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**Comments on White Paper on National Health Insurance (NHI), 11 December 2015**

Thank you for this opportunity to submit comments on the proposed policy. We are submitting these comments on behalf of the Health Systems Research Unit (HSRU) of the South African Medical Research Council (SAMRC).

We strongly support the underlying principles of the policy reforms described in the National Health Insurance (NHI) White Paper. The NHI is clearly based on the principle of equity and we fully support this. It aims to reduce disparities in health, to organize health services around the country's needs and expectations, to integrate health into all sectors through public policy reform, and to ensure active public participation.

In order to facilitate progress, we, as the Health Systems Research Unit, make several recommendations below, and offer our assistance in monitoring and evaluating / researching the implementation and impact of the NHI. Our vision as the Health Systems Research Unit is to inform health systems policy through research. Therefore, we are committed to supporting government in policy reform initiatives such as the NHI.

Sincerely

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# Comments on and Contributions to the White Paper on National Health Insurance (NHI), 11 December 2015

## Health Systems Research Unit

## South African Medical Research Council

**Contracting private health service providers to provide health care within the NHI**

The NHI proposes public-private partnerships in the provision of public health care services. We recently attended a presentation by the Treasury at the Health Systems Trust conference. This presentation focussed on funding mechanisms for the NHI, and highlighted the importance of implementing best practices when contracting private service providers.

A Cochrane systematic review of the effects of contracting out (Odendaal et al, 2016, under review) found very little robust evidence on this question. Only one study from Cambodia was identified, in which non-governmental service providers (NGPs) were contracted to provide all preventive, promotional, and basic curative healthcare in selected districts. This study provides evidence of low certainty that contracting private health care providers to provide public health services may improve some measures of health. Contracting out may also reduce out-of-pocket spending on curative care, due to lower use of private health care. We do not know if contracting out impacts on health service utilization as the certainty of the evidence was very low. We also do not know if contracting out impacts on quality of care, health systems performance and equity as these outcomes were not measured. The systematic review concludes that our knowledge of the impacts of contracting out is currently very limited. It is uncertain whether contracting private health service providers will improve quality of care, satisfaction with care, health service utilization or health systems performance and it is unclear to what extent this approach is more effective than other strategies, including providing the same service through public health service providers. Contracting out initiatives should therefore be accompanied by rigorous evaluation to assess their impacts on quality of care, satisfaction with care, health service utilization, health systems performance, resource use and other economic outcomes, and health outcomes.

Many factors may shape the effectiveness of contracting out, and these need to be carefully considered in planning and implementing the contracting process. These include, but are not limited to, the tender processes, how the contracted deliverables are managed and the payment structure. For example, contracting out introduces opportunities for fraud and

corruption in the tender and contract management processes (Greve 2001; Heard 2011). It can also be more expensive than government provision of the same service because of high transaction costs between the government and private sector (Bel 2007). Distrust may exist or develop in the contractual relationships between the government and private sectors (Batley 2006; Girth 2014; Van Slyke 2007) and there is also the risk that governments may be unable to sustain the contracts (England 2004). It is also argued that in circumstances where contracting out is a response to ineffective or inefficient government service delivery, these same governments often lack the capacity to effectively manage the contract and this may undermine the process and outcomes of contracting out (Bustreo 2003; Mills 1998).

***Recommendations:***

- *Where contracting out to private health care providers is being considered for a particular service, the pros and cons of this need to be evaluated thoroughly, including whether this is likely to have any advantages over delivery by public health care providers*
- *Where contracting out is used, capacities need to be strengthened at national, provincial and district levels to manage this process and to monitor the performance of contracted providers. International experience has shown that public / private partnerships can turn out to be at the expense of the public sector due to lack of advanced knowledge of best-practice contracting approaches by the public purchaser. Contracting out should therefore not be used where the capacity to manage this appropriately is not available.*
- *All contracting out initiatives should be accompanied by rigorous evaluation, preferably in the form of a controlled study, to assess their impacts on quality of care, satisfaction with care, health service utilization, health systems performance, resource use and other economic outcomes, and health outcomes. The Health Systems Research Unit of the SAMRC has the capacity to conduct evaluations of contracting out initiatives.*

**Financing the NHI**

As the HSRU of the SAMRC support the approach of a single fund as a system which is more efficient, cheaper and better suited to cross-subsidisation than the current multiplicity of funds with public funding and private medical insurance (medical aids). We also welcome the approach of harnessing private sector funding. We have two main concerns regarding its implementation and sustainability:

