Strategic Purchasing Policy Brief Series

Brief 2: What is strategic purchasing?

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.

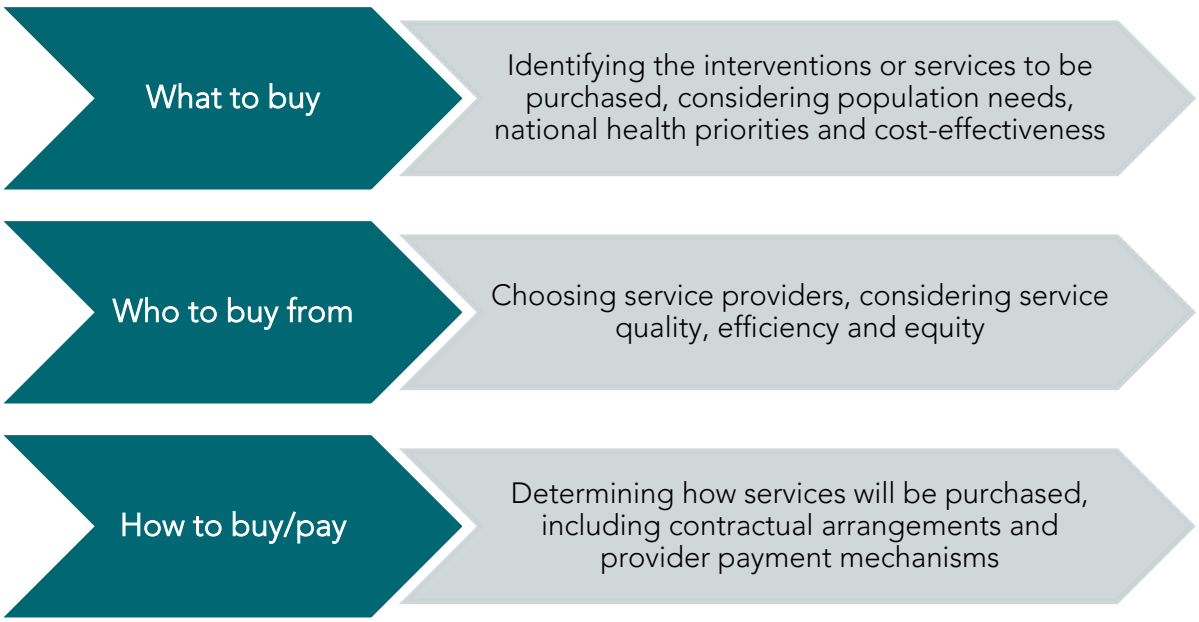
At the time of writing these briefs, NHI as a concept was informed by the framework as set out in the draft NHI Bill (2019) which was preceded by a previous draft version of the Bill (2018), two White Papers (2015 and 2017) and a Green (Policy) Paper (2011).

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

Introducing strategic purchasing

The first brief in this series discussed the roles of a purchaser and provider in health systems and the case for separating these functions. Part of the rationale for a purchaser-provider split is to generate greater accountability and quality of care by leveraging the purchasing function.

Healthcare purchasing is the process whereby an entity allocates pooled funds to healthcare providers, excluding situations in which individual clients do the purchasing on their own care (Klasa, Greer, and Ginneken 2018). It involves three sets of decisions (Honda, Ayako; McIntyre 2016):



Passive purchasing is where decisions are largely based on the budget available and what was bought in previous years. Purchasing becomes more active and ***strategic*** when it incorporates factors such as population needs, quality, evidence, efficiency, and a concern for equity and population health (Klasa, Greer, and Ginneken 2018). There is a continuum from passive to more strategic purchasing, characterised by a greater correlation between provider payment and the delivery of quality healthcare that meets population needs.

Klasa *et al*. (2018) propose that strategic purchasing should address population health needs, empower citizens, strengthen government stewardship and capacity, develop effective purchaser and provider organisations and incorporate cost-effective contracting. All of these are complex and multi-dimensional goals to achieve.

