Comments on the NHI Bill

28 November 2019

School of Public Health

We support the establishment of a predominately single tier health system with the introduction of an NHI fund to purchase care for all South Africans. We agree this is an important step towards ensuring all South Africans have access to quality health care.

However, we have serious concerns with the bill in its current form, and apparent process of implementation that is implied by the bill. Below, in the first section we set out our concerns about the immediate next steps, as well as our concerns about the design and operation of the fund – 'big picture issues'. In the second section, we provide a broader discussion of issues that will be important to think about as the reform moves forward. Our recommendations stem from evidence and experience of those at the coalface of service delivery and administration, our own research, as well as international evidence.[1-3]

SECTION ONE

Concerns about the immediate next steps

1. **The Bill – an inappropriate level of detail for statute of law.** We agree with recommendations by the organisation Section 27 that: a) the bill should simply include the necessary legislation to establish the fund, how it will be governed, and its purpose; b) the details of its operation should be in the regulations, rather than in the bill as they are now, in order to prevent the need for further legislative change in the future.
2. **Managing debate and uncertainty better as we chart the way forward.** However, the debate and the uncertainty that the bill has generated is due to the need to understand how the fund, and any associated reform will work. A more parsimonious bill will not meet this need. As a result, we recommend that the NDoH produces a series of comprehensive discussion documents providing greater detail of how the fund and other associated reforms will work, and how the transition will be managed. Once this discussion process has run its course, then any associated documents setting out legislative change or regulation, should be developed.
3. **A fund but no money.** The recent medium-term budget policy statement makes it clear there is only money to set up the fund, but not for its full establishment of the NHI system. However, what will this fund do without any money to purchase health care? We recommend that the bill be reconfigured to set up a fund that will have several different 'phases of life'. The purpose of the first phase (possibly 5 years) of the fund will be to do the detailed work required to properly manage the process of transition, under the guidance of the NDOH. This could include producing discussion papers on how, for example, the contracting will work, and possibly trying out some of the proposed strategies in different locations. The previous pilots were aimed at strengthening the public health system, rather than trying out strategic purchasing – this should be acknowledged. Even where contracting was included in the Phase 1 planning, it was unsuccessful and did not provide enough evidence on how this could and should be done nor did it sufficiently test purchasing mechanisms at

the lower levels as the project was mainly run from NDoH. The second phase of the fund's life will be to operate as health care purchaser.

Concerns regarding the design and operation of the fund

4. **Lack of clarity about the principles under which strategic purchasing will be implemented.** Contracting implies that the fund can contract with one provider for 5 years, and then decide that the provider didn't perform well enough, and so the fund terminates that contract and contracts with another provider. We are of the view that such an approach is inappropriate in health care, because it will lead to a significant loss of organizational and health care provision capacity that can take years to build up, and will lead to 'short-term' mentality among providers, because they don't know if they will be funded in the next 5 years. The 2017 White paper mentioned a continued, if reduced, flow of funds through provinces to providers, in addition to the payments from the fund. It is unclear whether this is still part of the plan. Private providers, who agree to contract with the fund, will also need some base funding (see discussion of global base payments – point 3d below.). We recommend that the discussion papers mentioned above provide greater clarity on this issue.
5. **Creating a vision for alternative models of care.** With undersupply of care in the public sector, and oversupply of care in the private sector, we recognise one objective of the NHI reform is to establish alternative reimbursement mechanisms (ARMs) (i.e. capitation and DRGs). The switch away from fee for service will encourage different models of care in the public and private sectors. The private sector needs to switch to models of care that are suited to larger volumes of patients, while maintaining quality of care. The public sector needs to be more efficient, by making use of digitization of health care to facilitate improvements as well as giving district level autonomy whilst reducing managerial level within provinces. It is these new models of care, improved accountability and effective use of data, which will assist in improving access to quality care for all South Africans, within the constraints of our limited resources. However, it seems that few health care providers understand the potential alternative models of care, or have a vision of how they could be implemented. We recommend that the discussion documents (mentioned above) stimulate discussion of different reimbursement mechanisms and their potential, in order to respond to the concerns about the future.
6. **The consequences of a financially unsustainable fund.** Given the country's constrained economic circumstances, the phasing in of the NHI is likely to be slower than stated in the bill. There is a danger that with expectations being high, the fund will overspend on its budget, threatening the fund's financial sustainability. A negative spiral has occurred in other lower- and middle-income countries (LMIC) where providers refuse to provide care to registered patients, because they are not reimbursed/or cannot rely on being reimbursed timeously, confidence is lost, and the fund falters. We recommend a longer time frame than that outlined in the bill, to allow for a more gradual phasing in and to build confidence amongst providers that the Fund will be able to reimburse at the agreed level and on time to ensure stability for them. The phasing in period should include the establishment of the information system necessary to measure outcomes.
7. **Governance - Learning from 'state capture'** Given the experience of state capture, it is inappropriate that so much power is in the hands of the position of minister of health. Spreading the responsibility among a broader range of structures (as is practical), with appointments being vetted

