as the gains to education decrease as life expectancy decreases. A decreased “work life” also translates into decreased life earnings and thereby

National Priority	How is the priority negatively affected by the identified problem?
	savings to support workers during retirement. These effects are further perpetuated as they become intergenerational. Children who cannot access health care are less likely to exhibit strong cognitive skills and become healthy adults within the workforce; and those that have to support aging parents with insufficient savings are also less likely to add to the knowledge economy.
4. Economic Inclusion (Job Creation and Equality)	The economy of any country is constrained by the number of economic active years of the labour force. Furthermore, a weak health system that cannot attract or retain health professionals, nor distribute them according to need, further undermines efforts toward job creation and equitable access to health care services.
5. Environmental Sustainability	N/A

2. Options

2.1. **List at least three options for addressing the identified problem, including (a) your preferred proposal, and (b) an option that does not involve new or changed regulation (baseline or existing option)**

a) National Health Insurance (Preferred Option)

NHI will involve a single purchaser/payer of health services and will drive the establishment of standardized high quality health services to the entire population irrespective of socio-economic status. NHI will also affect the pooling of collected revenue, distributing risks through one large pool, and offering government a high degree of control over the distribution of total health expenditure to address existing inequality. With a single payer, NHI will be administratively more efficient, ensure quality services through strategic purchasing, and purchase commodities in bulk to drive down the cost of health care.

b) Status Quo

This will involve the continuation of a fragmented dual/tiered health system with the associated inequities in access and delivery of quality health care, inefficiencies in their administration and management, and the inability to distribute the risk equally across the population.

c) Privatisation

This will involve full provider privatization, including mandatory contributions from employers. It will not be effective in reducing fragmentation, improving access, or reducing the costs of delivering healthcare.

2.2. **What social groups would gain and which would lose most from the each of the three or above options? Consider specifically the implications for the households earning under R 7000 a month; micro and small business; black people, youth and women; and rural development.**

Option	Main Beneficiaries	Main Cost bearers
a) NHI	- All South Africans, in particular vulnerable populations such as Women and Children, Elderly, the Disabled, and rural populations - 84% of the population currently not covered by medical schemes - Households	- All South Africans in the form of general tax revenue such as from personal income tax, excise duties, transactional taxes, VAT and capital gains tax - Employers and employees will be subject to NHI-specific tax

Option	Main Beneficiaries	Main Cost bearers
	- Current medical scheme beneficiaries - Public sector facilities and providers - Private sector health care providers - All employees and employers	- High income earners, capital income earners, unincorporated business and Corporates will be subject to corporate income tax, surcharge on taxable income (including interest a profits in the case of unincorporated businesses), and inheritance tax.
b) Status Quo	- All South Africans but particularly high socio-economic group including the wealthy and those who can afford to pay for private sector care	- National Revenue Fund - Contributors to tax revenue - Development Partners - Increasing number of population dependent on the public sector services who continue to receive a lower per capita level of health expenditure (i.e. fewer services) unrelated to their health needs
c) Privatisation	- All South Africans but particularly high socio-economic group including the wealthy and those who can afford private health care - Medical Schemes - Private providers - Private health care industry	- National Revenue Fund - Contributors to tax revenue - Contributors to private health insurance including individuals, employees and employers

2.3. **For each option, describe the possible implementation costs, compliance costs and the desired outcomes, listing who would bear the costs or, in case of the outcomes, enjoy the benefits.**

In its research brief on the Costing of Health Care Reforms to Move towards Universal Health Coverage (UHC), the World Health Organisation (WHO) indicates that the costs associated with implementing a UHC programme are influenced by many factors, including design elements and the pace of implementation. The WHO further cautions that while costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the exact number indicating the estimated costs. This is because evidence has shown that countries that have gone down this path have ended up tied to an endless cycle of revisions and efforts to dream up new revenue sources – thus focusing on issues that have more to do with tax policy than health policy. Therefore, focusing on the question of "what will NHI cost" is the wrong approach as it is better to frame the question around the implications of different scenarios for the

design and implementation of reforms to move towards UHC. These and many more factors need to be taken into account and the relative trade-offs evaluated, to understand the cost implications of reform.