While strategic purchasing of healthcare services is widely recommended as a policy instrument, there are still many questions and issues about its implementation (Klasa *et al*., 2018). Therefore, analysing the specific country's context and capacity is an important step for designing strategic purchasing.

Purchasing and competition in South Africa's healthcare system

Van de Ven *et al.* (1994) characterised healthcare systems from a competition perspective along three dimensions:

1. Whether there is competition between **purchasers** of care;
2. Whether there is competition between **providers** of care; and
3. The extent of the **integration** between purchasers and providers (ranging from reimbursement, which is the most hands off, to more integrated contracting).

The South African private sector is best described by the Van de Ven framework as a "competitive reimbursement model" (van de Ven et al. 1994) . This means that the structure of the sector assumes competition between purchasers (medical schemes) and competition between providers of care (e.g. doctor practices). There is also a purchaser-provider split, with the funder industry (medical schemes, administrators and managed care organisations) playing the role of purchaser.

This is not to say that these are perfectly competitive markets, nor that purchasing is done optimally. There are questions about both the extent and nature of competition. The factors impeding competition are multi-faceted and complex: the sector has been subject to a contentious multi-year process of inquiry into its competitive dynamics (Competition Commission South Africa 2019). Whilst some of these factors relate to market structure and concentration (for both providers and funders), there are also regulatory constraints. For example, incomplete medical scheme regulation mean that funders are not incentivised to compete solely on service levels and their ability to purchase based on quality and efficiency[1]. Regulation of health care providers is also flawed. For example, the Health Professions Council of South Africa (HPCSA) has been criticised for rules that inhibit innovation in how health care services are delivered.

Whilst the sector has historically been described as purchasing on a passive basis, there are indications of an increase in strategic purchasing efforts with the introduction of more alternative reimbursement models, more preferred providers networks and the gradual emergence of value-based approaches.

The public sector, by contrast is described as a "monopolistic integrated model" with no competition between purchasers, no competition between providers and no purchaser-provider split (i.e. an integrated system).

[1] This relates to the non-implementation of a risk-equalisation fund to limit the impact on the financial performance of individual medical of the profile of their risk pool. This is achieved through a transfer mechanism – schemes with better than average profiles contribute to a central fund, whislt schemes with worse than average risk profiles draw down from this fund.

Government is both the purchaser and provider and therefore there is no competition in the sector currently. Government provides healthcare for over 80% of South Africans (National Department of Health, 2017) and therefore can be considered a monopoly. Healthcare workers are paid salaries irrespective of health outcomes, utilisation or performance. While the efficiencies generated through competition are not available in the South African public health sector, the benefits of monopsonist buying, e.g. of pharmaceuticals, are more readily apparent.

The public sector is a 'monopolistic integrated model'. The private sector is a 'competitive reimbursement model'.

Both these models are resulting in sub-optimal outcomes. The private funder sector has historically experienced unsustainable levels of premium increases largely driven by worsening risk profiles, rising utilisation, above Consumer Price Index (CPI) input cost inflation, stagnant coverage and high administrative costs (Econex 2013). The public sector faces serious challenges around resource allocation, efficiency, accountability and quality (National Department of Health, 2017). Strategic purchasing offers an important set of tools, applicable for both sectors, to better manage and match the demand for and supply of healthcare (van de Ven et al. 1994).

The NHI Fund as a strategic purchaser

As described in Brief 1, the NHI Fund is intended to function as a purchaser and single payer of comprehensive healthcare services for South Africans. This corresponds to a **monopsony contract model** in the van de Van conceptualisation. The Fund intends to improve competition amongst providers (based not only on price but on quality, too), largely by using strategic purchasing (National Department of Health, 2018). Below we describe the theoretical functions of the NHI Fund as envisioned in draft legislation; we then go on to describe some of the potential implementation challenges.

1. Deciding on the benefit package

It is intended that the Fund will decide what benefits to cover, in conjunction with the Benefits Advisory Committee, by:

- Understanding and interpreting population health needs, both now and in the medium-term, using tools such as epidemiological models and forecasting. Quantifying need will be discussed more in Brief 3.
- Considering what is affordable, relative to revenue collected and pooled for NHI[2].