by independently appointed committees or parliament is important, as well as establishing processes for the removal of people whose performance is not appropriate. The reform is splitting the purchaser and provider roles, creating two 'arms' - a purchaser arm and a provider arm. The fund and its sub-national organisations (the CUPs) will be headed by the CEO. We recommend considering appointing a separate head of the provider arm, to whom the DHMOs will report, (or perhaps converting the role of the National DG for health into this position). This will leave the minister's position as an arbiter between the various organisations that have a governance role in the health system.

8. **A new vision of the role for NDOH: Governing a network of governance organisations, rather than governing directly** Steering a health system requires a network of organizations with different responsibilities. In South Africa this already includes Council of Medical Schemes, OHSC, and many others. However, these organisations need to be sufficiently independent to do their work without fear or favour. South Africa does not have a good track record of this. For example, the OHSC doesn't measure health outcomes (the key outcome) and the National Health Council has the ability to curtail the role, stifle reports, and decrease the number of indicators. Nor does OHSC have the funding it requires, which has slowed down its ability to assess facilities and make its recommendations. The NDOH needs to envisage a different role for itself – one in which it has oversight of a network of organisations that have specific roles in steering the health system. This oversight should include assessing the performance of these organisations against agreed deliverables and targets, and a transparent process to appoint and remove heads of non-performing organisations. Because the NDOH sees itself as responsible for the performance of the public health providers, it attempts to control, for example, public access to data that might portray the public health system in a poor light. This needs to change and the NDOH needs to see itself as steering the whole health system, with other organisations having specific, more direct roles in the performance of the health system.

SECTION TWO

In this section we discuss the following issues:

9. Purchasing structures, roles and relationships
10. Provider roles
11. Provider payment mechanisms
12. An accountability framework: The role of regulation
13. A balanced relationship between the provider and the purchaser
14. Building alliances: Alignment between national policy, the fund and the CUPs
15. The benefit package: Guidelines of cost-effective and affordable interventions
16. Membership of the fund
17. Community engagement and patient empowerment
18. NHI committees and external agencies
19. The interface between the health market inquiry findings and the NHI.

9. Purchasing structures, roles and relationships

a. Not repeating the existing fragmentation with new structures Some of the reasons for non-attainment of improved population health in South Africa relate to the existence of multiple administrative structures at sub-national level, operating in a fragmented way, with overlapping roles and dual or more lines of accountability, so decisions are delayed or not taken. The NHI provides an opportunity to streamline and strengthen health system oversight at sub-national levels, for improved accountability and efficiency. Clarity about who will do what, with which powers, is a critical part of this.

Despite careful reading of the bill, and drawing of several diagrams, we found it hard to understand the roles of the various organization in the new system.

b. Role of CUPs: Sections 37 and 58 state that contracting units for primary health care (CUP) will be directly contracted by the NHI Fund for the provision of PHC services (including the district hospital). This implies that the CUPs fall on the provider side of the purchaser-provider split. However, elsewhere it suggests the CUPs will oversee provision and commission or purchase services on behalf of the Fund – i.e. acting as agents of the fund. We assume the latter is what is envisaged, but greater clarity is needed.
c. Contracting role of CUPs: There is inconsistency in how the envisaged contractual arrangements are defined. For example, Section 39 notes the Fund will contract PHC providers directly for the provision of services, while Sections 35 and 37 indicate the Fund will contract directly with the CUPs for provision of services. If the Fund is contracting directly with providers and health establishments, the CUPs appear to be an additional layer of red tape. We assume the CUPs will be local agents of the fund, so that they are part of the same organization. If this is correct it needs to be clearer. We are of the view that CUPs should be at the district level – see point below.)
d. Ensuring performance from the CUPs: It would also be important to think through the incentives facing the CUPs, and their responsibilities to other parties, including the fund. In Nigeria, the regional contracting units were the local offices of the central fund. They had faced no penalties if payments weren't made, and there were often conflicts of interest with managers of the contracting units also being on the board of the central fund.[4]