Policy options that will impact on costs include the range of private service providers from whom services are purchased and the reimbursement arrangements; and trends in population health service needs and utilisation (e.g. epidemiological trends, rates of hospitalisation and use of outpatient services).. Costs will also depend on the extent to which economies of scale are achieved through active purchasing and the effectiveness of cost controls. It must be anticipated that medical costs will rise over time – independent of NHI implementation – because of factors such as population ageing, technological advances and higher demand for health care. Total health expenditure growth will be influenced by the extent to which users come to trust the health services covered by the NHI Fund and choose to reduce voluntary health insurance cover.

The establishment of NHI will require that the NHI Fund is structured as a Schedule 3b public entity that is created by law and will not form part of the National or Provincial Department of Health. The fund will be supported by a project team with support staff with expertise in the areas of Health financing and economics, public health, health policy, contract management, information systems, financial management, legal drafting administrative support, and overall project management; and administration costs are estimated at increasing gradually to the international best practise of 3%, by 2025/2026.

The expected implementation and compliance costs of NHI are summarised in the table below as well as those for the Status Quo ad Privatisation options.

Option	Implementation costs	Compliance costs	Desired Outcomes (Benefits)
a) NHI	This includes the costs of setting up the physical infrastructure and administrative systems of the NHI Fund (e.g. information management systems for registration, claims, patient information etc.). These costs will gradually increase until they are in line with international best-practice that is at 3% of total direct health care costs. Administration costs will	This includes significant initial costs for capital investment in infrastructure as required to meet the norms and standards set by the Office of Health Standards Compliance (OHSC) such that every facility is certified. This is estimated at 10% of the total health expenditure. It also includes the cost of ongoing review and adjustment to incentive structures (See 1.3 above) over	- Equity in health service access to all South Africans, e.g. irrespective of socio-economic status and with increased geographical access especially for rural and vulnerable communities such that utilisation levels reflect need - Values of social solidarity and social cohesion upheld - Social and financial risk protection for all - Improved quality of health

Option	Implementation costs	Compliance costs	Desired Outcomes (Benefits)
	include costs of a project team that includes expertise in the areas of Health financing and economics, public health, health policy, contract management, information systems, financial management, legal drafting administrative support, and overall project management.	time to support and monitor ongoing adherence by all relevant actors to the regulatory framework, e.g. gate-keeping to ensure that the public adhere to the referral network Regulations such as the Certificate of need will regulate geographic distributions of provision of services by health professionals to areas of greatest need Medical schemes will bear the cost of aligning to the minimum service benefits prescribed under NHI	services leading to increased life expectancy, increased quality of life, and decreased morbidity - Increased health system efficiency leading to possible reduced per capita costs of providing the existing health care services; and reduced cost per outcome -
b) Status Quo	Continuation of current efforts to improve the health system, i.e. human resources, strategic information, etc. and development of wide range of regulation that would aim to limit the private sector with a view to reducing inequality.	It would include all costs that would be incurred under the NHI option as well as significant cost associated with the ongoing monitoring of regulation for compliance.	Equity in health service access to all South Africans, e.g. irrespective of socio-economic status and with increased geographical access especially for rural and vulnerable communities such that utilisation levels reflect need Improved quality of health services leading to increased life expectancy, increased quality of life, and decreased morbidity Increased health system efficiency leading to possible reduced per capita costs of

Option	Implementation costs	Compliance costs	Desired Outcomes (Benefits)
			providing the existing health care services; and reduced cost per outcome Under the NHI option, the degree of success possible in terms of increased life expectancy, decreased morbidity, and increased efficiency will be severely constrained due to the inability to pool funds and share risk/ provide financial protection and thereby address the root cause of inequality in access to health services.
c) Privatisation	Currently, the cost associated with administration of the private medical scheme industry is estimated at 20% to 25% of overall health expenditure in the private sector. This level, which supports duplication in administration and management, would be expected to remain or rise. It would also require development of wide range of regulation that would aim to limit the private sector with a view to reducing inequality.	It would include all costs that would be incurred under the NHI option as well as significant cost associated with the ongoing monitoring of regulation for compliance.	Free market principles upheld Improved access to services for high socio-economic groups including wealthy and those who can afford to pay for private health care Profit maximisation by both private funders and providers of private health care Minimisation of regulation in the funding and provision of healthcare