[2] As an aside, the design of this process does not adequately account for the iterative relationship between benefit package design, the contracting mechanisms to enable delivery of the package, and the costing of the benefit package.

- Identifying the most cost-effective interventions, using data and scientific research to select the appropriate level and mix of healthcare goods and services. This process will include the NHI Health Technology Assessment agency, supported by external research entities such as NICE (UK) and PRICELESS (SA).

It is intended that the Fund will also define standard treatment protocols and referral pathways which contracted providers will be required to follow. We will examine this process of matching supply to need in Brief 4.

2. Contracting providers

The NHI Fund is envisaged to enter into contracts directly with healthcare providers. The intention is to select providers based on criteria such as the quality of service, geographical footprint and service capacity. The Office of Health Standards Compliance (OHSC) will play a certification function, assessing which providers meet minimum norms and standards, with the Fund being responsible for final accreditation. Providers that satisfy certification criteria and some additional accreditation requirements set by the Fund will be granted accreditation and will thus be eligible to contract with the Fund. To date the OHSC has highlighted severe and wide-spread quality failings in the public sector and it is unclear what the process is to ensure improvement over time, or how service delivery and access will be achieved in areas where no providers meet minimum criteria. Accreditation will be discussed more in Brief 6.

3. Payment mechanisms for healthcare providers

It is intended that the Fund will contract services differently, based on the level of care:

- **Primary healthcare:** The Fund intends to reimburse primary healthcare providers through capitation, which incentivises a population health and team-based approach to healthcare.
- **Higher levels of care:** The Fund intends to contract directly with hospitals, specialists and other providers for particular services, using payment mechanisms such as diagnostic related groupers (DRGs)[3] which incentivise efficient use of resources.

Furthermore, the idea is that the Fund will likely move towards a value-based contracting (VBC) approach, incorporating payment-for-performance to further incentivise quality and efficiency. Provider payment mechanism, including VBC, are conceptually and practically complex and as such we dedicate brief 6 to unpacking these.

The purchasing process can be disaggregated into these three decision sets (what to buy, who to buy from and how to pay), yet each dimension influences the other. NHI will have to balance affordability, quality and access.

[3] It is concerning that the reimbursement mechanisms have been named in the draft Bill. Globally, thinking on reimbursement mechanisms continues to evolve. Naming the mechanisms introduce an unnecessary rigidity into the system.

Brief 7 will explore the tensions between payment mechanisms and budget predictability, between quality and access, and between access and affordability. If implemented effectively, NHI could employ strategic purchasing as a powerful tool for healthcare reform.

The application of strategic purchasing under South Africa's NHI

The NHI Fund will be legally and financially empowered to represent millions of people, allowing it to consolidate buyer power and employ strategic purchasing on a national scale. The Fund could theoretically lower costs, improve quality and ensure access in the following ways (the challenges to doing so are presented in the next section):

High volume purchasing

As outlined above, the Fund is expected to negotiate lower prices (although still fair, evidence-based and sustainable) through the promise of volumes. This means that contracted private providers will potentially see more clients (or provide more goods) than they are currently, at a lower cost per client. Increased contracting with private providers will be dependent on both the scope and depth of benefits. It is not clear what will happen to the patient load of current public providers.

Creation of standard benefits and treatments

The Fund will only pay for pre-defined benefits if the standard treatment protocols (e.g. formularies, procedures, referrals) are followed. This could guide service delivery for maximal effectiveness by:

- specifying minimum quality standards that all providers (whether historically public or private) will be held accountable to;
- ensuring all health technologies are the most efficient and effective option for the condition in question;
- ensuring that the conduct of health professionals is well-regulated, through the accreditation and quality measurement programmes, which could reduce the medico-legal risk and resulting cost to providers and the State; and
- empowering clients to understand their benefit entitlements and treatment pathways and have avenues for redress when this is not followed or when they receive poor quality care. This aspect of accountability is key to ensure we address implementation gaps.