1. Availability of funds: The calculations presented are based on the assumptions of a 3.5% increase in GDP per year and a similar increase in public sector funding since 2010. Observed and expected growth rate have been hovering around 1% or below. Whatever the mix of tax (from income & corporate tax to consumption tax) chosen, the increase in tax rates will have to be limited given the very tight economic

situation. Reaching the goal of the NHI will require a commitment of the government to increase the share of health in the budget. If such an increase does not take place, how will the services within the basket of services be prioritised? What mechanisms will be used to ensure that prioritising will be implemented in an equitable manner?

2. Tax mix: The share of VAT increase in the additional funding basket will be inequitable as it is a consumption-based tax that will proportionally affect the poor more than the wealthy.

***Recommendation:***

1. *In order to limit some of the impact of the increase on the poor, the basket of services which are VAT exempt should be reconsidered and extended (such an approach would aim at including basic commodities like sanitary towels, for example, in the VAT exempt list).*

**Human resources (HR)**

In Section 6.6: "enhancing human resources for health", the White Paper determines that human resource requirements will be identified through the use of the Workload Indicator of Staffing Need (WISN) tool. The WISN tool is currently used to define the guidelines for HR for primary health care in the country. It is essential that the suggested norms are evaluated against current practice and availability of funds. Whilst we recognize that current practice reflects a critical shortage of human resources, the gap between current practice and the WISN recommendations raise concerns around the feasibility of implementation of these guidelines.

***Recommendations:***

1. *We suggest a mechanism is set up to evaluate the recommendations emanating from the WISN tool (both in terms of quantity and skill mix). This evaluation would benefit from inclusion of participants from NGOs and academic institutions in addition to health managers.*
2. *To assist this evaluation, a systematic costing of the implications of the guidelines should be conducted. Researchers in the Health Systems Research Unit of the South African Medical Research Council are currently working on such a costing exercise and would welcome the opportunity to share their findings as a contribution to this discussion.*

**Improving equity in distribution of health professionals**

One of the inequities recognized in the White paper is the mal-distribution of health professionals between urban and rural areas, across districts, and between private and public services. Although the White Paper, describes strategies to increase equity in distribution of health professionals, more detail or consideration is needed on the 'how to'/systems that will be established to facilitate this:

Paragraph 227 indicates that incentives will attract health professionals to rural and hard-to-reach areas.
Paragraph 230 indicates that there will be a "multi-sectoral response to providing basic social infrastructure and amenities in these areas".
Implementing the provision of social infrastructure and amenities may not be affordable to implement alongside the implementation of the NHI.
As the HSRU, we are concerned that without an elaborate, well-funded and evidence-based strategy to attract health workers to rural, hard-to-reach and poor peri-urban areas, the NHI will struggle to ensure equity in the distribution of health workers.

***Recommendations:***

1. *We recommend the development of a strategy to increase equity in distribution of health professionals. We recommend this strategy is developed in a consultative manner with health professionals and is based on evidence and global best-practice.*
2. *The Health Systems Research Unit is available to summarise the best available evidence on strategies to encourage equitable distribution of health workers, including the effect of incentives for health workers to be placed in rural and poorly-resourced settings.*

**Improving equity in access to good quality personal health services**

The NHI White Paper proposes to make health care universal accessible, and it proposes to prioritise the provision of health care to the most vulnerable persons within our society. People living in rural, hard-to-reach and poor per-urban areas are often the most vulnerable (Harris 2011; Goudge 2009). The public health services in these areas are likely to need a disproportionate amount of resources and support, and it would be ideal if the systems that will facilitate this are articulated in the paper

We note the progress in setting up the Office of Health Standards Compliance (OHSC) and the appointment of a Health Ombudsman. The OHSC has completed several rounds of nation-wide audits of health care facilities over the last four years, to establish baselines and guide quality improvement efforts. These audits show the wide range on quality, with low quality on some standards in some clinics. Poor leadership, management and governance are important factors undermining the quality of care, (Rispel 2016), and systems that facilitate good governance should ideally be articulated in the White paper.