2.4. **Based on the above table on costs and benefits, describe how different options would contribute to or detract from the national priorities. Remember this is a think-tool, so explore the issues freely.**

Priority	Option 1: NHI	Option 2: Status Quo	Option 3: Privatisation
1. Social Cohesion	NHI will move towards the attainment of UHC through the creation of mechanisms for a common financial and risk pool that ensures that values such as equity and solidarity become a reality, and social cohesion strengthened. The effects of decreased health inequalities and improved health outcomes will have positive impact on other social sectors by contributing to the creation of a healthier population, improvement in education outcomes of learners, improved skills level of the labour force, a healthier labour force and happier homes thus driving a reduction in poverty and crime. Estimates also show that a one year increase in a nation's 'average life expectancy' can increase GDP per capita by 4% in the long run. This translates to increased happiness of the population for whom improved quality of life as increased longevity is within their grasp	Without addressing fragmentation in risk pools and equity of access, progress towards the achievement of UHC will always be slower than otherwise. As a result, social cohesion will not be built at the rate possible with pooled funds nor provide universal financial and risk protection that would otherwise support a healthy labour force.	Multi-payment and provision systems will not contribute to financial and risk pooling, thereby undermining the ability to achieve equity and social cohesion.
2. Security (Safety,	Implementation of NHI will improve the capacity of the State	The limitation to the Government's ability to	A strong private provider system will contribute to

Priority	Option 1: NHI	Option 2: Status Quo	Option 3: Privatisation
Financial, Food, Energy and etc.)	to progressively delivery good quality and effective health services, giving all South Africans the best chance of enjoying a long and healthy life, and thereby decreasing the risk of service delivery protest and strengthening national security. Households will enjoy reduced financial risk as they benefit from health care that is free at the point of care; from increased disposable income because of a significantly lower mandatory prepayment level; and from savings that will be made due to decreased out of pocket expenditure	redistribute resources to address equity and progressively deliver good quality and effective health services to all, will increase the risk of service delivery protests and undermine national security. In addition, recent experience of countries that have been affected by outbreaks of highly contagious disease (e.g. Ebola in West Africa and MERS in North Africa) have shown that weak and fragmented health systems can have massive negative implications for all facets of a country's economy.	reduced threat from global health security issues; however continued or increasing level of inequality may lead to service delivery protests and undermine national security.
3. Economic Growth	NHI will contribute to improved health outcomes, increased productivity; and number of economic active years and disproportionately affect the poor and vulnerable. These are those who are typically providing unskilled or semi-skilled labour. Support for them will ensure that economic growth is driven by all sections of the labour force and all sectors; not just those that are driven by skilled labour intensive associated with high socio-economic groups.	As long as there is inequality in access to healthcare, there will be inequality in productivity of the labour force, i.e. poorer productivity in the lower socio-economic groups that form the unskilled or semi-skilled labour force. This will decrease competitiveness of associated South African output and thereby economic growth. If health outcomes and life expectancy fail to improve, it will reduce the economic active years available and so	A for-profit privatisation model will contribute to improved health outcomes, improved productivity, and number of economic active years; but will be limited to a subset of the non-poor population who are most likely to benefit A privatisation model will in itself contribute to economic growth.

Priority	Option 1: NHI	Option 2: Status Quo	Option 3: Privatisation
		directly impact on the ability to economy to grow.	
4. Economic Inclusion (Job Creation and Equality)	Children who cannot access health care are less likely to exhibit strong cognitive skills and become healthy adults within the workforce. Those that have to support aging parents with insufficient savings are also less likely to add to the knowledge economy. Through strategic purchasing that links available human resources to health need, and creates arrangements beneficial to both provider and purchaser, will strengthen the ability of Government to address health care workers shortages or changes in quality of care.	A continuation of existing approaches to challenges in recruiting and retaining human resources will undermine the capacity to improve health outcomes and life expectancy; Any reduction in inequality or inefficiency that is achieved will be limited by the fragmented funding and the limitation that this puts to conduct strategic purchasing.	Privatisation may increase the cost of labour and result in job losses.
5. Environmental Sustainability	The introduction of NHI as a path towards universal health coverage will create strong resilient health systems that can be used to respond to public health emergencies that result from outbreaks of disease that consequent to environmental degradation.	N/A	N/A

2.5. **Describe the potential risks that could threaten implementation of each option and indicate what can be done to mitigate the identified risks.**