10. Provider roles

a. Role of DHMOs: We welcome the focus on maintaining the health district as the foundation of the health system (Sections 36 and 58). We interpret the DHMO to be equivalent to the current district health management teams (DHMTs). We understand that the DHMO will account to the NDOH rather than PDOH. However, NDOH will now be overseeing 52 districts (instead of 9 provinces); we suggest that this task will require additional capacity at the NDOH.
b. Lack of clarity between DHMOs and CUP roles: We are concerned that the DHMOs and CUPs will seemingly have some overlapping roles in terms of coordinating the provision of personal PHC services. We recognize that the DHMOs roles and powers will be detailed in proposed amendments to the National Health Act (as outlined in section 58) and future Regulations to the NHI Bill. As these details are developed, there is need to clarify the respective roles and powers of DHMOs and CUPs as well as the relationships between them.

c. Role of private health establishments: The Bill indicates that the Fund will contract "health establishments" for the provision of care. However, it is left open to interpretation whether this includes contracting with private hospitals. The National Health Act definition of "health establishments" includes private hospitals. The NHI Bill states that private GPs will be eligible for contracting under the NHI Fund, but it is silent on whether or not private specialists and private health establishments (including hospitals) will be eligible for contracting with the NHI Fund. It needs to be clear whether private specialist services that fall within the NHI benefits package could be funded by the NHI.

d. Employment of doctors: For the new models of care to emerge, as discussed in point 1 above, it is crucial that health establishments, that are being reimbursed by a non-fee for service system, are able to employ doctors. We recommend that the HPCSA regulations on this are changed.

11. Provider Payment Mechanisms

a. **Which reimbursement mechanism will used to pay PHC providers?** The bill is unclear what reimbursement mechanism will be used to pay primary health care providers. (Section 35 refers to using DRGs for hospitals, and elsewhere, DRGs for reimbursing EMS. Section 35(3), which is about purchasing from PHC providers, states funds will be transferred to CUPs but does not specify the reimbursement mechanism. Capitation is mentioned only in Section 58 of the Bill, the schedule outlining proposed repeals and amendments of legislation affected by the Act. It reads as follows: "The Fund must transfer funds to the Contracting Units for Primary Heath Care guided by district health resource allocation formulae or capitation formulae prescribed by the Fund ….." (page 43 of NHI Bill)). Rather than being specific about the reimbursement mechanism, we suggest that the bill simply says that fee for service won't be used as a reimbursement mechanism.

b. **Who will carry the cost of switching to new models of care?** If the private providers are going to be willing to invest funds to develop new models of care that can cope with large volumes of patients, they need some certainty about how reimbursement will work and that they will be paid on time. Furthermore, in the early phases, we recommend including some 'set-up' costs in the capitation rate to allow the private sector GPs to reorganize from solo to group practices.

c. **Controlling overall expenditure.** We are of the view that a form of capitation and DRG-based payment are the most appropriate reimbursement mechanisms. Given the importance of controlling the overall expenditure, we assume the plan is to distribute available resources in proportion to care provided, keeping total expenditure in line with available resources, rather than setting reimbursement rate per service provided. (If this is not the case, once the funding runs out, the supply side of the health system will quickly collapse.)

d. **Global base payments with quality incentives = international best practice.** According to a recent systematic review, global base payments (a form of a bundled payment constructed at a higher level than individual conditions or treatments) with quality incentives and risk sharing to encourage quality care, cost-conscious behavior as well as coordinated care, are best practice internationally. [5] As Cattel et al says: "Any provider payment system will at least

consist of a base component that is not directly linked to providers' measured performance. The reason is that many aspects of value, such as well-coordinated care and many health outcomes, are difficult or impossible to measure and attribute."