***Recommendations:***

1. *A coherent, effective, acceptable and sustained approach to improving quality of health care service delivery, which is cognizant of the extra needs of the poorest performing public health services and the services providing care to the most vulnerable, and which improves leadership, management and governance.*
2. *That the White paper articulate more clearly how systems will be established to ensure / monitor good governance, and quality health services by all. This may include the addition*

*of 1-3 extra sentences that articulate systems to monitor equity in access and quality of care.*

**Addressing the social determinants of health through intersectoral activity**

Any strategy to reduce social and health disparities and inequities needs to address the social determinants of health. A large proportion of the burden of disease in South Africa is driven by social determinants (Coovadia 2009). Much of the burden of disease is preventable through, for example, better access to water, sanitation and housing, or access to employment and safe neighbourhoods.

Paragraph 100 of the White Paper recognizes the importance of addressing the social determinants of health. "The need to address social determinants of health is highlighted by increasing healthcare costs, morbidity and mortality associated with the management and treatment of communicable and non-communicable diseases impacting adversely on the affordability of the health system".

Without addressing the social determinants of health, we will not effectively reduce the burden of disease, which is one of the goals of the NHI stated in Paragraph 105. The NHI, as stated in Paragraph 108c of the White paper, aims to "enhance the role of the health sector in improving the social and economic welfare of the population".

Despite recognizing the importance of addressing the social determinants of health, the NHI White Paper does <u>not</u> adequately address reforms in public health policy to create the social conditions which will ensure good health and which reduce the burden of disease. The main focus of the NHI White paper is proposals for reform in the financing, organization and quality of personal health services.

Below are some objectives that have been shown to create the social conditions that will ensure good health at population level. (These objectives have been adopted in the Swedish Public Health Objective Bill, and are relevant to South Africa too.)

- Citizen participation and influence in society
- Economic and social security
- Secure and favorable conditions during childhood and adolescence
- Healthy and safe environments and products
- Effective protection against communicable diseases

- Safe sexuality and good reproductive health
- Increased physical activity
- Good eating habits and safe food
- Reduced use of tobacco and alcohol and a society free of illicit drugs, doping and harmful, excessive gambling

If these objectives are to be adopted, then responsibility for meeting them will lie not only within the health domain, but across sectors. Achieving these objectives will require joint effort across sectors in society.

There is evidence that public policy and legislation to incentivise health promoting behaviour and dis-incentivise disease-inducing behaviour, can be a powerful tool for improving population health. This has been applied to good effect in South Africa and worldwide with tobacco control legislation. However, more public policy and regulation is required to reduce the devastating impact trauma, violence and injury, the burden of alcohol abuse and to promote healthy lifestyles and nutrition. Given the scale of reform required for the NHI, and the financial resources it attempts to harness, there is a danger that this will not be matched by an equally large effort for health promotion and prevention. In particular, good quality education, access to housing, employment and economic growth are critical factors to promote health and prevent disease. Addressing these issues requires effective intersectoral collaboration in planning, policy, legislation, budgeting and programming across various government departments. Without effective, wide-scale, comprehensive intersectoral efforts, increasing access to better quality personal health services will have a limited effect on promoting the health of the population.

Whilst the NHI document acknowledges this, it does not elaborate a plan to address the broader social causes of ill-health, including the effects of marketing on health (e.g. marketing of tobacco/sugary drinks/preservative-laden snacks etc).

Paragraph 188 of the White Paper shows that the government's intentions to develop and strengthen health policy across sectors: "Health promotion and disease prevention will form an important aspect of contributing to the reduction in the burden of disease and rising costs of health care. The NDP 2030 envisions promoting health and wellness as critical, preventing and managing diseases of lifestyle that are likely to pose a major threat over the next three decades. Optimal collaboration between stakeholders from government and non-government sectors is required to address the risk factors that contribute to diseases of lifestyle. A National Health Commission will be established to ensure the required multi-sectoral collaboration."

***Recommendations:***

1. *In addition to focusing on individual health care, we recommend a stronger focus on living conditions, environments, products and lifestyles that promote health and prevent disease. It would be valuable if the NHI White paper contained a detailed plan for the*

*strengthening of public health policy across sectors and at all levels (national, regional, local).*

2. *Greater emphasis should be placed on early childhood development and mental health promotion. We recommend an evidence-based approach to child and adolescent health and mental health promotion within, for example, the Integrated School Health Policy.*
3. *We recommend that this aspect of public health policy is further developed as a priority. It is not clear the nature of relationships between the National Health Commission, the Department of Health, and the NHI.*
4. *The purview, roles and responsibilities of the various institutions and elaborating the management and coordination of the National Health Commission should be clarified.*

**Maternal and Child health**

- Keeping mothers and children healthy is a pillar of a healthy society. There is cursory mention of maternal and child health in the white paper, in the context of disease burden (page 19) and including maternal and child health on page 26. Whilst we understand that this document provides broad policy directions, lack of detail and specifications related to maternal and child health is a shortfall. More details need to be provide on the non-negotiable elements that will optimize maternal health and paediatric and child health in the context of NHI.

