Strategic Purchasing Policy Brief Series

Brief 1: Implementation of a purchaser-provider split

About this series

National Health Insurance (NHI) refers to a wide-ranging set of reforms of the South African healthcare system, including the establishment of the NHI Fund as a new entity tasked with the *strategic purchasing* of healthcare.

The broad aim of the NHI reforms is to achieve universal health coverage (UHC) in South Africa. UHC offers "all individuals and communities the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. UHC emphasizes not only what services are covered, but also how they are funded, managed, and delivered" (World Health Organization 2019).

Much of the discussion in South Africa on how we achieve these aims has been divisive and polarised. For many, it is difficult to engage in the debates meaningfully without understanding the jargon and myriad of complex concepts. In support of meaningful discourse, we offer this series of briefs to deepen public awareness and enrich discussions on one particular aspect of the proposed reforms: the notion of strategic purchasing. What is strategic purchasing? Who will do the purchasing? How do we hold the purchaser(s) accountable?

The providers of healthcare services, both public and private, are important stakeholders in a healthcare system. The ways in which the proposed reforms are likely to impact on providers is an often-neglected perspective, one which we hope to consider here.

Seven briefs explore what a purchaser-provider split in a healthcare system is, what strategic purchasing is, the nuances of matching the need for care with the supply of services, how to ensure quality and access and how to balance all this with affordability.

At the time of writing these briefs, NHI as a concept was informed by the framework as set out in the draft NHI Bill (2019) which was preceded by a previous draft version of the Bill (2018), two White Papers (2015 and 2017) and a Green (Policy) Paper (2011).

This work was funded by the Hospital Association of South Africa, although the views presented here are the authors' own.

In this brief...

South Africa has been bruised by the capture, corruption and failure of large State institutions. It is therefore not unexpected that there is wide-spread cynicism about the creation of a new entity of unprecedented size to purchase healthcare services. The idea of a gargantuan single purchaser of health services has faced resistance from across the political spectrum. The intricacies of how a single purchaser would work, and the implications for providers and the health system at large will likely only unfold over time. We aim to provide an overview of the possibilities, strengths and implementation challenges of a single purchaser system.

The creation of the NHI Fund is predicated on two ideas: the need to create a purchaser-provider split in the healthcare system, and that a single purchaser is the best way to achieve cost efficiency and improved quality of care. In order to engage with questions of accountability, governance and the ability of the Fund to drive improved healthcare outcomes for South Africa, we need to take a step back and understand the roles of purchasers and providers of healthcare and explore the benefits and challenges of separating these roles.

Understanding the functions of a health system

The most widely-used conceptual outline of the various functions within a healthcare system is the framework proposed by Joseph Kutzin (Kutzin 2001). Kutzin distinguishes between four key areas: **revenue collection, pooling, service delivery and purchasing**. Below, we detail each area and its application under South Africa's NHI.

Revenue collection refers to the way in which a health system is funded. Examples include general taxation, taxes that are directed specifically to health and household/employer contributions to health insurance. **Pooling** refers to the accumulation of money for healthcare for a specific population, such that the contribution by a specific household is not necessarily equal to their expenditure. Money can be accumulated in government departments, funding vehicles such as medical schemes or a new entity like the NHI Fund. Pooling offers the benefits of pre-funding, and the engineering of income and risk cross-subsidies (i.e. between healthy and sick, young and old).

> **"Where the economy is in recession and the level and growth of the proportion of the population in formal sector employment is low, it is difficult to impose or increase taxes for health care and these may have harmful effects on [...] economic growth." Kutzin (2001)**

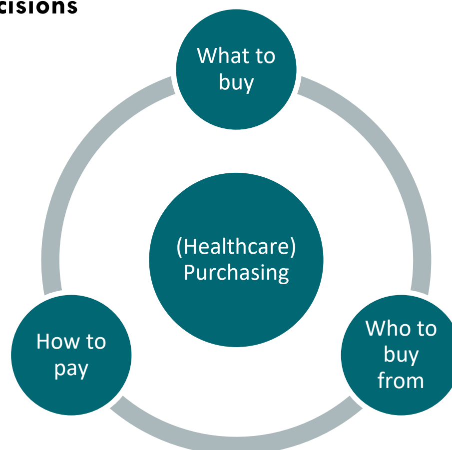
The combination of revenue collection and pooling is important in a health system because of the overarching principle of equity. In South Africa, we already have a public service that is free for those who cannot afford to contribute, which means that the Government has already made a commitment to ensure a minimum level of access to healthcare for all. Social solidarity principles would mean that revenue collection is based on the ability to pay (i.e. the wealthier pay more), and allocations from the pool are based on healthcare needs (i.e.

the sicker receive more), within the limits of the available budget. Pooling occurs in relation to a common or core package of benefits that everyone in the pool is entitled to, irrespective of ability to pay.

