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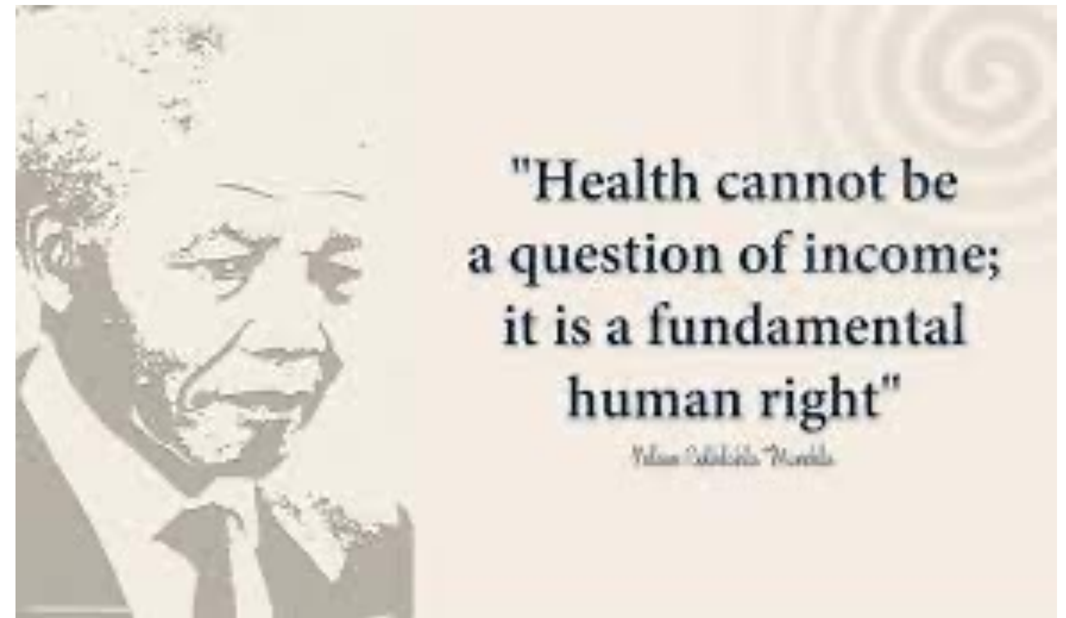
Unpacking the NHI future practically

Prof Shabir Moosa

Division of Family Medicine, University of Witwatersrand

SAACHS Conference, 10th January 2024

UHC in SA



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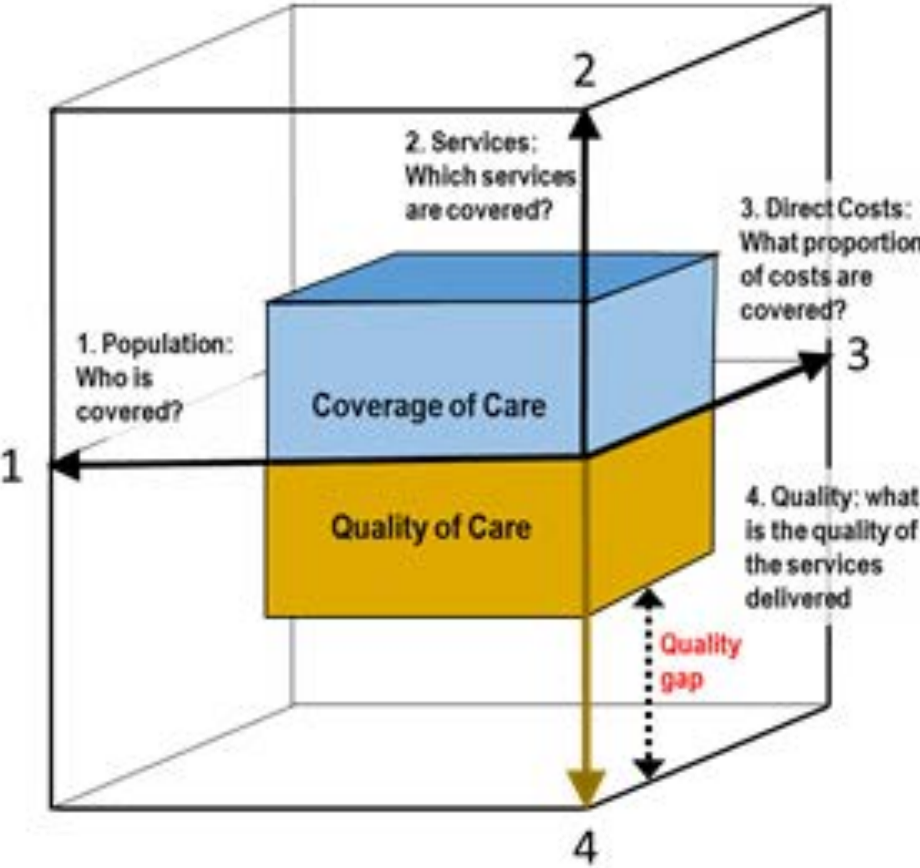
GAUTENG
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