- We note that the Ward-based Primary Health Care Outreach Teams (WBPHCOTs) are considered to be a potential 'game changer' (pg. 32 of the White Paper). Whilst there is large potential for these teams of community health workers (CHWs) to make a difference to population health there are two aspects which should be considered. Firstly, the ratio of CHWs to population proposed of 6000 individuals (or 1500 households) per team, which equates to roughly 1000 individuals per CHW, is far higher than other countries where community-based delivery platforms have had a positive impact especially on child health. For example, the ratio of CHWs to population in Rwanda is 1 CHW to 255 people (Ministry of Health, Rwanda. National Community Health Strategic Plan: July 2013 – June 2018. Kigali: May 2013. http://moh.gov.rw/fileadmin/templates/CHD_Docs/CHD-Strategic_plan.pdf) . Given the quadruple burden of disease in SA and the important role of social determinants of health, the proposed ratio of WBOTs to population is unlikely to achieve the desired health improvements. A higher CHW-to-population ratio would increase the frequency of contact with community members and thus increase the potential impact on behaviour change and coverage of health interventions.

- In Ethiopia, there is a two-tier community-based delivery platform with trained health extension workers (HEWs), who operate out of static health posts. They are supported by a volunteer cadre known as the health development army, who are mainly responsible for promoting essential family practices. An evaluation of the nutrition support programme concluded that volunteers most likely contributed to a drop in stunting levels and underweight children and that the high ratio of volunteers to households (1 volunteer to 10 - 15 households and 10 volunteers to 1 full-time CHW) was central to this success. The ratio of volunteers to population is close to the volunteer-to-child population ratio of 1:10 – the WHO-recommended optimal density for effective preventive healthcare.

- In SA, ~24% of children under 5 are moderately or severely stunted; a prevalence rate that has not shifted significantly over the past few decades. Furthermore, SA has one of the lowest exclusive breastfeeding rates in Africa (8% in infants under 6 months of age).[There is evidence from low- and middle-income countries, including SA, of the impact of CHWs undertaking breastfeeding promotion and counselling on improving exclusive breastfeeding.

- In addition to concerns over the low CHW-to-population ratio, the proposed role for CHWs in SA is extremely narrow, focusing primarily on counselling around prevention activities and adherence support. There are no curative functions included in their scope of work. Neonatal causes, diarrhoea and pneumonia have overtaken HIV as leading causes of under-5 death in South Africa and there is increasing evidence that CHWs can treat infectious childhood diseases in the community with quality of care equivalent to nurses at PHC facilities. We would encourage an enlarged scope for WBOTs that should also include community-based support for premature babies in the critical few weeks following discharge and treatment of neonatal sepsis, diarrhoea, suspected pneumonia and acute malnutrition.

***Recommendations:***

1. *The NHI framework should review the ratio of WBOTs to population, with the aim of increasing it to closer to one CHW to 250 people.*
2. *The NHI framework should re-assess the scope of work of CHWs to consider inclusion of breastfeeding support and promotion, early neonatal care and curative care for leading causes of under-5 deaths.*
3. *The NHI framework should state upfront the importance of a marketing and health promotion strategy for maternal and child health in the South African NHI context.*

4. *The NHI paper should refer to the development of a strong M&E framework for MCH specifically, within the context of NHI.*
5. *The NHI paper should list the non-negotiable elements of care specifically for maternal and child health at different levels of the health system.*
6. *The HSRU is willing to engage with the National Department of Health to think through these issues and propose solutions or frameworks for monitoring and evaluation and to undertake some of the key evaluations needed in the maternal and child health context.*

**Community Participation**

The NHI White Paper recognises the importance of establishing Clinic Committees and Hospital Boards in the management of primary health care facilities, central and public health hospitals. However, overall, references to community participation are subtle and non-specific. There is no clear outline of how Clinic Committees are going to be composed, and to what extent they are going to be involved in the planning, governance and provision of health services.