Strategic purchasing is a potential tool for:

(1) high volume purchasing (2) ensuring standardisation throughout the system (3) contracting for value (4) enabling evidence-based decision making.

Alternative (performance-linked) reimbursement models (ARMs)

It is intended that the Fund, or CUPs in the case of PHC, will contract with providers based on the health needs of the population in specific areas. Population needs will be linked to the provider payment mechanism, for

example a risk-adjusted fee per person in the provider's population (capitation). Ideally, these reimbursement models will ensure sufficient provider autonomy so that providers will continue to innovate and develop more cost-effective methods to keep their population well-managed and in good health. ARMs should shift the incentives of both the private sector and the public sector. The current private sector reimbursement model is fee-for-service which encourages a greater volume of services to be rendered. The budget system on the other hand incentivises under-servicing. Well-designed ARMs provide a middle way.

Data and information systems

The Fund will be required to collect, consolidate and analyse data about population health needs, providers, treatments and costs. This will allow for more useful research, more accurate forecasting and better resource allocation. This strengthening of data capability should take place prior to implementation. Common data definitions that apply to both sectors will need to be established.

The table below summarises the potential benefits of strategic purchasing that the NHI Fund could realise:

Figure 1: Benefits of strategic purchasing

Intervention	Affordability	Quality	Equity and access	Innovation
Buying high volumes (bulk-buying) goods and services at lower cost	X		X	
ARMs	Depends on price-setting	Depends on the incentive design	Depends on the incentive design	Depends on the extent of provider autonomy
Gatekeeping and referral network to control costs	X		X	
Benefit design and treatment protocols to ensure high-quality care	Depends on the protocols	X	X	
Centralised health data and information for better planning and forecasting		X	X	

Implementation challenges

Klasa *et al.* (2018) cautions that strategic purchasing may not be able to realise all its theoretical benefits, given how difficult it is to implement.

One possible risk mitigation strategy is to build purchasing capability before implementation of the NHI Fund. This can be done in the public sector by piloting some services through a dedicated fund for the whole country (for example, providing cataract surgeries for those who need), to test the purchasing and payment functions. In the private sector, schemes could similarly pilot different payment mechanisms and test the behaviour of providers in response to different incentives.

Outlined below are some of the key risks and challenges that may arise in implementing strategic purchasing through the NHI Fund as it is currently envisioned:

1. **Responsiveness**

While cost savings are likely to be generated by the centralised buying power of a single purchaser, the efficiencies that could be achieved by having competition between multiple purchasers will be lost. A centralised entity is susceptible to bureaucracy and inefficiency. For example, contracting mechanisms will need to evolve over time and there may be insufficient incentive to experiment with alternative contracting strategies. Furthermore, in order to reap all the benefits of a purchaser-provider split, competition between providers is required to achieve optimal levels of efficiency. There is, however, a question about whether, even with a purchaser-provider split, the majority of (public) providers will remain too integrated with the Fund to achieve the envisaged competition benefits. This is exacerbated by the extensive powers of the Minister of Health across the split.

It is worth noting that the transition to a single purchaser is smoother if the purchasing function is already strong in a health system (which it is not in South Africa), because then the move is more about consolidating functions as opposed to building them from scratch.

A monopsony may not have enough economic incentive to act on behalf of their clients (van de Ven et al. 1994) – this is a concern in the South African context where we have experienced poor service delivery and insufficient sensitivity to clients navigating the system. The proposed reforms are strongly linked to top-down accountability, with little consideration of how to drive bottom-up accountability[4]. Linked to this is a concern about whether a central purchaser can be adequately attuned

[4] Examples of bottom-up accountability mechanisms include the ability for clients to opt out of the Fund (i.e. if medical schemes were able to provide substitutive or duplicative cover), strong complaints mechanisms and public reporting of outcomes achieved.

to local dynamics. However, this has to be offset against the inequity that arises from variation in local capacity – a considerable risk associated with the proposed CUP structures.