GGT2030
GROWING GAUTENG TOGETHER

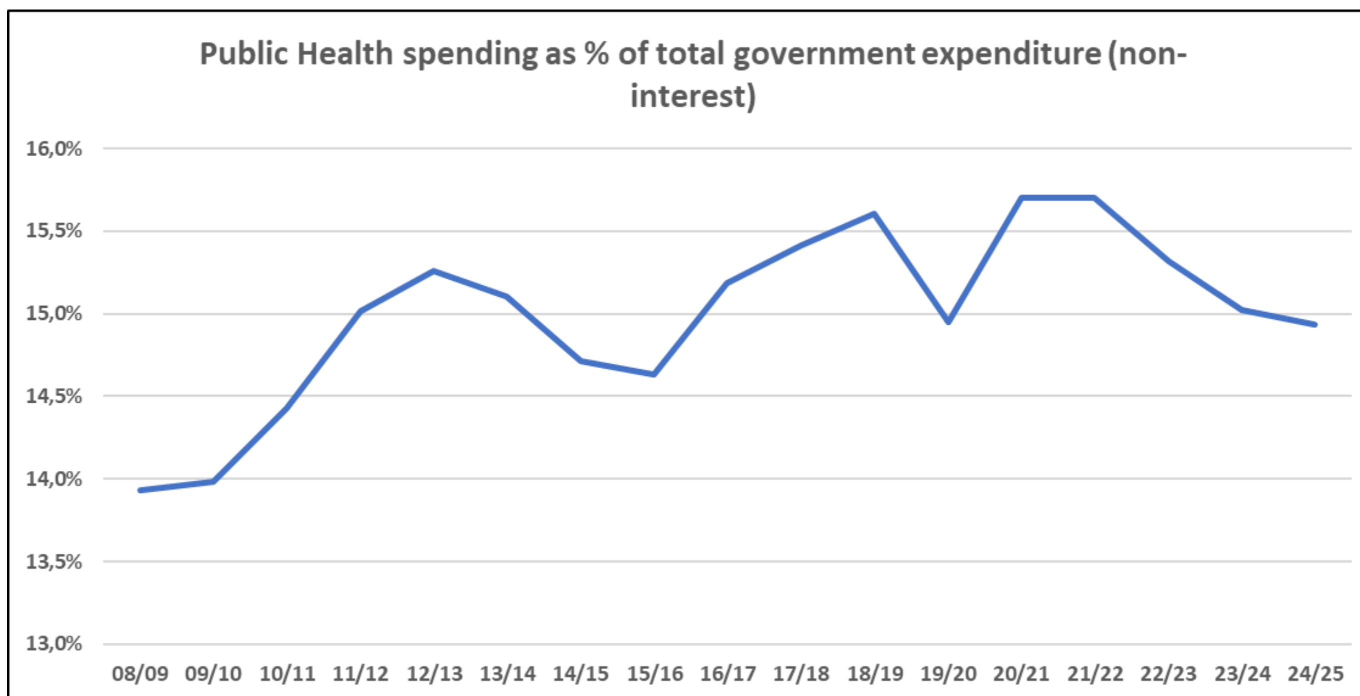
SA Progress

- Apartheid demise→ private deregulation
- 1994 President Mandela [PHC Nurses in LG clinics]
  - 1997 Constitution established
  - 2001 Local Govt established
- 2004 District Health System established along local govt lines
  - Public-Private divide
- 2011 – NHI Green Paper
  - Capacity
  - State Capture / COVID 19

