Rural Health
Advocacy Project

From Green Paper to Final Policy: Has there been a change in how rural is considered in relation to the National Health Insurance process in South Africa

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Summary

Since the publication of the NHI Green Paper in 2011, the Rural Health Advocacy Project (RHAP) and its rural health partners have engaged extensively with the NHI policy development and review process. This engagement has included providing comment on various components of various versions of the draft policy as well as providing substantive input on specific work areas such as the Ward Based Outreach Team (WBOT) policy[1], GP contracting, human resources for health[2], and financing[3]. This work has been done with a view to ensuring that the NHI fully accounts for the needs and complexities of health care reform in rural settings.

The recent publication of the final NHI Policy (July 2017) by the Minister of Health suggests that legislative and regulatory work of NHI implementation is about to begin. While the NHI Policy itself is only the roadmap for more complex regulatory and systemic change that will continue, it does commit to the foundational principles of the NHI and the priority areas that are likely to receive attention going forward. This is important for rural health as it is an indication of if rural health is being given sufficient priority in the framing of the NHI.

In this this review, we do not detail our position on every aspect of position or work on the NHI, its associated reforms and the implications for rural health. This has been done extensively in our NHI Green Paper[4] and White Paper[5] submissions. We have also produced extensive input on various aspects of health system policy, reform and service delivery that are likely to influence implementation. In this review, we simply look at how the NDoH has, or has not, addressed the main concerns we have raised through our submissions and advocacy work over the past five years and then outline critical issues that will need priority going forward. The content of this work is summarised in Table 1

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[1] See for example http://www.rhap.org.za/rhap-position-community-health-workers/ and more recently our work on the costing of WBOT http://www.mrc.ac.za/healthsystems/CBCReport.pdf

[2] See http://www.rhap.org.za/category/goal-03/

[3] See http://www.rhap.org.za/category/goal-02/

[4] Available here http://www.rhap.org.za/wp-content/uploads/2014/03/NHI_GreenPaper-RuDASA-and-partners_11-December-2011.pdf

[5] Available here http://rhap.org.za/wp-content/uploads/2016/06/Rural-Health-Advocacy-Project-and-Partners-Submission-on-National-Health...-6.pdf

Table 1 Summary of NHI policy review and rural priorities

NHI Policy issue	Issues highlighted in submissions on NHI policy drafts	Resolution in final NHI policy	Rural priorities going forward
Accounting for rural context	In the Green Paper, rural was not explicitly considered. In White Paper, Rural is considered: • Rural populations amongst first to be registered • Rural factors including geography to be considered in resourcing of interventions But, still no clear approach to defining rural in White Paper	Rural populations continue to be given priority in final NHI Policy: • Addressing inequity between urban and rural health systems is a stated priority (p. 5) • Rural context to be considered in the assessment of need and resourcing (p. 21 and 24) • Rural populations among first to be registered under NHI fund (p.64) Still no clear articulation of how rural will be defined under the NHI though	An approach to defining rural for the purposes of policy, planning and resource allocation are needed. This should account for factors such as: • Demographic characteristics of rural areas; • Epidemiological characteristics of rural areas (health care need); • Geographic characteristics (longer distances and more difficult topography; and • Account for rural cost factors (e.g. diseconomies of scale)
Role of the private sector	There was a lack of clarity on the role the private sector would play under the NHI The absence of a mechanism to ensure the equitable distribution of available and new resources between urban and rural settings would mean that drawing private sector provision into the NHI is likely to deepen inequities. Private providers would increase availability in urban areas but there is no incentive for them to do the same in rural contexts	More pragmatic approach to private sector provision under the NHI and greater clarity on how services will be contracted. Commitment to risk-adjusted capitation at PHC level and DRGs at hospital levels could improve access to private resources for all regardless of income and ability to pay. Issues around how to achieve equitable distribution of private sector resources remain unresolved. NHI Policy skirts certificate of need issue	The NDoH needs to critically evaluate how it will address equity concerns in the accreditation of private providers under the NHI. This speaks to broader concerns around how to ensure additional resources for service delivery flow to underserved settings and rural contexts. While a central component of accreditation, quality norms and standards, cannot be the only basis on which private providers are accredited.
Emergency	Policy proposals provided no indication of	Rural EMS considerations not addressed in	Unlike PHC, EMS has not been addressed

Medical Services	how EMS will be improved in rural and remote settings: • No consideration of additional resources needed to address distance and topographical barriers in rural areas (e.g. poor quality of roads) • Patient transport not considered as a mechanism to improve access in rural areas	final Policy but mention is made of providing patient transport to address distance and topography issues in rural settings. Final NHI Policy does suggest drawing on private EMS industry to bolster access under NHI but does not consider how this may exacerbate inequity. Private EMS will bolster access in urban areas but there is no benefit for rural contexts where private EMS does not operate	adequately as part of reforms being implemented in preparation for the NHI. A strategy like (or as a component of) PHC re-engineering should be developed. This should include strategies that address: • Quality of EMS services; • Equitable access to services; • Context appropriate service delivery methods that account for rural factors (distance and topography); and • Accreditation based on equity principles
PHC re-engineering	Rural context not explicitly considered in design of PHC re-engineering. Factors such as rural geography (distance and topography), demographics (density, age and socioeconomic status) and epidemiology not considered in early policy proposals and piloting	Rural now a priority in NHI policy and rural-proofing a foundational principle of WBOTs draft policy. General acceptance of rural-proofing as necessary to meet equity principles of PHC re-engineering approach. But, for this to be effective rural-proofing must extend to financing, administrative, and institutional components of NHI	Rural-proofing should become an underlying principle of reform under the banner of the NHI. This would include legislative and institutional reform around NHI administration, financing and service delivery platforms. PHC re-engineering should be the first aspect where rural-proofing is undertaken in full.
Human resources for health	Human resources stated as a core priority of NHI policy proposals but no specific attention given to attraction and retention of HRH to rural contexts.	HRH remains a NHI Policy priority but still no detail given on recruitment and retention strategies. Reference is made to National HRH strategy for guidance and so HRH appears to remain a NDoH function. The Current strategy comes to an end in 2017. New strategy yet to be developed and must include mechanisms that facilitate the equitable distribution of HRH	The new National HRH strategy should be developed with the NHI and its institutional components in mind. This new strategy should, as the current one does, include a rural education, recruitment and retention strategy as a core component. This must be supported by legislative mechanisms that promote the equitable distribution of HRH. This cold form part of the accreditation process of establishing new service providers or facilities, for example.