Beyond the global endorsement that community participation enjoys when it comes to health governance and service delivery, in South Africa the concept has a particularly strong political and social currency, due to the historical political, social and economic exclusion of the majority of its citizens. It is enshrined in the Constitution and featured prominently in the White Paper on Transformation of the Health System (Department of Health, 1997), and in the National Health Act 61 of 2003. The White Paper on the Transformation of the Health System considers participation essential in the governance and delivery of primary health care. It also positions communities as important actors, engaged in "various aspects of the planning and provision of health services" (DOH, 1997). The National Health Act 61 of 2003 makes provision for the establishment of health/clinic committees and hospital boards. Given the substantial importance given to community/public participation in the health policies preceding the NHI, the NHI White Paper should feature it prominently and clearly. Further, a clear distinction could be made between community *involvement* and community *participation*; in the former communities play a utilitarian, supportive role to the health system, whereas in the latter the community is engaged as a partner in health service planning, decision making and in holding the health system accountable.

**Recommendations:**

1. *Clearly define the composition, role and powers of Clinic Committees and Hospital Boards.*
2. *Include measurements for monitoring and evaluation of the functioning and effectiveness of Clinic Committees and Hospital Boards.*

**Timeline**

The NHI White Paper proposes a 3-phase process of implementation over a 14-year period.

- Phase 1 (5 years, from 2012/13- 2016/17) focusses on strengthening the public health sector, including 'key enablers' such as the Office of Health Standards Compliance (OHSC) and the Health Ombudsman.
- Phase 2 focusses on the creation of a transitional NHI fund to purchase non-specialist services from 'certified and accredited public and private providers'.

However, as we near the end of Phase 1, to our knowledge, there is an absence of evidence of success of Phase 1. We are unaware of whether there is a systematic and robust monitoring and evaluation plan for Phase 1. We do not know what the impact is of the range of quality improvements and increased funding over the last four years. We are concerned that the public and private health facilities in the pilot sites might not have all been 'accredited'. We do not know of evaluations of the public-private partnerships envisioned as the requirement for Phase 2, and a cornerstone for the new NHI finance and service model.

We note the progress made regarding the legislative reforms required for the NHI, such as the Pharmacy Act, The Medicine Schemes Act, and the Medicines and related Substance Act. However, we note the absence of reform of the Nursing Act to allow nurses to prescribe medicines or take bloods (e.g. lower level nurses doing infant heel prick blood tests for HIV diagnosis), more easily.

***Recommendations:***

1. *An extension of the timeline for Phase 1, until there is good evidence of success in achieving quality standards and in models of public-private partnerships.*
2. *That the implementation of Phase 1 is divided into a series of scaffolding steps.*
3. *That a robust, transparent monitoring and evaluation framework is developed, with allocated responsibilities to key individuals or organisations is adopted for all 3 phases of NHI implementation.*

**Engaging managers and frontline workers in the process of implementation**

"Street-level bureaucrats are frontline workers in bureaucracies, e.g. nurses, who regularly interact directly with citizens in discharging their policy implementation duties and who have some discretion over which services are offered, how services are offered and the benefits and sanctions allocated to citizens" (Erasmus 2014). Previous research and experience in South Africa has shown that when frontline workers are not engaged with about the expectations of a new policy, that they can in fact act in manners that are either counter to that policy or detrimental to the policy. Examples include nurses' refusal to offer termination of pregnancy, when they were not consulted about their values in relation to offering such a service (Harries 2009); nurses rationing services when feeling overwhelmed by the sudden of offer of free care

in primary health care facilities (Walker 2004); health care managers having to make sense of community health worker policies, and acting on their own understanding after not having these policy explained to them, or even having seen them (Lehmann 2012). These examples highlight the importance of engaging with frontline workers, so as to ensure not only that they understand the new policy and what is expected of them, but that their needs and concerns related to service delivery are also considered and incorporated. Gilson et al, 2014, have shown that centrally led initiatives can lead to a lack of ownership and a sense of disempowerment by frontline workers. However, they also show the crucial role played by local area managers in mediating the implementation process, so that frontline workers are enabled to use their discretionary power in a way that strengths service delivery in line with the policy intentions (Gilson 2014).

***Recommendations***

*Currently, very little attention is given to the engagement of local area managers and frontline workers in the process of implementation. We recommend that this area requires a focused plan, so as to ensure that the policy as intended becomes the policy as delivered.*

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