12. An accountability framework: The role of regulation

a. An accountability framework. Given the aim of the regulatory framework to address multiple desired outcomes (health system responsiveness, equity of patient access and efficient resource use) the framework needs to be sufficiently broad, and recognize that purchasing occurs in an interconnected network of patients, provider and purchasers. Therefore, a regulatory system that is too narrowly focused on discrete elements of the purchasing system (e.g. contracts or payment mechanisms) or purely economic concerns (e.g. cost control) is unlikely to deliver balanced outcomes. **Therefore regulation needs to consider four domains[2]:**

i. that purchasers are accountable to patients through various mechanisms to provide information, facilitate participation in purchasing decisions, and set out rights and means of redress. Some, but not all of this is considered in the complaints and appeals process as set out in the bill. The proposed information platform of the fund (Section 40) seems to be a 'one-way street'. The fund will receive information from contracted providers and uses this for its own decision-making, but there is no mechanism for feeding back information to users about the performance (esp. quality) of the providers. Our current patient satisfaction surveys haven't led to change, so an additional mechanism is required. The HMI inquiry suggests an external organization responsible for collecting and reporting data on health outcomes (OMRO). This is an important activity and we recommend that OMRO is established as soon as possible.

ii. that purchasers are accountable to government for the efficient and equitable use of insurance premiums or taxpayers' money in the purchasing of healthcare services. We understand that the fund will be accountable to DoH and Parliament, and the fund's finances will be audited by the AG under the PFMA. (Sections 50 and 51) The same mechanisms are currently in place for holding ministers', CEOs of parastatals etc to account. The Bill has no additional checks and balances. This does not instill confidence. Ensuring effective accountability will require proper oversight by a component board. Further work should be done with the AGSA to determine audit measures that also look at health outcomes alongside finances. The current audit of patient files is a step but requires more interrogation to ensure the volume of services also matches the health status of the population.

iii. regulation should act to ensure fairness and transparency in the commissioning and contracting processes that take place between purchasers and providers. This is not clear in the bill. In Nigeria the lack of transparency and discussion with providers led to a lack of confidence in the central fund, and withdrawal of services by the providers.[4]

iv. regulation should focus on ensuring that providers are safe and competent to deliver healthcare of the required quality. We note this will be the responsibility of the Office of Health Standards Compliance. Several schemes in other countries have failed to invest sufficiently in the workforce necessary to carry out accreditation, leading to many unaccredited establishments continuing to receive funds. It is unclear how those public institutions who do not meet the minimum criteria will be dealt with. International experience suggest that accreditation should focus on ensuring a sustained quality improvement system is established in each health facility, and to put in place an incentive scheme with additional payments for progressing up a series of levels. (For example: step 1= risk identification system established; step2: quality assurance and quality improvement system established; Step 3: full certification and re-certification every 2-3 yeas). This may help reduce the number of uncertified facilities.[6] Moreover, accreditation should also include health outcomes.

b. Preventing fraud: DRG creep and defining what is complementary care. International evidence suggests that the regulatory framework ought to set out clear minimum standards and monitoring mechanisms, while also leaving some freedom from detailed oversight to encourage purchasers to innovate.[2] However, given the resources of the private sector, a different strategy might be needed in the SA context. For example, fraud investigation into DRG creep and defining what care is actually complementary (through a negative list of benefits, ie benefits that aren't covered by the fund), will be important activities. Several schemes in other countries have failed to invest sufficiently in these activities, leading to mis-use of funds.

c. Conflict between important goals: system responsiveness, equity and efficiency. It should be noted that a key challenge for purchasers is that system responsiveness, equity of access and resource efficiency might be in conflict with one another. For example, consolidation of a service in 1 main location to enhance cost effectiveness and increase quality is very likely to have an adverse impact on equity of access for patients living further away. Decisions aimed at improving provider performance will therefore require purchasers to make trade-offs. This needs to be taken into account in the relationship between purchasers and providers (See section 13)