Cost of the NHI	NHI implementation cost projections provided in all draft policy. Costing widely criticised for being based on best guess and not detailed activities. No mention of need to consider differences in costs associated with service delivery in various contexts. Of importance for RHAP, no provision for rural/urban costing	Costing in final policy takes a more cautious approach by not committing to detailed item or fixed cost projections. Instead it includes broad cost projections. These do, to some extent, make allowances for context specific and needs based cost differentials. There is space for this to be included in subsequent legislative and strategic planning processes for rural cost factors to be included. E.g. rural cost factors are considered in WBOT investment case and policy	Going forward all legislative, administrative and structural reforms under the NHI should include a full costing, which should account for rural/urban cost differentials. An example of this can be taken from the WBOT policy process that is currently under way. These rural cost factors then should be built in to cost forecasting as the NHI fund starts to become the primary healthcare financing mechanism in SA. This would add greater predictability and equity resource allocation processes over time.
Raising Revenue	Regressive mechanisms to generate additional needed revenue were favoured. Increases to VAT mooted as a popular option and user fees were provided for	Various TAX scenarios provided, some of which still include increase to VAT. However, state preference is for increase to income taxes and levies and no increase to VAT. User fee proposals have been scrapped in policy.	Revenue should only be generated from progressive sources, which should exclude VAT.
Provider payment: hospitals	RHAP broadly supportive of move to DRG reimbursement mechanism but worried that depending too heavily on utilisation measures will disadvantage rural facilities because unmet need is greater in these settings.	These concerns not specifically addressed in final policy. But, policy does note that final DRG approach will cater for context. This approach to be developed during legislative and institutional reform processes	Design of DRG approach should not be limited to inpatient assessments of need. Utilisation tends to be lower in areas of greatest need and often with most complicated cases. DRGs should be linked with broader assessments of need that encompass need seen at PHC level and from within communities
Provider payment: PHC	RHAP broadly supportive of risk-adjusted capitation approach to reimbursement of both public and private providers but concerned that sufficient attention not paid to rural unmet need and rural/urban cost	Risk adjusted capitation approach remains in final Policy. There is also greater clarity on the organisation of purchaser provider split for PHC. Contracting Units for PHC as purchaser and District Management Offices as	Risk adjustment should be made using data that extends beyond what is collected within facilities and as far as possible encompass unmet need. This is most apparent for services to the disabled. A cost adjustment

	differentials in such approaches	coordinating provision. No explicit mention of rural consideration in policy.	should also be made for higher costs associated with delivery in rural settings due to diseconomies of scale and the need for alternative service delivery methods (e.g. increased outreach)
Improving leadership and governance	Not addressed in earlier submissions on NHI draft policy.	Priority given to decentralization of authority: • Hospitals as semi-autonomous business units • District Health Management Offices responsibility for planning and administration • Decentralised CUPs responsible for contracting and purchasing services at PHC level While broadly supportive of decentralised authority to enable context appropriate service delivery, capacity must be enhanced in rural settings to enable effective delegation	Rural districts must be targeted for administrative skills development and capacity enhancement. This could, for example, include strategies that attract and retain skilled managers/administrators to rural areas
Changing intergovernmental relationships	Not addressed in previous submissions on NHI.	Policy mentions need to reform intergovernmental relations (particularly fiscal relations) but not clear on detail. Particularly vague on future role of provinces.	Changes should be supported in as far as the promote greater equity in resourcing and planning that is more cognisant of the needs of rural communities. This demands a rural proofing approach to NHI institutional processes where appropriate.

Introduction

On 28 June 2017, South Africa's Health Minister, Dr Aaron Motsoaledi, signed off on the final version of the National Health Insurance (NHI) Policy. The policy has been under development since 2011 and has evolved from earlier versions, in the form of the NHI Green and White paper. Throughout its development the NHI Policy has been subject to extensive scrutiny from stakeholders from civil society, public health care sector, the private health care sector and the public.

The attention that the NHI policy has received throughout its development is indicative of its importance in the transformation of South Africa into a more just and equal society. The NHI is one of the most ambitious social service reform projects of the last 20 years. The introduction of the National Health Insurance (NHI) has the potential to fundamentally shift how health care is funded, how the system is structured and how services are accessed. The NHI could, if implemented to its full potential, could be one of the country's most important social justice projects. The NHI has the potential to promote greater equity in health care provisioning and ensure all people who reside in South Africa enjoy full access to health care services as enshrined in Section 27 of South Africa's Constitution (Act 108 of 1996)

For the Rural Health Advocacy Project (RHAP) the NHI offers a critical opportunity to reform the resourcing and provision of health care in a manner that will finally address historic and structural inequities in health care that have disproportionately affected rural communities.[6]

In our submissions on the Green and White Papers, developed in collaboration with our Rural Health Partners, we detail the causes and nature of underlying structural inequities in the South African Health system and how rural populations are particularly disadvantaged by the inequitable distribution of human and financial resources. We outline the basic principles that should underpin health system and financing reform under the NHI if it is going to meaningfully address persistent historical and structural inequities between urban and rural settings. We then draw attention to how proposals contained within the draft NHI Policies do or do not address these structural issues. Finally, we offer insight into how a NHI policy could be rural-proofed so that it progressively addresses these structural issues.

Having already established our vision for how the NHI could contribute to addressing vast inequities in access to health care between urban and rural contexts in earlier NHI policy proposals, we will not repeat that input here. Instead, the purpose of this document is to critically evaluate how and if the final NHI Policy addresses the concerns we highlighted in our earlier submissions. Where new elements are included in the final policy that did not appear in the Green or White Papers we will evaluate these in terms of their impact on rural

[6] The RHAP has a Rural Health fact sheet that provides a detailed outline of the state of rural health in South Africa across a range of epidemiological, social and health system metrics. This fact sheet is available here: http://www.rhap.org.za/wp-content/uploads/2015/09/RHAP-Rural-Health-Fact-Sheet-2015-web.pdf

health. We end by providing an overview of what we believe the next steps should be and how these could be rural-proofed.