Universal Health Coverage



Health as % Total Government Expenditure



High level

- **Spending by government on health has increased as a % of allocations from the fiscus (from 14% to 15,5% and now at around 15%)**

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Public Private per capita

Public Private Per Capita Health Spend

30000
25000
20000
15000
10000
5000
0

2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021

Public Private

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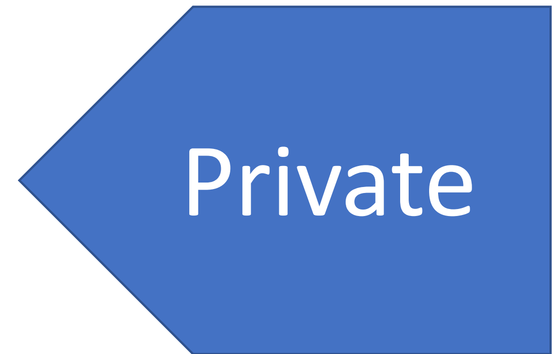
NHI Purpose

- Single payer/purchaser – strategic purchasing from public and private

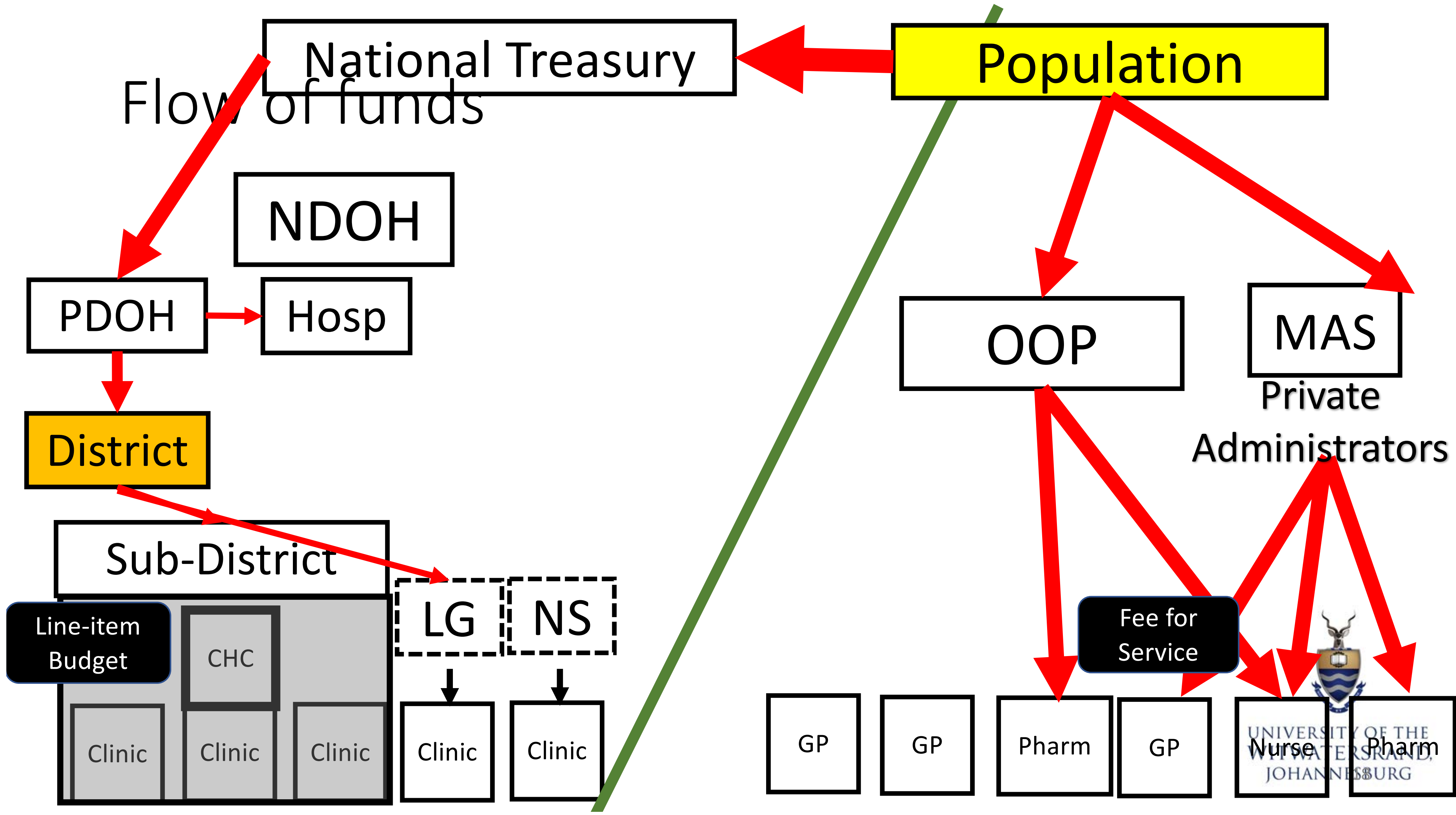
Clinics
Public Mandate
No doctor

Public + Private Providers
Clinics with doctor
Public Mandate
Curative + Preventive