Option	Potential Risks	Mitigation Measures	Comments
a) NHI	1. Poor provider uptake and public resistance and/or apathy;	1. Continuous stakeholder engagement and education on the principle of universal health coverage and the mechanisms that government plans to utilise to achieve this (which is NHI within the South African context) will be critical.	
	2. The need for sustained political commitment and risk of constraints to fiscal space	2. This is considered unlikely as the government has given increased attention to accelerating service delivery including health, and as this agenda forms part of the National Development Plan 2030. Nonetheless, a collective political will from local to national government is critical for the sustainability and the effectiveness of the system as it draws resistance from other sectors or interest groups;	
	3. Weak or unreliable information systems	3. This will require a comprehensive review of the current information systems deployed in government and the private sector and to develop technology that will allow for the integration and expansion of these systems as well as development of new	

Option	Potential Risks	Mitigation Measures	Comments
		systems that are aligned, e.g. population registration, facility registration, claims processing etc.	
	4. Lack of inter-sectoral collaboration	4. Ensure the sectors that impact on the social determinants of health, which include employment and income, water, sanitation, nutrition, primary schooling and road infrastructure, are engaged with throughout the process to ensure alignment in strategy and budget and prevent duplication of efforts.	
	5. Under-resourced OHSC such that it is not capacitated to fulfil its mandate	5. Government must ensure that this Office has adequate resources and regulatory power to undertake inspection of all health facilities, public and private, with regards to compliance with the National Core Standards.	
	6. Quality of care and patient safety compromised due to HR constraints	6. Government must work closely with training institutions to ensure adequate intake and throughput for key health professional categories in the medium to long term, taking into account changing population demographics and epidemiology; ad work to address constraints to access to	
	7. Immigration law that restricts		

Option	Potential Risks	Mitigation Measures	Comments
	access to skilled health care professionals but also leads to large numbers of undocumented immigrants that access health services 8. Lack of integration of traditional healers into the process that results in significant proportion of the population accessing services through these practitioners being excluded from the benefits of NHI 9. Mismanagement and the risk of inept or corrupt management: This could lead to misallocation of funds, taking away funding from vital services and decreasing quality of care	health care workers through current immigration law and regulatory bureaucracy that restricts access to skilled health care workers 7. These matters need to be adequately addressed by government, including consideration for the creation of a contingency fund to meet the health needs of undocumented migrants, refugees and asylum seekers. This must be done through working in close partnership with regional bodies such as the SADC and the African Union; 8. Continuous stakeholder engagement with these practitioners on the principle of universal health coverage and the mechanisms that government plans to utilise to achieve this (which is NHI within the South African context) will be critical. It will ensure that they can be progressively form part of the health service entitlements covered by the NHI Fund. 9. The proposed governance structure for NHI provides for direct accountability of the Fund to the Minister of Health. In	

Option	Potential Risks	Mitigation Measures	Comments
		addition, the NHI Fund will ensure that expenditure is equitably distributed, i.e. according to need	
b) Status Quo	1. Continued inefficiency in the public health sector limiting the degree of coverage available for a given resource envelope	1. Implementation of strategic purchasing	None of the mitigating strategies will be able to fully address the low and inequitable level of financial risk protection felt disproportionately by the low socioeconomic groups including poor and vulnerable. Only implementation of mandatory prepayment will enable this. Thus, the status quo option does not allow for utilisation to be linked to need. In addition, any benefits of strategic purchasing will be limited by the degree of continued fragmentation in
	2. Affordability/ rising prices in the private sector	2. Increased regulation of the private sector including price, reimbursement mechanisms, and service benefits	
	3. Increased Inequality: Exacerbation of income-based segregation in terms of access to and outcomes from available health care.	3. Increased breadth to the regulatory environment including regulation of price and service benefits and restriction in geographical provision; Standardisation of service benefits and clinical guidelines across public and private sector	
	4. Lack of financial risk protection to those accessing the public sector; Access to public health care at the time of need not defined: Patients exposed to implicit rationing (e.g. long waiting times, stockouts)	4. Increase investment in public sector infrastructure and production of health professionals in the public sector; development of explicit service benefit list; creation of new incentives and/or changes to regulatory environment that support increased retention of health professionals in the public sector	
	5. Lack of financial risk protection to	5. Further regulation of medical	