Service delivery is the easiest part of the health system to understand. The service delivery function is performed by all the entities that provide healthcare goods and services. These include doctors, nurses, traditional healers, allied health professionals, pharmacies and healthcare facilities like hospitals. The entities are referred to as **providers** and can be either public or private.

The **purchasing** function in a healthcare system is about deciding how to allocate money from the pool to providers of care. This means deciding what services to purchase for which client[1], and how to pay for them. The terms purchaser and payer are sometimes used interchangeably, although it is possible to separate payment and purchasing functions. Our focus is on the concept of a purchaser because it is more strategic in nature. The term payer de-emphasises the need for explicit thought to be given to questions of what to purchase, from whom and on what terms.

Fig1: Aspects of purchasing decisions



Application of healthcare functions in the South African healthcare setting

All of these concepts can be better understood by considering the current structure of the public and private health sectors in South Africa.

In the private sector, medical schemes (and to a lesser extent, health insurers) collect contributions from households and employers (revenue collection) and accumulate these contributions (pooling). There is effectively

[1] The term client is used instead of patient, because not all users of a healthcare system are ill. The envisaged health system encompasses preventative care, family planning and other services for those who are well. The term client is preferred to the term user as it more strongly signals the centrality of those receiving services in the system (as opposed to being passive recipients of care).

also a contribution from government to private medical scheme cover because taxpayers are entitled to a tax credit to offset their medical scheme contributions. The allocation of funds to providers (purchasing) is often done by companies providing services to medical schemes, namely administrators and manged care organisations. Purchasing decisions are made based on a combination of medical scheme benefits (**package of services**), clinical eligibility (matching clinical conditions with the care required) and administrative rules that ensure appropriate gatekeeping and referral. **The providers are therefore separate to the purchaser: in effect, the private sector has a purchaser- provider split.**

In the public health system, Government collects revenue from general taxes. National Treasury allocates funding to the provinces, and the provincial treasuries then allocate funding to provincial departments of health, who in turn make allocations to districts. The risk of higher-than-expected need for care is therefore decentralised, and resource allocation is not equitable across the country.

Both the current public and private health systems are fragmented in terms of the pooling of funds: each medical scheme functions as a pool in the private sector, and each province (and to some extent each district) functions as a pool in the public sector. Reducing the number of pools should improve equity because of the ability to better balance between the needs of the population (i.e. ensuring the risk and income cross subsidies are consistent and equitable). There are, however, other ways to achieve this other than creating a single pool of funds. Income cross-subsidisation can be done at the revenue collection stage, resource allocation to sub-pools can be done on the basis of the needs of the population covered by the pool and retrospective adjustments can made for higher than expected need. The technical methods used to balance resources between sub-pools are referred to as virtual pooling, risk-equalisation and/or reinsurance and have been used successfully in systems such as the Netherlands.

The provincial department of health (PDoH) allocates the funding according to budget programmes and levels of care (i.e. clinics, hospitals, etc.) and services are provided by the PDoH. **In the public sector the purchaser and the provider are the same entity.**

Linked to the current fragmentation of risk pools, purchasing ***decisions*** are currently made by many entities in South Africa. In the private sector, decisions are made by medical schemes, their administrators and their managed care companies. Public sector purchasing decisions are made by National government, Provincial government, districts and sometimes by individual facilities if they are given autonomy over their allocated budget. Therefore, neither sector is achieving the most co-ordinated, equitable or efficient purchasing of services.

A large number of purchasers with little co-ordination can lead to inefficiency and inequity. A single purchaser can lead to complacency and a lack of responsiveness.

Elements of a purchaser-provider split

There are a range of theoretical reasons to introduce a purchaser-provider split into the South African public sector, such as the closely-linked objectives of **controlling healthcare costs**, increased **provider accountability**, increased efficiency through **competition** and the extension of **access** to private sector providers.