13. A balanced relationship between providers and the purchaser

a. The literature identifies two factors that influence the response of providers to purchasing decisions, and therefore determine how these tradeoffs are expressed in practice. [2,3]
   i. Degree and types of autonomy. Autonomy could be in staffing, financial management, the scope of activities and capital investment. The rationale for autonomy is incentivizing innovative and efficient choices by giving providers the right to retain 'surplus' resources. However, there is potential for autonomy to create scope for opportunistic behavior (e.g. this might take the form of using fewer or less well qualified staff, only partially carrying out certain tasks, or choosing to focus on less risky and less costly treatments and categories of patients.) This trade-off is likely to be mitigated by

the balance of power between providers and purchasers (See next point below) (as well as embedded measures to pick up gaming and curtail this timeously).

ii. Creating a balanced relationship between providers and purchasers. Sanderson et al has the following to say:
- a provider's performance and its willingness to improve are significantly influenced by the prevailing balance of power and the dynamics of change in that balance over time.
- A dominant provider is likely to resist or subvert changes requested by a purchaser where the changes are perceived as damaging to its interests. For example, where a purchaser is seeking to improve the performance of a provider through, for example, information sharing and service redesign, evidence suggests that moves by the provider to create or maintain a position of dominance might create barriers to the desired improvement.
- Similarly, if a purchaser is seen as too powerful by smaller providers they are unlikely to want to share ideas for service improvement for fear that the purchaser will simply pirate those ideas and use them as part of a competitive tendering process involving other providers.
- Rather, purchaser-provider collaboration and the development of trust to support performance improvement is best incentivised by interdependence, a balanced and committed power structure.
- The broad lesson for policy-makers is that purchasers dealing with relatively autonomous providers need to be enabled to develop countervailing power (see next point) if they are to achieve interdependence.

b. A balanced relationship between the DHMOs and the CUPs This would suggest that the NHI should seek to foster collaborative relationships between the DHMO and the CUPs that support performance (rather than undermines it). As a result, the CUPs should probably be placed at district level, rather than the sub-district. However, the relationship between the DHMOs and private providers is unclear. Will private providers be able to become part of the DHMO cluster of service organisations?

14. Building alliances: Alignment between national policy, the fund and the CUPs.

a. The Bill highlights the use of explicit performance expectations which we support. Economic theory suggests that it is important to go beyond vague aspirations and use specific well-defined targets to ensure purchase activities lead to national policy objectives. However, experience in other countries suggests that, where explicit targets have been adopted, implementation has been mixed. International evidence suggests the following:

i. While stretching targets can encourage improvement, care needs to be taken to ensure that targets are technically realistic and culturally legitimate to enable implementation and avoid demotivation of purchasers. We have seen in the current system how unrealistic targets have created a situation where planning is not viewed as valuable by many with the services.

ii. The development of targets needs to be transparent and evidence-based to assist in measurement and funding allocation needs to be matched to the targets to ensure there are sufficient resources to attain them.
iii. Targets need to be integrated into performance management contracts alongside appropriate payment incentives to ensure implementation. Some form of value-based care contract is likely the most appropriate mechanism to ensure quality. Scott et al have conducted the most recent systematic review on value-based health care.[7] Please see section 6d on the global base payments above for the most recent developments in value-based health care.
iv. In practice, this means that government imposition of top-down national targets is likely to disenfranchise healthcare purchasers, stifle innovation and potentially provoke resistance at a local level. Evidence suggests that national development of targets blended with local input is likely to prove more effective.

b. These points suggest that a key element of stewardship is likely to involve building alliances between the NDoH responsible for overall health strategy and the NHI fund, and between the CUPs and the DHMOs, will be important, to find ways of achieving a consensus that aligns national policy objectives with potentially competing local interests

15. The benefit package: guidelines of cost-effective and affordable interventions

a. As mentioned above, presumably DRGs and capitation will be used in such a way to contain overall expenditure, keeping expenditure with the available resource envelope.
b. We recommend that accreditation, performance contracts with reimbursement payments linked to quality outcomes, and treatment guidelines should work together to ensure adequate services are provided and improvements in the quality of care occur over time.
c. We do not think that a detailed a detailed list of services to be covered will assist in ensuring quality care. Instead, we recommend that a negative list of services be provided to define complementary care, as Thailand has done.
d. We are of the view that detailed treatment guidelines (mentioned in section 25), which are based on available evidence about the most effective and cost-effective interventions, should guide care. It is important that these guidelines only contain cost-effective, and affordable interventions.
e. We wish to point out that specification of a detailed benefits package may lead to legal challenges by patients when they don't receive the benefits to which they are entitled. The health system is carrying an enormous weight of medio-legal challenges and associated cost due to negligence. (It is important that this latter system moves from a fault-based to a no-fault system, to reduce the costs as soon as possible.) It would add considerably to this burden if the fund were to face legal challenges when specified benefits are not provided. If a list of services is developed, communication to the public will not be sufficient to fend off legal cases. If lawyers think that a person has a case, they will encourage the person to file a legal suit against the government.
f. Rather, we see it as important to build the capacity to change decisions as to what care is provided. For example, it should be possible to pay fee for service for individual important