Option	Potential Risks	Mitigation Measures	Comments
	those accessing the private sector	scheme benefit options including introduction of risk equalisation mechanism across schemes;	pooling arrangements.
	6. Continued poor quality of health services as a result of maldistribution of financial and human resources, and absence of national clinical practise guidelines	6. Improvement in quality through compliance with OHSC norms and standards; expansion of the Standard Treatment Guidelines and implementation of clinical audits; Strategic purchasing that links payment to outcomes	
	7. Fiscal federalism in the public health sector undermining equity considerations	7. Introduction of budget development for and direct contracting with sub-district level contracting units.	
	8. Continued inefficiency due to duplicated administrative functions for each existing risk pool.	8. More stringent regulations to the minimise the individual schemes' administrative costs	
c) Privatisation	1. Affordability/ rising prices in the private sector	1. Increased regulation of the private sector including price, reimbursement mechanisms, and service benefits. Note: There would be high administrative and transaction costs associated with introduction of data intensive risk equalisation mechanism.	As above
	2. Increased Inequality: Exacerbation of income-based segregation in terms of access to and outcomes from available health care.	2. Increased breadth to the regulatory environment including regulation of price and service benefits and restriction in geographical provision;	

Option	Potential Risks	Mitigation Measures	Comments
		Standardisation of service benefits and clinical guidelines across public and private sector	
	3. Lack of financial risk protection	3. Regulation of medical scheme benefit options - price and service benefits; Standardisation of service benefits across public and private sector;	
	4. High administrative and transaction costs associated with data intensive and expensive risk equalisation mechanisms to achieve some form of appropriate cross-subsidisation	4. More stringent regulations to the privatised funding environment	

3. Summary

3.1. **Based on your analysis, as reflected in the discussion of the three options above, summarise which option seems more desirable and explain?**

The alternatives to the preferred option of National Health insurance (NHI) are a continuation of the Status quo, and Privatisation.

The Status quo has the advantage of requiring no structural reform. And while it is likely that prices would continue to rise, and availability of resources continue to be inequitably distributed, there would still be opportunity for ongoing system strengthening and increasing regulatory intervention. The services benefits available through the public sector can be made more explicit and aligned with those provided in entry-level options available in the private medical schemes. Efforts to improve efficiency and value for money can also continue to be pursued through strategic purchasing and the identification and implementation of incentive structures that promote equitable resource distribution. Resources can be channelled into the training of health professions and the development of incentives to retain them, although the limited success to date suggests the approach under the status quo is not effective. Investment in infrastructure and improvement in quality of services may be possible through compliance with the Office for Health Standards Compliance (OHSC). However, a gap will remain in financial risk protection. Failure to implement a mechanism for prepayment of health care will still leave the majority of people exposed to health care costs associated with catastrophic illness. Furthermore, the absence of any mechanism for risk pooling which would present an obstacle to the realisation of efficiency gains which are so critical in the current economic climate; and were national health outcomes and life expectancy to increase, the benefits would likely accrue only to select sub-populations from higher socio-economic background. In addition, the development and implementation of a greater regulatory environment will bring with it significant increase in costs associated with monitoring adherence to regulations and sanctioning non-adherence. Therefore, continuation of the Status quo will not address the primary issue of equitable access and therefore progress towards universal health coverage (UHC); and it is likely to lead to increased administrative costs as well as have negative consequences for the national priorities, in particular social cohesion, security, economic growth and investment, and economic inclusion.

A Privatisation model would bring about similar results to the Status quo option and increase the number of economic active years in the labour force thereby positively affecting economic growth. However, it is also likely to lead to an increase in the cost of labour and ultimately job losses and exacerbation of income-based segregation or tiering in terms of access to health care and undermine social cohesion. It would also require the initial development of a range of regulations, and then ongoing cost of monitoring for adherence to them.

National Health Insurance (NHI) is aimed at moving South Africa towards universal health coverage (UHC). NHI is aimed at ensuring that all South Africans irrespective of their socio-economic status have access to quality

health services, free at the point of care when they need to access the health system and are afforded financial risk protection, especially from catastrophic health expenditure.