Creating a purchaser-provider split is insufficient to effect change in the health system. A purchaser also needs to be **strategic**, defining the service-mix and volume, and selecting the provider-mix in order to maximise health outcomes. The purchaser or purchasers also need to **purchase responsibly**, ensuring the long-term sustainability of the provision of care. For example, the recent collapse of midwife services in parts of the UK has been attributed to unsustainable purchasing of these services[2].

There are also theoretical arguments to support the critical mass of a centralised purchaser. A single purchaser allows for funds to be leveraged for greatest health impact, rather than the current segmented environment, which has duplication and inefficiencies. The creation of a purchaser-provider split does not automatically imply a single purchaser, hence the arguments for and against a single purchaser need to be considered separately.

The purchaser-provider split: The purchaser

The NHI Fund is intended to function as a **risk pool, a purchaser and single payer** of a comprehensive package of healthcare services on behalf of all South Africans under the NHI. The idea is to centralise the pooling of public healthcare funds, the design of the benefit package and the basis of payment to healthcare providers and in that way, **bring down the cost of healthcare, and improve the quality of care,** through more strategic purchasing and economies of scale.

It is intended that the Fund will contract directly with health facilities and providers (both public and private) who meet the criteria and are willing to service the NHI population. However, for primary healthcare services, the Fund will purchase from newly created entities known as Contracting Units for Primary Healthcare Services (CUPs), which are tasked with the contracting of primary care at the district level. Their role involves identifying the health needs of the local population, together with identifying, paying and monitoring providers at a local level. The primary healthcare set up is different, given the recognition that a decentralised entity, that is closer to the population in need, would be better positioned to make some of the purchasing decisions that help to maintain and improve population health, resulting in lesser health costs down the line.

[2] https://www.bbc.com/news/health-49170278

This consolidation of money creates concern about corruption and governance. The scale of the NHI Fund as a single entity would be unprecedented in South Africa.

The establishment of the NHI Fund as a single payer creates a monopsony, a situation in which one entity has market power by virtue of its control of the purchasing of services[3]. In any market, the creation of a monopsony is of concern for those providing services as their autonomy and negotiating power is dramatically diminished. The risks of poor decision-making, bureaucratic processes and failure to pay are all magnified from the provider perspective.

A strong central purchaser may be able to more effectively control costs, assuming that they are sufficiently motivated to do so. There are some aspects of the health system which clearly benefit from the economies of scale of central purchasing (for example, the public procurement of medicines which already takes place). However, there are other aspects of the health system where local relevance and responsiveness are more important than scale. The benefits of centralising purchasing functions for efficiency must be weighed against the sacrifice of local relevance. The creation of CUPs should ensure responsiveness to local community needs for primary healthcare, at least, assuming they are appropriately capacitated and supported.

The purchaser-provider split: effects on the provider market

Below we detail the theoretical benefits of a purchaser-provider split in light of the objectives of **provider accountability** and increased efficiency through **competition** between providers and the extension of **access** to private sector providers.

Provider accountability

A key question is whether the promise of increased accountability is sufficient to convince South Africans to accept the risks associated with creating a large new State entity.

Accountability is expected to increase as a consequence of a more arms-length contracting relationship between the purchaser (the NHI fund) and providers of care (for example, individual facilities and CUPs). There are a range of ways in which the purchaser can drive accountability. For example, the purchaser can put in place requirements, such as minimum quality standards, that providers have to meet in order to be contracted (ideally accompanied by mechanisms for driving quality improvement in those facilities that do not meet the standards). The purchaser can also pay providers based on the

[3] This does not mean that medical schemes and health insurers will cease to exist, but it seems likely that they will be limited to covering benefits not covered by the NHI Fund (so-called complementary benefits). However, exactly how those dividing lines will be determined remains unclear; this is one of the key features on which the private healthcare market in South Africa is currently seeking clarity from policymakers.

quality of care delivered, by using health outcome data to measure impact. Both of these concepts are articulated in the draft NHI Bill (National Department of Health 2019) at a conceptual level. A single purchaser is not enough to change incentives; attention must be paid to **how** providers are **contracted, how** the purchaser **measures** their performance, and **how** the purchaser **addresses poor performance**.