Solo
Curative/Wasteful
Doctor

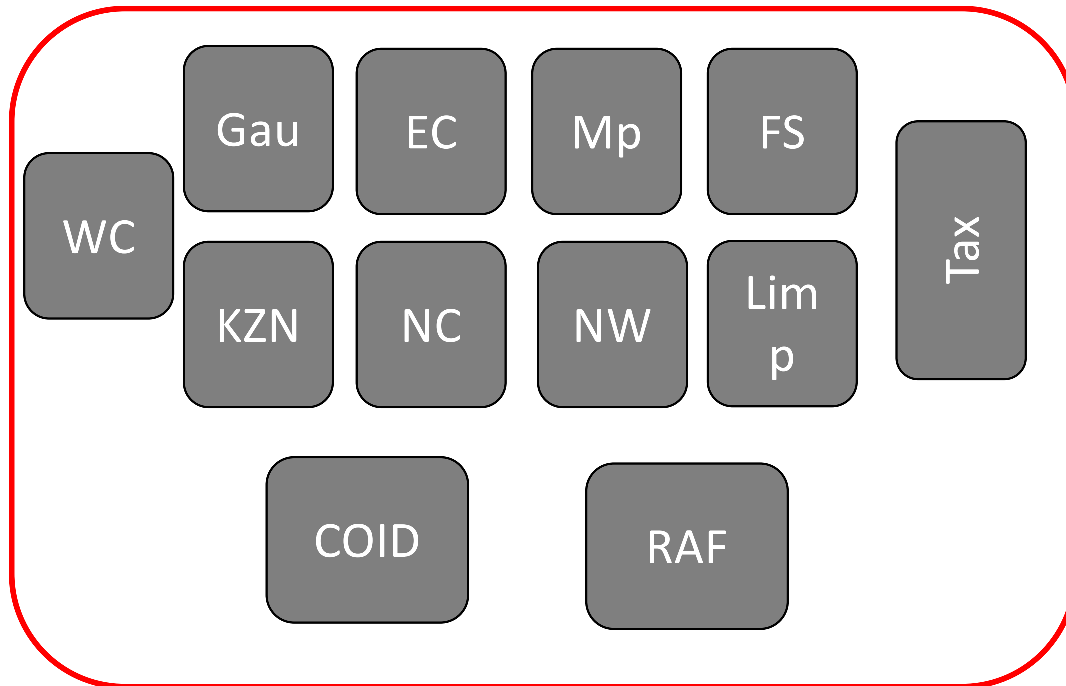
Flow of funds

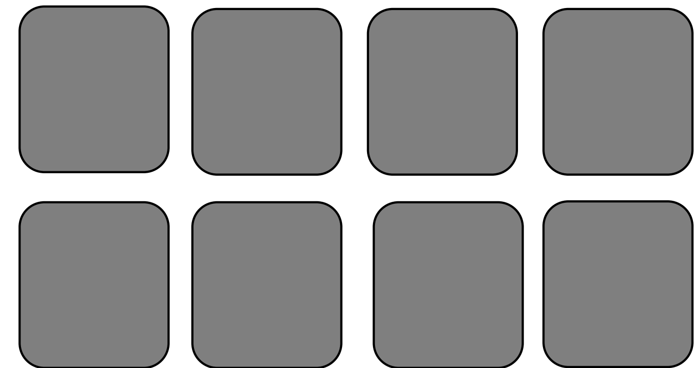


Pooling of funds

Public pools

Private pools