Accounting for rural in NHI Policy and process

Our submission on the Green Paper was premised on the fact that the initial policy proposals on the NHI did not explicitly identify rural populations as vulnerable and in need of prioritisation[7]. So our early policy recommendations focused largely on why rural contexts and communities should be prioritised for special attention. Our input was based on the acronym RURAL NOW, which detailed the core components of a rural-proofed NHI. Priorities here included:

> **R**ural Accreditation First
> **U**ser Fees Abolished and No Increase on VAT
> **R**everse the Existing Infrastructure/Inequality Trap through Needs-Based Budgeting
> **A**ccess to Health by Addressing Social Determinants including Transport
> **L**ure Sufficient Human Resources to Rural Areas
> **N**o to Delegated Management Responsibility WITHOUT Authority and Accountability
> **O**nly *through* Consultation with Communities, Health Workers and Activists
> **W**ide-ranging PHC benefit package including Rehab, Mental Health Care and
> Eye Care at all levels of care

The White Paper marked a notable shift in how rural contexts and populations are to be considered under the NHI and its reform process. Most importantly the White Paper included rural populations as vulnerable populations. Practically, the White Paper made provision for these populations to be amongst the first to be registered under the NHI and issued with benefit cards. The White Paper also committed to improving the recruitment and retention of health care workers to rural areas by improving living and working conditions in rural facilities. In this respect the White paper made provision for our first ask, which was that rural contexts should be the first to be accredited.

More broadly, the White Paper noted that rural contexts would be given priority through strategies that consider factors such as “topography, facilities and structures, living environment, social and health deprivation and other contextual dynamics” in the identification of population need. This was a particularly welcome addition because it made provision for the tailoring of service delivery for rural settings.

In most respects the foregrounding of rural under the NHI has been retained in the final NHI Policy. In fact, addressing inequities between urban and rural service provision and access is now cited, in the same way as addressing inequities between public and private health care, as a foundational goal of the NHI. In this regard the NHI Policy states that:

> “The imperatives of the RDP and the Constitutional obligation to ‘take reasonable legislative measures’ resulted in the 1997 White Paper for the Transformation of the

[7] Available here: http://www.rhap.org.za/wp-content/uploads/2014/03/NHI_GreenPaper-RuDASA-and-partners_11-December-2011.pdf

> Health System in South Africa provided a framework for the country to develop health care financing policies that promote equity, accessibility and utilisation of health services, to ensure greater equity between people living in rural and urban areas, and between people served by the public and private health sectors within a single, unified national health system." (p. 5)

The NHI policy then reiterates that rural should be a consideration in the assessment of need and priority setting by stating that:

> "NHI requires that users of the health system should be registered and be identifiable at the point of use. Registration of the population in catchment areas will take into account various factors including personal information, the size of the population in the area, disease profile of a catchment area, facilities and structures, living environment, social and health deprivation and other contextual dynamics. In addition, there will be a need to promote equitable distribution of resources and address the rural-urban divide." (p. 21)

Rural areas will also be given priority in the initial phases of implementation:

> "During the early stages of this phase the NHI Fund will purchase personal health services such as PHC services, maternity and child healthcare services including school health services, healthcare services for the aged, people with disabilities and rural communities from contracted public and private providers including general practitioners, audiologists, oral health practitioners, optometrists, speech therapists and other designated providers at a PHC level focusing on disease prevention, health promotion, provision of PHC services and addressing certain critical backlogs. The implementation of prioritised NHI service benefits." (p. 21)

The retention of the commitment to prioritize rural in the implementation of the NHI in the final policy is an important and progressive first step in improving access to care for rural populations.

The extent to which equity is achieved is, however, dependent on how rural contexts and populations are understood and catered for within each substantive component part of the NHI. Stated commitment is only meaningful if it is translated into effective and sustainable structural change. Much of our critique of the Green and White papers was concerned with the lack of detail in framing of various elements (such as financing and the role of the private sector in service provisioning) of the NHI and how they do or do not adequately consider rural health. As discussed in more detail below, much of this critique is relevant to the final policy but now also extends to the functioning of many of the administrative institutions such as the Contracting Unit for Primary Healthcare (CUP).

Role of the private sector in the NHI

As mentioned earlier, the NHI has emerged as a national priority largely because of the vast inequities in access to health care. The most prominent of these inequities—at least in

terms of initial work on the NHI—are those that exist between the public and private sectors. Fundamentally, the NHI is about using all available resources for health (human, infrastructural and financial) for the benefit of all who reside in South Africa based on need rather than ability to pay. Therefore, significant attention has been paid to how resources available in the private sector could be redistributed for the benefit of all regardless of ability to pay or the availability of private medical insurance.

Initial NHI policy proposals seemed to indicate that the private sector provision would eventually be phased out and absorbed into the public sector. In the White Paper, and more so now in the final NHI Policy, the approach to the private sector has become more pragmatic and the policy position is one where private providers will continue to be largely autonomous (although heavily regulated) and for profit entities that will be contracted to provide service under the NHI.

The Policy provides some additional clarity on how the relationship between the NHI and private sector provision will work at the PHC level. Here the Policy paper notes that:

> "Contracting-in will be undertaken to reduce patient-overload in public health facilities whilst not depleting the numbers of salaried employees of the state. Contracting-out of PHC services will require that multi-disciplinary practices should be configured into horizontal networks that are contracted through the Contracting Unit for PHC (CUPs)." (p. 30)

So, under the NHI private PHC providers will be contracted through CUPs to provide services on the same basis as public sector PHC services (clinics and district hospitals). While there is little detail on the precise structure and operation of these CUPs, it seems as if these units will be established within each district as strategic purchasers of services based on their registered populations health care needs. It seems as if the CUPs will then reimburse both public and private providers based on a risk-adjusted capitation approach rather than on a fee for service basis. This approach to reimbursement of private providers under the NHI is important for a few reasons, including:

- It provides for a fairer distribution of budgets based on need and not existing levels of access or utilization;
- Bases service provision on need and not ability to pay;
- Reduces the risk of adverse selection where providers favor low risk patients and may reward providers who take on more complex patients with greater healthcare needs; and
- Because reimbursement is based on the kinds of cases treated and not just numbers, it should improve record keeping and data collection.