Increased accountability is a laudable goal for the South African health system where crises like Life Esidemeni highlight gross accountability failures. The journey towards increased accountability is however likely to be over some considerable period of time. Much of the debate has focussed on the governance and accountability of the Fund itself, however, it is as important to consider how the Fund will effect accountability throughout the health system.

Accountability strengthening will require a change management process for all system stakeholders, including providers, managers, health workers and unions, and will require some structural changes, too. Feedback mechanisms also need to not only be put in place, but the feedback used to guide corrective actions, to ensure that bottom-up accountability measures are developed over time. Driving accountability through a purchaser is a 'top-down' approach as opposed to a bottom-up approach where clients are empowered to demand quality care from providers. Ideally, you would want both mechanisms in place. An over-reliance of top-down approaches erodes sensitivity to the client voice, their autonomy and their dignity.

A central purchaser can use alternative reimbursement mechanisms (ARMs) such as capitation and diagnostic related groupers (DRGs), which will be explained in later briefs, to improve equity in the health system, ensuring that resources are allocated on the basis of patient needs. ARMs require a re-organisation of how services are delivered and managed – the time, resources and impact of this should not be under-estimated. ARMs will be challenging to implement in practice, especially in those parts of the system that have previously been managed using a dedicated budget. The transition to ARMs could be smoothed by allocating at least some of the funding in the form of a centrally allocated budget (at least for the initial period), and by giving providers funding that is sufficiently sensitive to local population needs.

The draft NHI legislation provides for outcomes-based payment – in other words, paying healthcare providers to provide quality care. This means using ARMs to deliberately incentivise quality improvement. This means that providers have to measure and report on health outcomes (which in and of themselves are difficult to define and measure) for each patient. The time and resources required for both public and private providers to adapt to new requirements (for example, re-organising to work in multi-disciplinary teams) are important considerations – this requires an approach that is sensitive to the provider perspective, recognising that the

Outcomes-based payment requires trust between the purchaser and providers, clear contracting, credible and timely data, ongoing monitoring and evaluation relative to expectations and assertive people management.

public and private sectors will differ in terms of both the adaptations required and the ability to adapt.

A risk of a purchaser applying too much control is that providers feel hamstrung and unable to innovate or meet their clients' needs effectively. Therefore, contracting needs to be sufficiently flexible to allow providers to apply clinical judgement and to be innovative, while also being specific enough to maintain a minimum set of norms and standards to safeguard quality and control costs. Contracting approaches are likely to evolve over time in an attempt to strike this tricky balance.

Efficiency gains through increased competition

A purchaser-provider split may facilitate increased competition between health providers in order to secure funds from the purchaser. The idea is that this increased competition drives innovation and improves **efficiency** in delivering healthcare.

Much of the draw of a purchaser-provider split relies on the effects of competition to incentivise quality and bring down prices. However, even in high-income countries like England, where there is a long-standing purchaser-provider split, there has not always been enough providers in each regional area for these competitive mechanisms to be a key driver of efficiency. This is likely to be exacerbated in South Africa where there are shortages of healthcare resources in many geographic areas, even if contracting from both sectors. More attention will have to be given to ensuring quality in rural or vulnerable areas.

If strong price ceilings or administered prices apply (as is likely under NHI), providers are unable to compete on price. Economic theory tells us that providers are then more likely to compete on quality under these circumstances, assuming that the prices are adequate (Gaynor, Ho, and Town 2015). There is a risk, however, that if quality measures are not pushed and enforced by the Fund, some of the competition may occur on less important dimensions of healthcare, e.g. "hotel" aspects of healthcare provision such as beautiful rooms or buildings- which is not an indicator of efficiency or effectiveness of the care received but could impact on clients' willingness to seek healthcare.

Access to private sector resources

A key effect of the purchaser-provider split in the South African context is that it enables the NHI Fund to purchase healthcare goods and services from private healthcare providers in a way that is more flexible than under current procurement rules. For example, currently the public sector would need to enter into individual contracts with providers if they wanted to contract services from the private sector. The ability to purchase from both sectors is referred to as pluralistic purchasing.

Given the resources such as hospital beds and medical specialists in the private sector, this ability to purchase care from private providers would improve access (Dell and Kahn 2017), leveraging these resources for the

population as a whole. However, the NHI Bill focuses on purchasing primary care from private providers and is largely silent on the possibilities of enabling access to private hospitals and specialists.