NHI is based on the following principles:

i. Right to access health care as enshrined in the Bill of Rights, Section 27 of the Constitution
ii. Equity
iii. Social Solidarity
iv. Health as a public good
v. Affordability
vi. Appropriateness
vii. Efficiency
viii. Effectiveness

NHI will be funded through a prepayment mechanism that is largely tax-funded and involves pooling of available public and private resources into a single pool that will strategically purchase personal health services on behalf of the covered population. Individuals will contribute according to their ability to pay and they will be able to access a better standard of health care. NHI is pro-poor and will provide greater access to health services for women, children, the vulnerable, the elderly and the disabled. Appropriately determined poor and indigent individuals will be exempt from contributing towards the NHI but will still benefit from health services according to their health needs.

The benefits of implementing single payor, single purchaser NHI are multiple: improved access to quality health care especially for the poor, working class, people with disabilities, the elderly and women especially in under-privileged areas and this will be achieved through accreditation of public and private providers and strategic purchasing of personal health services; better health outcomes across all socio-economic groups, improved efficiency and cost containment through streamlined administration and purchaser-provider split; improved accountability on use of funds through appropriate governance mechanisms and transparency in performance reporting; Improved financial protection through increased pre-mandatory payment funding; Improved human capital and productivity; economic growth and social cohesion. A more responsive health system is likely to improve user satisfaction and contribute to the general quality of life of the citizens.

3.2. **What specific measures can you propose to minimise the implementation and the compliance costs of your preferred option, to maximise the benefits?**

The centralised nature of a publicly administered single payer NHI will save money by reducing administrative costs. However, in addition, Government will implement various measures to effectively control costs and to ensure that NHI remains sustainable and affordable. The cost containment measures implemented will address both supply side and demand side constraints, while ensuring that providers are fairly reimbursed for the health services provided without compromising the quality of care rendered to the population, as outlined

in Table xxx:

Table xxxx: Summary of supply side and demand side cost containment measures

Demand side	Supply side
Reforms to the voluntary health insurance tax policies (including subsidies)	Reforms to provider reimbursement methods
Stronger enforcement of referral systems through gate-keeping function	Promoting greater provider competition
Compliance with stipulated treatment protocols and clinical guidelines	Strategic purchasing including selective contracting
[redacted]	Innovative pharmaceutical procurement and distribution policies
[redacted]	Budget caps
[redacted]	Workforce and malpractice legislation

Strategic purchasing will ensure that the health system operates efficiently, and does not experience uncontrolled expenditure increases and maintains quality in health services on an ongoing basis.

Strategic purchasing will ensure affordability and sustainability through:

i. A strong emphasis on disease prevention and health promotion and not only on curative services through a re-engineered PHC platform.
ii. With the exception of medical emergencies, accessing of health services at the primary health care level, with referral to specialist services when needed.
iii. Provision of the most cost-effective, evidence-based interventions, which can be ensured by developing an essential list of generic drugs, surgical and other medical supplies and standard treatment guidelines that indicate the appropriate range of diagnostic tests and treatment interventions for all common illnesses.
iv. Centralised procurement of pharmaceutical products, medical and surgical consumables and medical equipment;
v. Efficient use of laboratory services, and blood and blood products;
vi. Health technology assessment and economic evaluation for high cost and new technologies to assess whether they reflect the most cost-effective health service interventions available; and

The service providers that will be accredited and contracted to provide services covered by the NHI Fund will be chosen based the essential considerations including:

i. All public health facilities (clinics, community health centres and hospitals) which provide services at

considerably lower cost than private for-profit providers, should be the backbone of the health system

ii. Providers from whom services will be purchased will be accredited on the basis of their ability to provide a comprehensive range of services (to ensure access for all irrespective of where they live), quality of care, location relative to the population in need of health services, and acceptance of the provider reimbursement tools and rates; and

Government will put into place the necessary regulatory and policy interventions to determine tariffs for health services (including provider tariffs, and prices for pharmaceuticals and related products). The law will equally apply to public and private providers including suppliers of medicines.