2. Provider relationships

From a provider perspective, a monopsony also presents a risk. Etiaba *et al.* (2018) studied Nigeria's social health insurance scheme and found that providers' dissatisfaction had an adverse effect on healthcare service delivery, because providers were not involved in ongoing decision-making and there was an absence of clear communication and feedback channels with the purchaser (Etiaba et al. 2018). This risk can, however, be mitigated by ensuring ongoing interaction between the purchaser and providers. However, centralisation increases the risk of this disconnect. An additional concern in the South African context is the history of weak (and fraught) engagement between the State and private providers and the weak regulatory systems that exist today.

Providers may have little motivation for efficiency and innovation if they feel disempowered in the purchasing process.

3. Pricing framework and review

Mistrust in the State's ability to design what is perceived as a reasonable pricing framework, and regularly updating these prices, has been fuelled by failures in the process around the National Health Reference Pricing List (NHRPL) in the private sector and infrequent review of the Uniform Patient Fee Schedule (UPFS) in the public sector.

It is important that in the pursuit of lower prices, the Fund does not compromise on quality- meaning that reimbursement rates need to be determined in conjunction with providers to ensure the incentives remain swayed towards the sustainable provision of quality care. The design and implementation of price determination and price review processes are critical, and as yet unknown, aspects of the system.This risk relates to the fiscal controls over the Fund together with the Constitutional requirements for progressive realisation. Once benefits have been granted there will be a strong obligation to continue to provide them. Any fiscal pressure is therefore likely to translate into lower prices for providers. This risk can be managed through gradually expanding the Fund over time.

4. Incentives for innovation, efficiency and quality improvement

Centralising benefit design and treatment protocols might reduce competition on these aspects. Providers could rely on certain payments with insufficient incentive for efficiency, research and development (R&D) and innovation. There is the risk with standardisation that innovation is stifled and that new and responsive service delivery models do not emerge. Rigid treatment pathways do not necessarily recognise nuances in patient needs and preferences. The system will need deliberate mechanisms to seek out innovation and to find ways of testing and evaluating alternative approaches.

It may also slow down the adoption of new technology, if there is insufficient communication between providers, technology companies and a health technology assessment agency or if the health technology assessment agency is slow to act. South Africa has experienced some of this lethargy in its approval of new medicines through the South African Health Products Regulatory Authority (SAHPRA) (previously the Medicines Control Council) which controls which medications can be dispensed in the country. Furthermore, if private providers feel the centralised prices don't sufficiently reimburse them for investments in new technology, adoption of these technologies may be slowed.

5. ARM design and implementation

A critical success factor is the Fund's ability to contract effectively with providers (Siverbo 2004). The contracts need to specify performance standards clearly enough that providers can be paid accordingly, without constraining the providers' ability to tailor healthcare for a specific patient's needs.

There are numerous considerations to ensure appropriate design of the contracts: the ease of implementation (including the ability and willingness of providers to take on financial risk), the long-term sustainability (in terms of a fair return on investment) and the resultant incentives (in terms of both efficiency and quality). This will need to be supported by monitoring both the volume and the quality of services delivered. Determining the right metrics will need to be an iterative process and there will have to be ongoing experimentation with the reimbursement approach. There will also need to be ongoing engagement with providers to build trust, to ensure that contracting mechanisms are understood and supported, and to enable the organisational change required to adapt to new forms of reimbursement. All of these elements are difficult to achieve, and will require significant investments, the development of new capacities and time.

6. Governance

Assuming NHI is effectively financed, the Fund will control a huge pot of money. This makes the Fund a target for wasteful expenditure and corruption. Aside from the political challenges (discussed later), this poses a significant challenge for governance and will require careful design of governance arrangements. Adapting recommendations on governance for UHC from Mathauer *et al*. (2017):

- The Fund will require a clear mandate and legal powers as a strategic purchaser (including separate oversight from the provider, which is currently not envisioned).
- It should be practically able to shift resources; however, if most of the funds are already obligated (for example, to existing Provincial Departments of Health due to existing salary obligations), there is limited scope for strategic purchasing.
- Providers need sufficient autonomy to exercise their professional skills and judgement, while remaining accountable to the purchaser. This balance between autonomy and accountability needs to be built into the

treatment protocols and payment mechanisms. Although there is likely to be significant variation between public sector providers, the current organisational culture within these providers may not promote autonomy and accountability.