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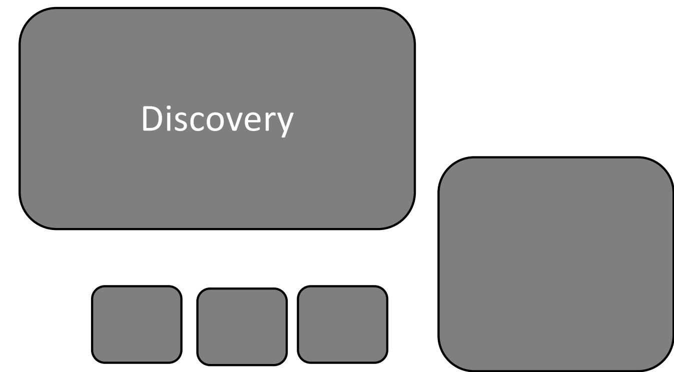
Pooling of funds

Public pools

Private pools



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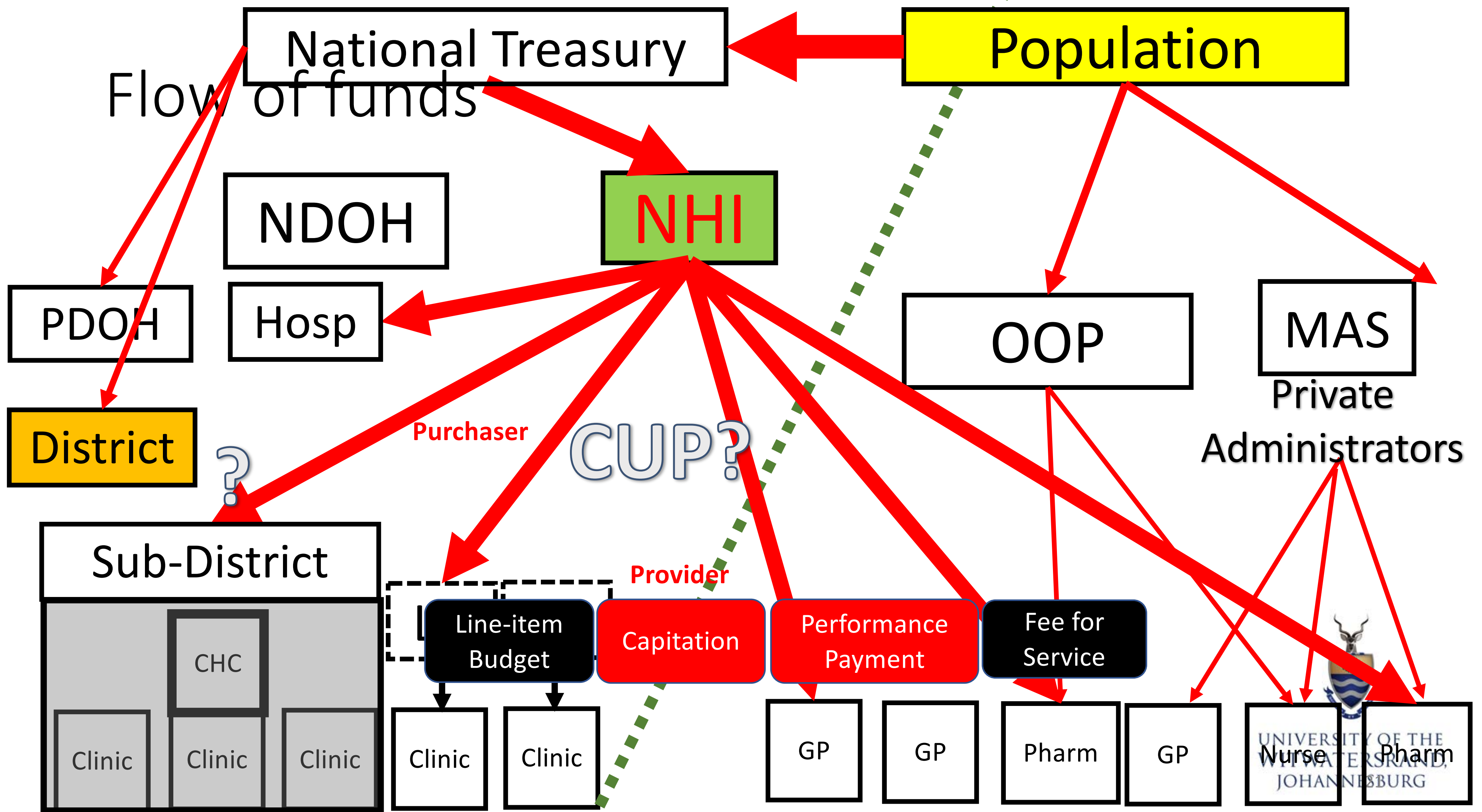