Robust systems are put into place to influence how services will be purchased through:

i. Creating a purchaser-provider split that will introduce the active purchasing function by strategic engagement with suppliers to ensure value for money
ii. Establishing service agreements or contracts with service providers (public and private sectors) to clarify expectations on the range and quality of services to be delivered, requiring adherence to the essential drug list and standard treatment guidelines, and specifying information that providers should submit to the NHI Fund and the methods and rates of payment.
iii. Introducing ways of paying providers that create appropriate incentives to promote efficient provision of quality services, such as capitation payment for primary health care services and diagnosis related group payments for hospital services, with comparable rates being paid to public and private providers. This should be accompanied by global budget caps to ensure that overall expenditure does not exceed available resources.
iv. Ensuring that the NHI Fund can use its purchasing power (as a single, large fund purchasing personal health services for the entire population) to establish affordable provider payment rates and ensure that they do not increase at an unsustainable pace. Providers will be free not to contract with the NHI Fund if they choose not to. The substantial purchasing power of the NHI Fund can also be used to procure pharmaceuticals, surgical and other medical consumables at the lowest possible cost for distribution to all accredited providers.

There are other strategic purchasing actions that will be implemented to further strengthen cost containment interventions as phased implementation progresses. The NHI Fund will use strong information systems that will enable routine monitoring of service provision (e.g. clinical quality of services in terms of appropriateness of diagnostic and treatment interventions; evaluating provider payment claims) and to ensure that expenditure is in line with available resources. The information system will also have to support the risk identification and mitigation interventions to ensure all fraudulent activities (on the part of providers and users) are immediately identified and addressed.

Further, the creation of the NHI Fund as a strategic purchaser will be accompanied by increased management autonomy in public facilities to enable them to respond to incentives for the efficient provision of quality services (e.g. to make decisions on the appropriate and least costly staff mix). Cost containment will also focus on legislative reforms that create a transparent tariff determination.

3.3. **What are the main risks associated with your preferred option, and how can they best be managed?**

The first key area of risk relates to key stakeholders having a common understanding of the principle and objectives of UHC, and the way in which NHI as a mechanism enables the Government to address these. These stakeholders include private sector providers, professional associations, the general public, different levels of Government, traditional healers, and other sectors such as education and water who's work impacts on the social determinants of health alongside Health. However, this risk is one that can be relatively easily managed through development of a strong communication strategy paired with a consultative approach that ensures that the views and concerns of all stakeholders are considered, and questions answered.

A second risk is the impact that human resource constraints have on the ability to provide high quality care and patient safety. To address this, the government will work with training institutions to ensure adequate intake and throughput for key health professional categories in the medium to long term, taking into account changing population demographics and epidemiology. It will further work to address constraints to access to health care workers through current immigration law and regulatory red-tape that is currently an obstacle. The implementation of strategic purchasing will further ensure that purchasing arrangements are negotiated to be ones that are clearly defined and acceptable to both provider and purchaser. We recognise that this requires an ongoing engagement with the Council for Medical Schemes, the Department of Home Affairs, the Department of Labour, and the South African Qualifications Authority.

A further risk is the availability of an integrated information system which is required to support all aspects of NHI rollout, from patient-level information to surveillance to administration systems for population and facility registration to claims management. Government has therefore committed to a comprehensive review of the existing information systems with a view to understand how and where these will need to be further developed or expanded to meet the information needs of NHI. We recognise this requires an ingoing engagement with the Department of Telecommunications and the State Information Technology Agency.

A fourth risk identified is that the Office of Health Standards Compliance will not have sufficient resources to fulfil the significant responsibilities within its remit. This will be addressed through prioritisation of this critical office during every budget period. This is considered unlikely as the government has given increased attention to accelerating service delivery including health, and as this agenda forms part of the National Development

Plan 2030. Nonetheless, a collective political will from local to national government is critical for the sustainability and the effectiveness of the system as it draws resistance from other sectors or interest groups.

A fifth and final risk identified relates to mismanagement and inept or corrupt management: This could lead to misallocation of funds, taking away funding from vital services and decreasing quality of care. To address this, the NHI Fund will be supported by a robust governance framework in which expenditure is equitably distributed, and the leadership of which is directly accountable to the Fund to the Minister of Health. Furthermore, only providers that are accredited by the Office of Health Standards Compliance will be contracted and reimbursed by the fund; and it is our view that should a provider that previously attains accreditation but thereafter fails to maintain this, they will consequently lose the ability to contract with the Fund.

3.4. What additional research should you do to improve your understanding of the costs and benefits of the option adopted?

N/A

For the purpose of building SEIAS body of knowledge please complete the following:

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