7. Data and information systems, and other capabilities

Purchasing becomes strategic when it uses information to link population health needs to provider payment. Therefore, strategic purchasing and its governance requires a comprehensive data and information management system for payment (Mathauer, Dale, and Meessen 2017). This is provided for in the draft NHI Bill (National Department of Health 2019) – although it is not clear that the full practical implications are well understood. The implementation challenges may include:

- Agility in the system in terms of how data are collected, stored and analysed. Large systems are more difficult to change and adapt;
- Specifying what data to generate, collect and use and ensuring that this evolves over time;
- Developing a culture that values information and prioritises evidence in decision-making. Performance-based provider payment mechanisms can create an economic incentive to improve data, as seen in Estonia and Burundi (Mathauer, Dale, and Meessen 2017). ; and
- Building analytical skills to continuously generate, analyse and interpret data.

It is important to recognise that our starting point is one of poor data. We currently do not collect patient-level data in the public sector, there is very little in the way of diagnosis and procedure coding and almost no activity-based costing. There are considerable challenges associated with both the collection and use of data in the public sector currently. For exampleSouth Africa has fragmented health data and information systems and many are not easily able to integrate with other systems (South African National Department of Health 2017). This is not insurmountable but will require time and resources to develop. The proposed timelines for NHI implementation do not appear to account for the time required to build a meaningful data capability.

8. Dynamic health systems

Health systems are always changing, so purchasing interventions have to adapt accordingly. For one thing, population health needs change over time. Tracking this requires large amounts of data and information that is regularly updated (as described above). NHI will also require ongoing data analysis and specialised research to identify and interpret health trends and link this to benefit design.

In addition, as providers and their clients get accustomed to incentives, some stakeholders may begin to exploit the system. For example, the use of Diagnosis Related Groupers (DRG) coding can lead to up-coding of in-hospital cases in order to receive larger reimbursements. Again, integrated information systems are critical, so that fraud and perverse incentives can be quickly identified and removed.

The NHI Fund will have to develop the capacity to monitor and adjust to new conditions and stakeholders' reactions, including effects of strategic purchasing interventions themselves. Large organisations, particularly those with low economic incentives to be responsive, are not ideally suited to flexibility, agility and innovation. These are key risks inherent in a top-down, monopsonist approach.

9. The difficulty of disinvestment

Given that one of the central pillars of strategic purchasing is purchasing for delivery of a basic benefit package, it implies the possibility of disinvestment from some services that are currently provided in the public and private sectors. A purchaser-provider split is always implemented in the context of budget constraints and in the case of South Africa's low-growth environment the budget constraint is even more severe. Difficult choices will have to be made about what not to fund and these services will have to be removed from the currently available service menu. Experiences from other countries such as the United Kingdom (Rooshenas et al. 2015) and Netherlands (Moes et al. 2019) have shown that disinvestment tends to be prone to a lack of political support and even political interference and a reluctance to ration care. In order to push through with the required disinvestment, strong clinical leadership and political will is required (Moes et al. 2019).

10. Political challenges

The Fund faces significant political risks. These could be examined at two levels:

- Ruling party: The political party that implements NHI will be required to make tough decisions around resource allocations and will therefore take on reputational risk. For example, there may be job cuts required to improve efficiency and this will be difficult to navigate in a unionised environment. Some rare conditions and/or clients with a poor prognosis may not be fully covered, when using a health technology assessment/cost-effectiveness design. These decisions may be unpopular and as a result political concerns to remain in power, may override best practice. However, ensuring the NHI is affordable for the country is key to its success and therefore, explaining how decisions are made and the rationale will be key to building trust and support for the NHI.
- Risk of NHI being a political rather than technocratic mandate: The ruling party or national leadership may change. This could radically change the NHI implementation plan, as seen in the USA between the Trump and Obama administrations. NHI gives the Health Minister significant power, so the minister in-power could undermine and control strategic purchasing if the governance arrangements do not limit the powers of the Minister.