This reform, if implemented properly, is likely have greatest benefit for vulnerable patients in urban areas where private providers are already well established. In these contexts, access to a private GP nearby will no longer be determined by one's ability to pay but rather availability.

It remains to be seen, however, if in rural contexts, where there are few private providers, this shift is likely to have any positive impact. It is unlikely that private providers at either the hospital or PHC levels would choose to establish practices in rural areas. Diseconomies of scale, driven by comparatively low utilization relative to needed infrastructural and human resource investment, means that there is little margin for profit even if supposed efficiency gains of private operation are introduced. This holds true in all respects of private sector provision and includes private laboratory, pharmacy and emergency services.

Our concerns around private sector provision under the NHI, highlighted in previous submission on draft NHI policy proposals, remain. In those submissions, we argue that the concentration of private sector resources in urban settings may result in substantial improvements in capacity and access in urban areas. This increased capacity—improved access and consequently greater utilisation—may mean that a larger proportion of available resources would flow to urban settings. Without mechanisms (incentives or legislative requirements) to ensure private sector resources also benefit rural populations, it is unlikely that this capacity would consider moving to rural areas on their own.

As we argued in our submissions on the Green and White Papers, this issue could, in part, be dealt with accreditation processes that explicitly deal with the geographic distribution of resources. While this is implied in the foundational principles in the NHI Policy, the policy only addresses provider accreditation in terms of quality norms and standards by the Office of Health Standards Compliance. Once again there are no firm commitments on accreditation processes that include an assessment of the existing geographic distribution of available resources against population need.

The Policy once again seems to avoid committing to the final promulgation of Section 36 (3)(b) of the National Health Act, which makes provision for including a certificate of need in the provider accreditation process. The purpose of the certificate of need is to ensure that the accreditation process promotes "an equitable distribution and rationalization of health services and health care resources and the need to correct inequities based on racial, gender, economic and geographical factors".

The fact that Section 36 (3)(b) of the NHA has been ferociously contested by the private sector since the introduction of the Act is revealing of the kinds of challenges that the DoH is likely to face in trying to regulate how health care is distributed. It is also indicative of how the private sector is likely to respond to attempts regulation and constraints on practice more broadly.

Clarity on addressing the geographic distribution of new infrastructure and services should be sought as part of the legislative reform process that will follow the release of the final policy. The issuing of a certificate of need could form part of the responsibility NHI implementation structures such as the Office of Health Standards Compliance (OHSC) or the National Tertiary Services committee once legislation has been passed to this effect.[8]

[8] Provision for these structures is made in the National Health Amendment Act (No. 12 of 2013). The OHSC has already been established and currently only deals with quality

Emergency Medical Services

The lack of access to EMS in rural areas is one of the most pressing issues confronting rural populations. Ambulances are seldom available to attend to emergency situations in rural areas and people in need of urgent care are most often forced to go without that care or find alternative means to get to a hospital. This has obvious consequences for the likelihood of positive health outcomes for patients. Accessing emergency care, in the absence of emergency transport, is also costly for rural patients who are forced to make use of private transport at significant cost to their households. There is clear evidence that shows that a single trip to the hospital can cost more than R600.[9] This expense is often a significant portion of an average rural household's income and is catastrophic for most.[10]

Despite extensive evidence on the causes and consequences of what amounts to an EMS and human rights crisis in rural contexts the NHI policy does not provide any clear insight on how rural areas will be prioritised going forward. There is no indication of how existing public sector capacity is going to be extended or improved and there is no insight into how private sector involvement is likely to contribute in these areas. In all respects, our concerns raised in comments on the Green and White Papers remain. These include:

- The Policy does not account for service delivery in differing contexts. Specifically, it does not make provision for different models of reimbursement that consider the impact of distance, topography and the differing resource needs required to deliver services in rural settings. Meeting basic service delivery standards will require additional resources to be directed to rural contexts to ensure that rural patients will experience the same service quality as urban patients. Longer distances, dispersed populations and more difficult roads mean that EMS services take longer to reach patients and then to transfer them to the nearest facility. Vehicles operating in rural areas will also require servicing and repair more often because of distance and the poor quality of the roads in these areas. Unavoidably, these factors render service delivery in rural settings more expensive and this fact should be accounted for in reimbursement models for EMS services.
- The second factor that should be considered is that there is virtually no private EMS provision in rural settings. Private EMS companies are for-profit and the low number of patients who have medical aid or who can afford to pay for services out-of-pocket in combination with higher costs associated with delivering EMS services in rural areas, means that there is no financial incentive to establish services in these areas. If strategies are not introduced to mitigate these inequities—such as increasing public sector service offerings in rural areas or providing incentives for private

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assurance and not distribution, while the National Tertiary Services Committee is yet to be established

[9] Harris, B., Goudge, J., Ataguba, J.E., McIntyre, D., Nxumalo, N., Jikwana, S. and Chersich, M., 2011. Inequities in access to health care in South Africa. *Journal of public health policy*, *32*(1), pp.S102-S123.

[10] ibid

companies to start working in these areas—it is unlikely that access to EMS will be significantly improved for rural populations.

The NHI Policy does, however, recognize transport as a major barrier to access in rural areas and critically notes that:

> " NHI healthcare benefits will be portable throughout the country. Mobile healthcare services will be organised within a CUP. The contracting of accredited private providers will be prioritised with the aim of ameliorating geographical access challenges. Whilst assuring continuum of care communities, vulnerable groups (especially people with disabilities and the elderly) and those domiciled in rural settings may still experience limited access as a result of topography, and unaffordable transport costs. NHI will provide coverage for planned transportation in times of need and for the elderly and people with disabilities in rural and topographically inaccessible and rural localities." (p. 24).

This is an important acknowledgement and is an indication of rural-proofing taking hold in NHI policy work more broadly.