procedures, where there is a wide spread need, the intervention is affordable, and the close-ended payment (such as capitation) is leading to undersupply. The Health Technology Agency's contribution will be important in making such decisions, based on cost-effectiveness of the intervention, as well as the health needs.

g. While the Bill mentions health promotion and prevention, as a cornerstone to a healthy population, it requires a greater focus. Much of the bill is focused on paying for curative care, rather ensuring strategic level health promotion take place. Within the bill, health promotion activities are placed at a community level (and mostly on the shoulders of community health workers) without a concerted effort to establish population wide measures for health promotion and disease prevention. We recommend the establishment of a Health Promotion Foundation which will be responsible for population and policy level measures to address the quadruple burden of diseases in South Africa. It is worth noting that the health promotion foundation would use policy and other levers to influence change often outside of the health delivery system on an inter-departmental basis across government

16. Membership of the fund: Internal, South African, migrants

a. South Africa has a population that is in constant flux internally with many people living and working in different areas. This brings to the fore concerns about user registration and the possibility of users being denied access to healthcare (or penalized for by-passing the referral system) if they seek care at a facility where they have not been registered. A robust system for authorization of care at facilities will be needed whereby genuine need is recognized and accounted for but simultaneously attempts at fraud are kept at bay. It is likely that this will be an electronic system, presumably the Health Patient Registration System, that is currently being rolled out.

b. We note that within the education sector, a landmark case has been heard against the DBE and DHA to determine whether undocumented children are entitled to schooling (couldn't be removed from schooling); the ruling may have implications for the health sector. https://www.dailymaverick.co.za/article/2019-09-19-getchildrenintoschool-landmark-education-case-will-have-an-impact-on-undocumented-learners/

17. Community engagement and patient empowerment

a. As the academic community, we are pleased to have been privy to many engagements by the Department of Health and other interested parties on the NHI but have noted that important parties such as communities and frontline healthcare workers have not been afforded the same opportunity. Furthermore, this lends itself to the mistrust and erroneous messages that have plagued the NHI narrative. We see this as a missed opportunity to practice true community engagement with users and providers, whose buy-in is essential to a successful NHI.

b. Patient empowerment such that the health system can be responsive to their needs is important. There are four policy avenues through which patients can be empowered:

i. Assessment of population needs at an aggregate level – we understand that this will done by the CUPs
ii. Purchaser consultation with patients to better understand patient views regarding purchasing priorities – we see no mechanism for this within the bill
iii. Mechanisms to ensure that purchasers are accountable to patients – we note that are complaint and appeals procedures are included. See discussion under point 7.b.i
iv. Increasing patients' choice of providers – there is no mention of how often a patient will be able to change the PHC provider where they are registered. We presume this will be part of the regulations.

18. NHI Committees vs. External Agencies

a. While we appreciate that there are numerous committees under the fund, we would argue that some functions need to be carried out by independent entities. This includes strategic level activities for health promotion and prevention by a Health Promotion Foundation as in Thailand.
b. It is important that an independent entity review the effectiveness, cost-effectiveness and impact of different health interventions. This will not only provide the necessary information for the fund to be able to decide what care is affordable and what is not but will also lend credibility and outside validation to the decisions made by the DOH and NHI Fund.
c. We therefore welcome the inclusion of a Health Technology Agency (HTA) in the bill. However, the scope of HTA should not be limited only to assessment of medicines and devices, but for the purposes of NHI should encompass all interventions for health promotion, disease prevention, diagnosis, treatment and rehabilitation, in the true manner of HTA.
d. The Bill and supporting NHI documentation have mentioned several external agencies, such as NAPHISA, the OHSC, an HTA etc. It will be important that each agency has a clear mandate that does not overlap with each other, nor with the roles of the NDoH, DHMOS or CUPS.