The risks outlined above are well-known, below we discuss some of the key recommendations that can help mitigate risks and ensure success.

The way forward

We can strengthen strategic purchasing under NHI by using a **phased implementation approach.** The Constitution provides for the principle of progressive realisation – committing to delivering a specified end state while delivering only a portion of that now and increasing it over time. The NHI Bill allows for phased implementation to test mechanisms before national rollout and allow stakeholders time to adjust to the system, however full implementation by 2026 seems unrealistic (National Department of Health 2019).

One way to do phase in implementation may be to focus on specific population groups, for example the maternity population (women and children, high need and risk). The various facets of NHI can be implemented for that specific group to test contracting mechanisms, strategic purchasing and accreditation systems. Another way is to take a specific aspect of strategic purchasing and implement that within the existing system. For example, allowing for the use of more alternative reimbursement models (such as capitation or DRGs) to control costs and improve service delivery. This would require a fundamental shift in the public sector's resource allocation and payment mechanisms. The budget system can also be transitioned by more closely matching budgets to patient need – this will reduce resource-allocation shocks to the system.

Phased implementation also allows for the establishment of various aspects of purchasing capability, including leveraging existing capability. This reduces the risk of a complex and multi-faceted purchasing capability having to be built overnight.

The Draft NHI Bill gives significant executive and regulatory powers to the Minister, currently positioning the Minister as having oversight of both the Fund and the NDoH. This could blur the distinction between the purchaser and provider and undermine the efforts of splitting these functions. The Fund should also be protected from undue political control, as discussed in the risks. This can be done by setting up an **independent regulator** (not linked to the Minister), together with strengthening other regulatory mechanisms such as the Health Ombud, the OHSC and Health Professions Council of South Africa (HPCSA). It

While the current private sector does have a purchaser-provider split and some (albeit insufficient) level of strategic purchasing, it has not yielded the results we have outlined in this brief, for a wide variety of structural reasons. Therefore, South Africa's NHI will need to look beyond the private sector model when designing the Fund.

is widely accepted that the current regulatory bodies are not strong enough to fulfil their mandate. Therefore, there will need to be an intentional strengthening of these bodies to ensure sufficient oversight under NHI. The boards listed in the latest NHI draft Bill will not afford the requisite governance, given their connection to the Minister. **Citizen empowerment** can be explicitly incorporated through increasing awareness of patient rights, improving citizen representation within governance bodies and strengthening the formal complaints mechanism. The need for **ethical and strategic leadership** of the Fund is paramount. Strong multi-stakeholder involvement in key appointments, including public scrutiny and civil society input is desirable, particularly given the current trust deficits.

Affording clients and providers with choices will also strengthen accountability and responsiveness. This can be achieved by permitted medical schemes to offer substitutive or duplicative cover, or by implementing a multiple purchaser alternative design.

We have discussed in detail in this brief the importance of an **effective data management** system that is then used as evidence for benefit design, monitoring and evaluation. In the public sector, the District Health Information System (DHIS) is used to collect certain data elements at a facility level but it is not possible to track population health well enough to guide action. In the private sector, data systems are more robust given the fee-for-service reimbursement model. However, data is both personal and proprietary and data systems within schemes and providers are not always able to integrate seamlessly. Therefore, there is work to be done to create a real-time, eHealth system that allows for a greater understanding of patient needs, health and historical interactions with the healthcare system. All information, financial and anonymised health information should be audited and made available for public consumption to improve evidence, forecasting and research in South Africa.

Strategic purchasing is a core concept in health systems design with a still evolving track record (Klasa *et al.*, 2018). Yet each step toward strategic purchasing can be a step towards achieving the benefits and supporting the realisation of universal health coverage. It will, however, require significant investment, leadership and focus and cannot be done without bringing key stakeholders; public, private and communities along with it.

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