PHC re-engineering

From the start PHC re-engineering has been at the heart of service delivery reforms under the banner of the NHI. It is also an area where the DoH has made the most progress in terms of commitments under the NHI policy process. The DoH has started with the implementation of all four streams of PHC re-engineering. These include:

1) Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs);
2) Integrated School Health Programme;
3) District Clinical Specialist Teams; and
4) Contracting of private health practitioners at non-specialist level.

The implementation of these streams to date provides some important insight into issues confronting the health system reform and reform in rural contexts in particular.

For instance, the NDoH is in the process of finalising its WBPHCOT policy. The policy is important because it defines the roles and responsibilities of these teams in delivering services within vulnerable communities. The policy, while dealing with how these teams will function in general, will finally provide certainty around the roles, responsibilities and working conditions of Community Health Care Workers (CHWs). CHWs form the backbone of these teams and are critical in broadening access to health care for poor and marginalised populations. In rural settings, where access to facilities are limited for most people, CHWs are game changers.

The recent WBOT Investment Case, prepared for the NDoH, by the South African Medical Research Council (SAMRC) included the following findings that clearly illustrate why CHWs should be a critical component of PHC reforms under the banner of the NHI.[11]

The importance of a well-resourced and functioning WBPHCOT to improving access to care in rural areas demands policy that is cognisant of resource demands of service delivery in these contexts. A recent costing of CHW programmes in two districts (Sedibeng and uMzinyathi), undertaken by the RHAP in partnership with the MRC, found that because of geographic differences, more CHWs are needed in rural settings than in urban settings to deliver the same level of service[12].

Fortunately, close to final drafts of the WBPHCOT policy explicitly includes provision for rural considerations in the resourcing of teams. For example, the draft policy calls for the determination of CHW to household ratios based on geographic and population characteristics. This is likely to mean that to account for greater distances between houses and more time intensive tasks, CHWs working in rural areas will be responsible for proportionately fewer houses than CHWs working in urban areas.

Even though the WBPHCOT policy process has demonstrated what can be achieved regarding accounting for rural health as part of NHI reforms, it is also illustrative of how difficult and time consuming such reform can be. Since 2014 the policy has undergone several rounds of revision and re-drafting and at the time of writing this review, there is no clear indication of when it is likely to be finalised and implemented. Sticking points remain around the scope of practice of CHWs, their qualifications and critically how much the programme will cost. The cost issue is particularly challenging in a context where cost containment and budget austerity are clear government priorities.

Where the NDoH has forged ahead with the implementation of initiatives, resource constraints and real world complexities have hindered progress. For example, since 2014 the NDoH has embarked on a process of contracting private GPs in to work in public facilities as part of the fourth stream of PHC re-engineering. The phasing in of this GP contracting has been demonstrated how difficult health system reform will be, particularly regarding drawing private providers into the public system in rural areas.

In some respects, GP contracting has demonstrated progress. By the end of the 2015/16 financial year more than 390 GPs had been contracted to work in public sector facilities and NDoH targets suggest an additional 290 are likely to be contracted by the end of the 2016/17 financial year. [13] The challenge here is that there is no mention of where these GPs have been contracted to and if there is an equitable distribution between urban and rural contexts. This speaks to limitations with the current GP contracting policy, which does not require the equitable distribution of contracts but only provides it as a nice to have. The equitable distribution of contracts between urban, underserved and rural contexts should

[11] The investment case is not yet in the public domain, so the key findings cannot be included here. This report will be updated as soon as the document has been officially released

[12] Available here: http://www.mrc.ac.za/healthsystems/CBCReport.pdf

[13] National Department of Health: Annual Report 2015/16. Available: http://www.gov.za/documents/department-health-annual-report-20152016-22-nov-2016-0000

form part of the policy and legislative frameworks governing the contracting of private providers, including GPs.

In practice this programme has not been without its own significant difficulties. For example, we know that in 2016 the Department cancelled the contracts of GPs working in the North West Province, apparently due to growing resource constraints. In the Eastern Cape, systemic and administrative challenges have made it difficult to attract GPs to the initiative. A recent review of the GP contracting process in OR Tambo, a largely rural district in the Eastern Cape found that GPs were reluctant to take-up contracts due concerns over remuneration, professional support, poor infrastructure and a lack of communication from the department of health.[14] These are all issues confronting improving access to Human Resources for Health that the RHAP has highlighted in the past and are factors that must be considered in the rural-proofing of the NHI.

The NDoH has generally viewed initial work on contracting as showing good progress and has committed to broadening the scope of contracting to other categories of non-specialised health care professionals. But as with the contracting of GPs, attracting health care professionals to undertake work within PHC facilities requires extensive material, administrative and professional support.

As the backbone of healthcare in rural areas PHC re-engineering must consider rural contexts and populations more fully in the design of service delivery platforms and their resourcing. While existing PHC re-engineering approaches have done this to some extent, the approach to rural contexts has lacked urgency and the resources needed to achieve change have not followed the commitments that do exist.

Human resources for health

As in the Green and White Papers, in the final NHI policy Human Resources for Health (HRH) is identified as a critical component to the success of the NHI. Despite this recognition, the NHI Policy provides little detail on how HRH capacity will be improved and supported under the scheme. Beyond brief mention of increasing intake at medical schools and re-opening nursing colleges the NHI Policy does not provide any commitment to the development of a comprehensive long-term strategy on HRH. This is surprising as the National HRH Strategy is due for review and would provide an obvious policy and legislative opportunity to align HRH in South Africa with the NHI. The NHI policy should at a minimum provide guidance on the basic principles that would underpin the National HRH Strategy, even if it does not provide concrete activities and targets.

In the White Paper, specific mention was made of the need to implement strategies to attract and retain health care workers in rural and hard-to-reach locations. In the final NHI Policy no mention is made of rural health in relation to HRH.

[14] Hongoro, C., Funani, I.I.N., Chitha, W. and Godlimpi, L., 2015. An assessment of private General Practitioners contracting for public health services delivery in OR Tambo District, South Africa. *Journal of Public Health in Africa*, *6*(2).