19. The interface between the health market inquiry findings and the NHI.

a. The HMI report recommends the establishment of the Outcomes Measurement and Reporting Organization (OMRO), and the Supply Side Health Regulator (SSHR). These two organisations will lead to improvements in care in both the public and private sectors and we recommend that they should be implemented as soon as possible.
b. The HMI report recommends three key elements to fully regulate the private funder and provider environment, namely a single common benefit package, a risk adjustment mechanism (RAM), and price negotiation forum. While it would be beneficial to regulate the private sector properly, there are several issues that need to be considered.
    i. The HMI report recommends using the same package as that proposed for NHI. However, we recommended above that a detailed package isn't specified by

government. This would mean that the private sector would have to agree to a single common package by themselves. This is unlikely.

ii. The private funding industry has made no attempt to enable cross-subsidisation, rather it has segmented the market, enabling differential pricing as an alternative to risk rating. It is highly unlikely the industry will be able to collaborate sufficiently to establish a RAM, without government intervention. If the government did establish a RAM, and the private funder industry was viewed as being 'reformed', there might be pressure to merge the RAM with the NHI fund. This might lead to a half-baked system with fragmented funding pools, in which the funder industry has inappropriate levels of influence. This should be avoided.

iii. The single package and the RAM are necessary pre-conditions to level the playing field so that the private sector stakeholders are able to start price negotiations. Without these two first components the private sector is unable to set up the fund itself.

c. It is the Government's responsibility to regulate the private sector, and it has failed in this responsibility. Given the limited capacity at the NDOH, and the difficulty of achieving the desired outcomes through regulation, particularly of a large and well-resourced private sector, it seems likely that the NDOH will able to achieve reform the sector as a whole, and regulate the private sector, without additional resources. We recommend that the purpose of first phase of the fund is used to manage the transition, and sufficient additional resources be given to the NDOH to enable effective regulation of the private sector, including establishing the new regulatory bodies and strengthening the existing ones, and as well as steer the establishment of the fund and associated reform.

These comments have been complied by Jane Goudge, Mary Kawonga, Atiya Mosam, and Jodi Wishnia on behalf of the School of Public Health, University of the Witwatersrand. If you wish to discuss any of the issues, please contact Jane Goudge (jane.goudge@gmail.com; 083-616-0041)

References

1. Mathauer I, Dale E, Meessen B. Strategic purchasing for Universal Health Coverage: key policy issues and questions. A summary from expert and practitioners' discussions. Geneva: World Health Organization, 2017.
2. Sanderson J, Lonsdale C, Mannion R. What's Needed to Develop Strategic Purchasing in Healthcare? Policy Lessons from a Realist Review. *International journal of health policy and management* 2019; **8**(1): 4-17.
3. Hanson K, Barasa E, Honda A, Panichkriangkrai W, Patcharanarumol W. Strategic Purchasing: The Neglected Health Financing Function for Pursuing Universal Health Coverage in Low-and Middle-Income Countries Comment on "What's Needed to Develop Strategic Purchasing in Healthcare? Policy Lessons from a Realist Review". *International journal of health policy and management* 2019; **8**(8): 501-4.
4. Etiaba E, Onwujekwe O, Honda A, Ibe O, Uzochukwu B, Hanson K. Strategic purchasing for universal health coverage: examining the purchaser-provider relationship within a social health insurance scheme in Nigeria. *BMJ global health* 2018; **3**(5): e000917.

5. Cattel D, Eijkenaar F. Value-Based Provider Payment Initiatives Combining Global Payments With Explicit Quality Incentives: A Systematic Review. *Medical care research and review : MCRR* 2019: 1077558719856775.
6. Tangcharoensathien V, Limwattananon S, Patcharanarumol W, Thammatacharee J, Jongudomsuk P, Sirilak S. Achieving universal health coverage goals in Thailand: the vital role of strategic purchasing. *Health policy and planning* 2015; **30**(9): 1152-61.
7. Scott A, Liu M, Yong J. Financial Incentives to Encourage Value-Based Health Care. *Medical care research and review : MCRR* 2018; **75**(1): 3-32.