Flow of funds
National Treasury
Population
NDOH
NHI
PDOH
Hosp
OOP
MAS
Private Administrators
District
Purchaser
CUP?
?
Sub-District
CHC
Clinic
Clinic
Clinic
Provider
Line-item Budget
Capitation
Performance Payment
Fee for Service
Clinic
Clinic
GP
GP
Pharm
GP
Nurse
Pharm
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Gap in per capita spending

TREND IN RAND PER CAPITA HEALTH SPEND (PUBLIC vs PRIVATE) 2008/09 to 2021/22

35 000
30 000
25 000
20 000
15 000
10 000
5 000
0

08/09 09/10 10/11 11/12 12/13 13/14 14/15 15/16 16/17 17/18 18/19 19/20 20/21 21/22

- Rand per capita (private @ 15% of total)
- Rand per capita (private mean point)
- Rand per capita (private @ 20% of total)
- Rand per capita (public @ 80% of total)
- Rand per capita (private mean point)
- Rand per capita (public @ 85% of total)
- Linear (Rand per capita (private mean point))
- Linear (Rand per capita (private mean point))

If we spent:

- **private average of R26 700 per capita** on every South African we would need an annual health budget of R1 618 178 420 565 (R1,6 trillion)
- **public average of R5 322 per capita** on every South African we would need an annual health budget of R322 530 888 247 (R322,5bn)

- There is a growing gap in per capita spending
- (R5000 vs R25 500) is the challenge
- **Collective per capita spend 2021/22 is R9 147**
- Resources (HR, technology and infrastructure, etc) follow the money
- **This is the gap that needs to be closed by NHI**

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Funding

CURRENT SOURCE OF FUNDS	Rand (million)	REORGANISATION AND ROUTE TO NHI FUND	Rand (million)
National Department of Health core	12 947	Will be about R7bn excluding COVID	
National Department of Health Indirect Conditional Grants	85	R85m already national	
National Department of Health Direct Conditional Grants	60 000	All of this will move to NHI Fund	60 000
Provincial Departments of Health Provincial Equitable Share	175 892	Most of this will move to NHI Fund	150 000
Defence (SAMHS)	5 474	Will not move	
Correctional Services	1 216	All of this will move to NHI Fund	1 216
Local government (own revenue)	5 138	Will not move (mostly environmental)	
Workmen's Compensation contributions	3 502	All of this will move to NHI Fund	3 502
Road Accident Fund levies	1 675	All of this will move to NHI Fund	1 675
Medical schemes (Employer contribution public service)	230 618	This R70bn could be moved to NHI Fund early	70 000
Medical schemes (Employer contribution private employer)		The remaining R270bn will need to be raised through	
Medical schemes (Employee contribution)		1. tax credits redirected R34bn	34 000
Out of pocket	38 653	2. taxation route (+/- R200bn) and	200 000
Medical insurance	5 501	3. leave some for Complementary	
Employer private (including Occupational Health)	2 630		
Donors	11 095	Will not move	
2021/22 HEALTH FUNDS	**554 426**	**NHI FUND**	**520 393**