NHI Financing

Determining how much the NHI will cost, how revenue will be raised to pay for care, and how providers will be reimbursed for services rendered, are amongst the most important aspects of the NHI policy process. Without clearly articulated plans around how the NHI will be financed, there is little real hope that UHC can be achieved and the status quo is likely to persist. The success of the NHI depends largely on how effective health care financing reforms are in generating necessary revenue and then using those resources for the benefit of all regardless of ability to pay.

Cost of the NHI

A notable feature of the development of policy from the Green Paper has been a shift in how the schemes long-term costs have been dealt with. In the Green Paper the NDoH included long-term cost projections that estimated annual cost of implementation by 2025 to be R256 billion in 2010 prices. The costing was based on several assumptions on what services would be covered, private sector resources being absorbed into the scheme, and efficiencies gained from having a single fund and single payer. The Green Paper costing was criticised, correctly, for relying too heavily on guess work and vague policy proposals.

In the White Paper, and now the final NHI Policy, the NDoH was more cautious with how it framed cost estimates and has only provided broadly illustrative cost projections and scenarios. While they provided, updated costs based on data collected from the NHI Pilot Districts and PHC Re-engineering efforts, they did state that actual expenditure will depend on many factors such as trends in population health needs, utilization, supply capacity and reimbursement arrangements (p.49).

The caution with which cost estimates are presented in the final NHI Policy is understandable. More detail cost projections will only be possible once each component of the NHI has been detailed and specific activities and targets established. That said, costing remains a vital component in ensuring that goods and services are purchased as efficiently as possible while constantly promoting greater access and equity in the system. In our view an important component of the costing of health care services that has been absent for far too long has been the determination of cost differentials between urban and rural settings. Generally, the cost of delivering health care is higher in rural settings than in urban settings for several reasons, including:

- Higher infrastructure costs due to distance to facility sites
- Higher supply chain costs due to distance from urban centers to outlying rural facilities
- Higher per capita service delivery costs for priority interventions due to diseconomies of scale caused by low population densities and dispersion
- Greater cost burdens placed on patients due to higher transport costs and, on average, lower household incomes36

Consequently, more resources are required to realize similar health outcomes in a rural patient, when compared to an otherwise similar urban patient. The determination of these additional resource needs for service delivery in rural areas is critical in determining how providers should be reimbursed, but also in making decisions on what services will be offered and how those services should be delivered. Therefore, it is critical that when costing exercises are undertaken for each component of the NHI, the differences between urban and rural costs are quantified.

Raising revenue

The final NHI Policy does offer marginally more detail on how revenue could be generated to fund the NHI than the Green and White Papers. The Policy is clear that the NHI will be a pre-payment scheme funded from a combination of general tax revenue, earmarked taxes and NHI levies. Critically the Policy abandons most Out-of-Pocket (OOP) user-fees initially considered under the Green Paper will not form part of the NHI.

The scrapping of most OOPs is something the RHAP called for in its initial submissions and welcomes this decision. That said, we do call for caution around the implementation of bypass fees in rural settings. The NHI Policy mentions that bypass fees will be charged in instances where a patient chooses to bypass a PHC facility and head straight to a hospital as the first point of contact with the system. Appreciating the need to ensure that patients receive care at the correct level and do not unnecessarily burden hospitals, it is important to recognize that in the absence of alternatives patients often have no choice but to go to these facilities as a first point of call. In rural settings, poor infrastructure and a lack of transport mean that seeking care at a hospital is often the only rational choice. It is therefore critical that consideration be given to the phasing in of bypass fees until sufficient capacity exists within PHC in rural areas to provide good quality care supported by an effective referral system. Rural patients should not be punished financially for weaknesses in service provision.

Regarding generating revenue through various taxes and levies, the NHI does not yet commit to an approach and instead outlines five different scenarios that include different mixes of revenue sources (Table 2).

Table 2 Alternative TAX scenarios for funding NHI

	Payroll tax	Surcharge on taxable income	Increase in value-added tax
Scenario A: Surcharge on taxable income, VAT increase and payroll tax	1.0%	1.0%	1.0%
Scenario B: Payroll tax and surcharge on taxable income	2.0%	2.0%	
Scenario C: Surcharge on taxable income and VAT increase		2.0%	1.5%
Scenario D: Payroll tax and VAT increase	2.0%		1.5%
Scenario E: Surcharge on taxable income		4.0%	

In our submissions on the Green and White Paper we called for consideration to be given only to progressive sources of revenue. This means that, in our view, increases to VAT should not be included as an option since VAT disproportionately affects poor and rural households.

Unfortunately, three of the scenarios provided in Table x still include an increase to VAT as a revenue source. The NHI Policy does seem to suggest, however, that these scenarios are not favored. This is made apparent when the Policy states that, "the regressive aspects of a value-added tax increase would contradict the principles upon which NHI is based" (p. 48).

The policy does offer Option B, which includes a combination of payroll and surcharge income taxes, as the preferred choice. It is important to remember that this is a preference and that the final option will only become apparent once the NHI fund has been established and the process of reforming tax legislation takes place.

Provider payment: Hospitals

The NHI Policy envisions a significant shift in how hospitals in the public sector will function under the NHI. The Policy notes that hospitals will become semi-autonomous business units that will operate independently of broader administrative and management structures. This will require significant restructuring of administrative systems and how these hospitals will function. It is apparent that they will now contract with the NHI rather than receiving a budget from the National or Provincial departments of health. This has implications for how services are funded and will require a shift in how hospitals budget for service delivery.