Ultimately, it is hoped that a purchaser-provider split, if implemented effectively, will lead to improved **access** to quality care, not only through competition and accountability, but also by enabling Government to contract with a wider range of providers.

The ability to achieve this rests to a large extent on building trust between the State and private providers, a process which should begin ahead of NHI implementation. Private providers currently contract with multiple purchasers and are understandably nervous of engaging with a single purchaser as they become dependent on that purchaser being rational, fair and effective. Furthermore, past experience of the NDoH on contracting has not been positive, and trust will need to be re-established to attract sufficient private providers into the NHI service.

NHI holds the potential of simpler pricing and mechanisms for contracting. However, for some providers the accreditation criteria and data collection requirements that will be imposed could lead to an increase in their administrative burden.

Ultimately, we may see competition between public and private providers, vying for contracts from the Fund, which could lead to innovation and improvements in the quality of care. A fair-playing field in terms of prices across the two sectors is an important consideration to ensure that competition is possible between the two sectors. Private providers are subject to different cost and financial structures as compared to public providers, for example, value added tax (VAT) applies, there is a need to realise a return on capital and, at present, there are different rules relating to employment structures.

The notion of competition across the two sectors is politically loaded: private providers are likely to be concerned about the risk of political pressure to protect public providers from competition from the private sector whilst public providers are likely to be concerned about the diversion of funds to private providers. There is a question of equity, presuming a quality differential between public and private providers: which patients will access private providers, and which patients will access public providers? The Bill is largely silent on principles to guide the allocation of funds across sectors.

Conclusion

Creating a purchaser-provider split makes the role of the purchaser in the health system more explicit, and more distinct from the provision of services. Theoretically, it also means that providers will also be allowed to focus on patient care, with less financial administration. On the other hand, it is likely to be challenging to introduce a strategic purchasing mentality into a health system which has historically been highly bureaucratic (Kutzin 2001).

Although much of the detail of the NHI reforms remains to be clarified, it is clear that the NHI Fund will centralise many of the functions currently performed by the PDoHs in the public sector, resulting in extensive organisational change. It is not yet clear exactly how the role of the provinces will change, but it does seem clear that they will at least lose control of their current purchasing power – shifting their role primarily to the provision of services. The extent and pragmatic implications of decentralisation of the provision of services has been under-explored in the public discourse: will each facility need to bill and collect funds, what are the facility-level consequences of funding following the patient, what mechanisms will facilities have to deal with under-funding, at what entity level will staff be employed, how much procurement flexibility will individual facilities have? This **political restructuring** is an important and potentially contentious aspect of implementation. The questions for private providers are different, but equally far-reaching.

The rationale of the purchaser-provider split does offer hope of improving and sustaining access to quality, affordable healthcare. However, in order for the change to be effective we will need to address the significant economic, organisational and measurement challenges. In Sweden it has been found that the most effective implementation of a purchaser-provider split was in those regions that moved beyond formal agreements and competition, to dialogue and consultation to shape the future of healthcare (Siverbo 2004). **Co-operation and trust were found to be important qualities in the creation of a purchaser-provider split.** Given the trust deficits in the South African health system, the process of building trust cannot begin too soon and will be critical for the success of NHI.

The creation of a new State entity of unprecedented scale is likely to be resisted from many quarters – ranging from those concerned about State efficiency to those concerned about the diversion of funds away from service delivery. Much will need to be done to assure South Africans that the NHI Fund will be **well-governed, accountable and responsive** to the needs of South Africans. This, in turn, raises the question of competition between purchasers, as opposed to a single purchaser – the idea being that competition would ensure that purchasers do not become complacent. The creation of such a large single entity raises material risks of inefficiency and the potential for corruption, due to poor governance structures. These risks must be energetically monitored and controlled for. This is especially pressing given that the Fund is proposed to be within the ambit of the Minister of Health, meaning the Minister has oversight of both the purchaser and provider function- blurring the split and potentially reducing its value.

We conclude by reiterating that the establishment of a purchaser-provider split is not the end. It is a means to an end and only the beginning of a long-term reform process, where the end is the provision of high-quality care, at an affordable cost. Therefore, issues of prices, contracting mechanisms, access, accountability and governance still require thought and continual action even under a purchaser-provider split.

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