The NHI Policy provides less certainty on how hospitals will be paid for services delivered than the White Paper did. While it is still apparent that there will be a gradual shift from line-item budgeting to a case-mix activity based approach such as Diagnostic Related Groups, it provides little detail on the principles that will be used to structure this approach. Even though the detail of this approach is likely only to come with the legislative reform process, it is critical that commitments are made to the broad principles of the approach. For instance, the RHAP, while broadly supportive of the DRG approach, is concerned that if not designed with rural realities in mind, the approach may deepen inequities. The problem

is that using DRGs as a method uses inpatient numbers to determine utilisation. Utilisation is then used as a proxy for need. As is the case with other utilisation methods, this approach can be anti-rural if the following issues are not dealt with appropriately:

- Case mix complexity must not be evaluated on clinical criteria alone. The logistics associated with management of patients in rural areas increases the complexity and costs, for which more budget must be allocated.
- DRGs are concerned with in-patient numbers and case mix; but rural facilities spend proportionately more time and resources on comprehensive outpatient consultations than others, owing to the problems around continuity of care (referrals and admissions).
- Access to the health system will likely remain difficult in rural communities for the foreseeable future; this will mean outreach from the rural hospital will continue as a cost-effective method of health care delivery. This requires significant funding (transport, extra staff), and should be considered in addition to DRG funding mechanisms.
- Continuity of care and referral processes are, even if working well, more difficult between rural and their urban referral centres, resulting in greater treatment difficulty, higher resource intensity, and greater severity of illness (on average) being found at rural facilities, compared to similar urban facilities.
- Rural health needs are far greater than the current demand. It is vital to tie funding to health needs, rather than demand. Funding might be easy to calculate for the latter, based simply on provision of services and existing infrastructure and workforce, but this favours better-resourced, usually urban, facilities.
- DRGs are part of an utilisation-based model that incentivises unnecessary and inappropriate use of services.

Provider payment: PHC

Proposals for provider payment at the level of PHC are broadly the same as those included in the White Paper. As was the case then, reimbursement of PHC providers (both public and private) will be on a risk-adjusted capitation system. The Policy notes that capitation rates will be adjusted based on “registered population, target utilization and cost levels” (p.56).

In our submission on the White Paper we noted that one of the challenges with this approach as framed in the draft policy was that utilization would be used as a marker of need. This is problematic in rural contexts where utilization does not adequately reflect need within the population. Due to barriers associated with accessing facilities in rural areas (distance and transport cost), households tend to avoid or delay seeking care.

The second issue we raised is that on a per capita basis the cost of providing services is higher in rural areas than urban areas for the following reasons:

- The distance between facilities and different levels of care renders supply chain, referral and outreach more expensive

- Low population densities mean that rural facilities do not benefit from economies of scale, which results in higher per capita costs than in urban facilities
- The complexity of service delivery in rural settings (I.e. access and complexity of cases-mix) all renders the cost of providing services in rural communities more expensive

The NHI Policy does acknowledge that the determination of the capitation rate will need to be refined over time to account for the catchment population and epidemiological profiles of the PHC facility. While this refinement opens space for the consideration of rural need and cost factors, it is imperative that the routine collection of health and cost data to be used in determining capitation rates accurately measure the impact of the factors described above. This would allow for the inclusion of a rural weighting or adjuster in the capitation formula that would promote greater equity in resource allocation processes.

Improving leadership and governance

The introduction of the NHI will inevitably mean changes in the way that health care is managed within the public health system. Throughout the Policy it is apparent that while the NHI fund will be centralised at the national level, responsibility for service provision and the administration of the health system will be decentralised. For instance, the Policy notes that tertiary, regional, specialised and central hospitals will now become semi-autonomous units responsible for their own budgets and management and will contract directly with the NHI fund.

At the level of PHC, the policy makes provision for Contracting Units for PHC (CUP), which will be located at the district level. The purpose of the CUP in each district will be to determine the service needs of their populations, develop plans on how to meet these needs and then purchase those PHC services from public and private providers within their catchment areas. Broader planning, administration and management of PHC service provision will fall to District Health Management Offices

The RHAP has always been broadly supportive of this kind of decentralisation within the health system. Decentralisation allows for service delivery to be tailored to the needs of local communities by providing flexibility in priority setting and how services are delivered. We do note, however, that the success of decentralisation depends on the capacity at district level to take full control of administrative and management functions. Currently, districts have limited capacity to deliver on existing mandates and in their current form are unlikely to have necessary capacity to take on additional responsibilities. This is especially true of rural districts where it is often difficult to attract and retain skilled managers and technical staff. Therefore, as with other aspects of the NHI, the success of decentralisation will require investment in strategies that will attract and retain skilled managers to rural districts to work in the CUP and District Management offices.

Changing intergovernmental relations

The NHI will inevitably require a reorganisation of intergovernmental relations and a shift in authority over the financing and administration of health care within the public system. As noted above, the NHI Policy makes provision for decentralisation of administration and management to hospitals and in the case of PHC, districts. This will require changes to legislation to make provision for these changes.

This process is likely to be hotly contested within government. While local government only has a small role to play in health care service delivery, provinces are still responsible for the bulk of health budgets in the public system. As it stands, the NHI will result in diminishing responsibility for provinces in the administration of health care and consequently health care budgets. This is a change that provinces are unlikely to support willingly as it will significantly diminish their control over service provision and resources.

In the White Paper the NDoH skirts around the issue of the provinces by stating that "provinces might be responsible to ensure that the basic elements of the service are in place using part of the existing PES formula (supply side funding) while the NHI Fund reimburses for services delivered (demand side funding)." (p. 59) Without stating it explicitly, the NHI Policy suggests that provinces no longer have a role in the administration or provision of health care under the NHI

It is likely that the nature of the re-organisation of intergovernmental relations will only become apparent as legislative reform starts to take place. The most prominent of these processes is likely to be in relation to the establishment of the NHI fund and its supporting legislation. It is expected that provinces and the private health sector are likely to contest many of the provisions of bills that will be put forward for comment. It is imperative that

Recommendations

A marked change in NHI policy proposals over time has been the broad acceptance that there is the need to explicitly consider rural contexts in planning and resourcing. This is demonstrated in several instances in the final policy. For example:

- Addressing inequity between urban and rural health systems is a stated priority (p. 5)
- Rural context to be considered in the assessment of need and resourcing (p. 21 and 24)
- Rural populations among first to be registered under NHI fund (p.64)

Rural should be clearly defined

One significant limitation of the treatment of rural contexts in the final policy though is that there is still no clear articulation of how rural will be defined. A technically sound approach

to defining rural for the purposes of policy, planning and resource allocation is needed to ensure interventions are both equitable and effective in these contexts. Any definition should account for factors such as:

- Demographic characteristics of rural areas;
- Epidemiological characteristics of rural areas (health care need);
- Geographic characteristics (longer distances and more difficult topography; and
- account for rural cost factors (e.g. diseconomies of scale)

Brining the private sector in can deepen urban rural inequity

The final NHI Policy takes a more pragmatic approach to private sector provision and offers greater clarity on how services will be contracted. For example, the policy states that private providers will be contracted to the NHI through a risk-adjusted capitation approach at the PHC level and through DRGs at hospital levels. Both approaches could improve access to private resources for all regardless of income and ability to pay.

The trouble, however, is that Issues around how to achieve equitable distribution of private sector resources remain unresolved. The final NHI Policy continues to skirt certificate of need issue. This avoidance could only serve to deepen inequities. The NDoH needs to critically evaluate how it will address equity concerns in the accreditation of private providers under the NHI to ensure these resources move to rural settings in a manner that improves access to care regardless of ability to pay. This speaks to broader concerns around how to ensure additional resources for service delivery flow to underserved settings and rural contexts. While a central component of accreditation, quality norms and standards, cannot be the only basis on which private providers are accredited.

The NHI does not adequately address access to EMS in rural areas

Rural EMS considerations are not addressed in final Policy and more needs to be done to address access in these hard to reach communities. This would require consideration of additional resources to account for rural geography (topography and longer distances) and higher service delivery costs;

The final NHI Policy does suggest that drawing on the private EMS industry could bolster access to services under NHI but does not adequately consider how this could be done without further exacerbating inequity. Private EMS will bolster access in urban areas but there is no benefit for rural contexts where private EMS does not operate.

Unlike PHC, EMS has not been addressed adequately as part of reforms being implemented in preparation for the NHI. A strategy like (or as a component of) PHC re-engineering should be developed. This should include strategies that address:

- Quality of EMS services;
- Equitable access to services;

- Context appropriate service delivery methods that account for rural factors (distance and topography); and
- Accreditation based on equity principles

Some progress on rural-proofing of PHC re-engineering but more could be done

As part of PHC re-engineering reforms in preparation for the NHI, rural health has been clearly identified as a priority. For example, rural proofing is now foundational principle of WBOTs draft policy.

That said, for rural-proofing to become an effective component of the NHI its principles must extend to financing, administrative, and institutional components of NHI. Rural-proofing should. This would include legislative and institutional reform around NHI administration, financing and service delivery platforms. PHC re-engineering should be the first aspect where rural-proofing is undertaken in full.

National HRH strategy must do more for rural health

HRH remains a NHI policy priority but there is still no detail given on basic recruitment and retention strategies or how personnel are likely to be distributed between various contexts. Reference is made to National HRH strategy for guidance and so HRH appears to remain a NDoH function. The Current strategy comes to an end in 2017 and the new strategy has yet to be developed. The new National HRH strategy should be developed with the NHI and its institutional components in mind. This new strategy should, as the current one does, include a rural education, recruitment and retention strategy as a core component. This must be supported by legislative mechanisms that promote the equitable distribution of HRH. This could form part of the accreditation process of establishing new service providers or facilities, for example.

NHI costing must consider rural costs

The costing in the final NHI policy takes a more cautious approach to outlining potential future resource requirements by not committing to detailed item or fixed cost projections. Instead, it includes broad cost projections, which do make some allowances for context specific and needs based cost differentials. This means that there may be space for in subsequent legislative and strategic planning processes for rural cost factors to be included.

Going forward all legislative, administrative and structural reforms under the NHI should include a full costing, which should account for rural/urban cost differentials. An example of this can be taken from the WBOT policy process that is currently under way.

These rural cost factors then should be built in to cost forecasting as the NHI fund starts to become the primary healthcare financing mechanism in SA. This would add greater predictability and equity resource allocation processes over time.

Financing for the NHI must only be taken from progressive sources

In the final NHI policy various TAX scenarios are provided, some of which still include increase to VAT. However, the policy does clearly state that the preferred approach is one in which there is an increase to income taxes and levies and no increase to VAT.

Re-imbursement of providers must account for rural cost factors

RHAP broadly supportive of move to DRG reimbursement mechanism but worried that depending too heavily on utilisation measures will disadvantage rural facilities because unmet need is greater in these settings. These concerns are not specifically addressed in final policy but the policy does note that final DRG approach will cater for context. This approach should, therefore, be carefully considered and clarified during the formulation of the institutional and legislative components of the NHI.

Specifically, the Design of DRG approach should not be limited to inpatient assessments of need. Utilisation tends to be lower in areas of greatest need and often with most complicated cases. DRGs should be linked with broader assessments of need that encompass need seen at PHC level and from within communities

We welcome the retention of the risk adjusted capitation approach in the final Policy. There is also greater clarity on the organisation of purchaser provider split for PHC where Contracting Units for PHC (CUP) are designated as purchasers and District Management Offices (DMO) are designated as coordinating provision. There is no explicit mention of rural considerations in this aspect of the policy though.

Risk adjustment should be made using data that extends beyond what is collected within facilities and as far as possible encompass unmet need. This is most apparent for services to the disabled. A cost adjustment should also be made for higher costs associated with delivery in rural settings due to diseconomies of scale and the need for alternative service delivery methods (e.g. increased outreach).

In the final policy priority is given to decentralization of authority. Specifically, this includes:

- Hospitals as semi-autonomous business units;
- District Health Management Offices responsibility for planning and administration; and
- Decentralised CUPs responsible for contracting and purchasing services at PHC level

While the RHAP is broadly supportive of decentralised authority to enable context appropriate service delivery, capacity must be enhanced in rural settings to enable effective delegation.

Rural districts must be targeted for administrative skills development and capacity enhancement. This could, for example, include strategies that attract and retain skilled managers/administrators to rural areas.

Changes to intergovernmental relations is too vague

The final policy mentions that there is a need to reform intergovernmental relations (particularly fiscal relations) but it does not provide detail on what this means. The policy is particularly vague on future role of provinces. Changes should be supported in as far as the promote greater equity in resourcing and planning that is more cognisant of the needs of rural communities. This demands a rural proofing approach to NHI institutional processes where appropriate

For inputs and questions: Contact Russell@rhap.org.za

[ENDS]