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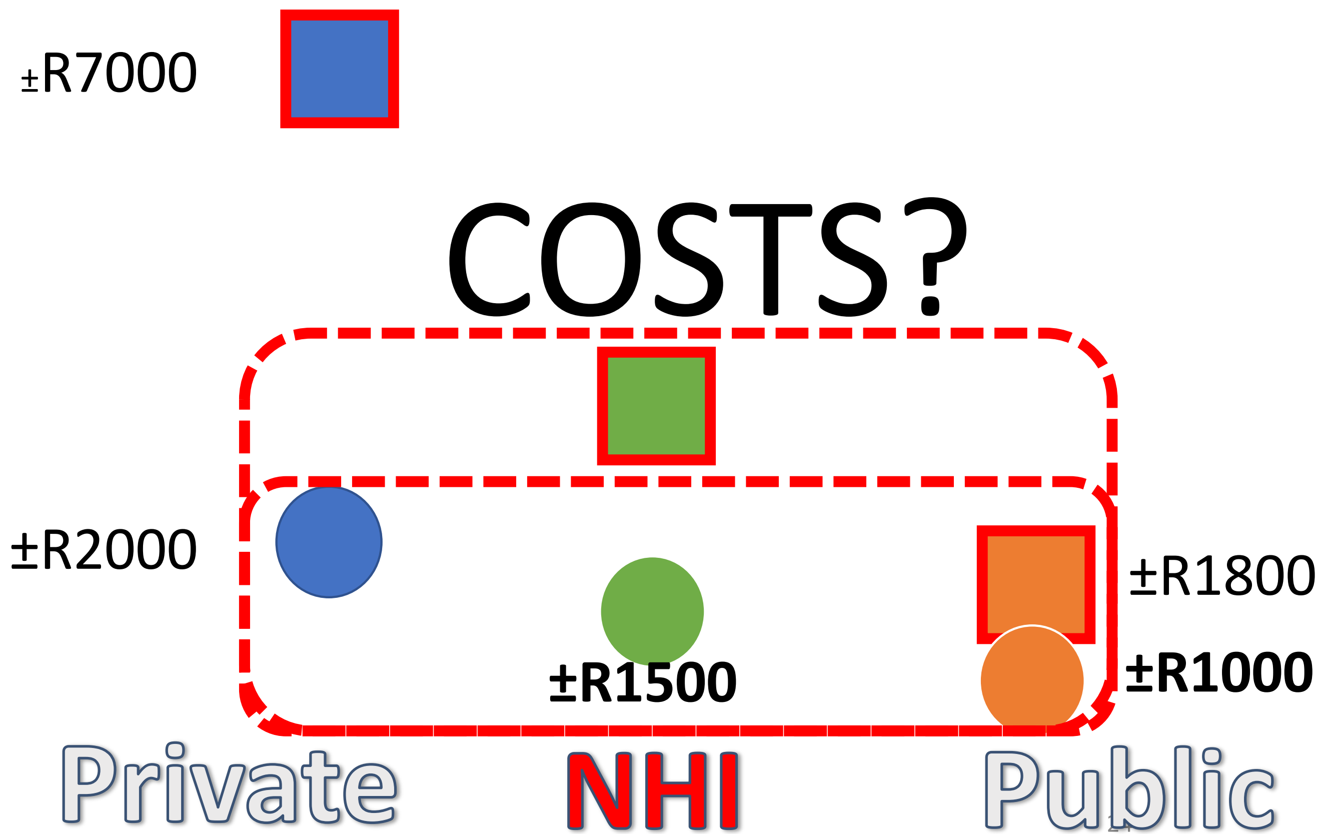
The bigger picture



Contracting Units for PHC (CUP)

- 37. (1) A Contracting Unit for Primary Health Care is hereby established. (2) A Contracting Unit for Primary Health Care must be comprised of a district hospital, clinics or community health centres and ward-based outreach teams and private providers **organised in horizontal networks within a specified geographical** sub-district area, and must, amongst others, assist the Fund to— ***profile disease, identify needs, improve access, identify & facilitate integration of public/private providers, ensure functional referral, manage contracts, monitor disbursements, resolve user complaints, amongst other things***

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Contracting Units for PHC (CUP)

A CUP can be defined as a coordinating platform which forms an integral part of district health services, contributing not only to clinical service delivery but, where appropriate, also clinical governance activities, and maintains strong working relationships with other elements of the district health care delivery system.

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Soweto Clinics

CHCs	Clinics		Hospitals
1. Lilian Ngoyi	1. Diepkloof Prov	**13.Senaoane**	1. Bheki Mlangeni District Hospital
2. Mofolo	**2. Orlando Prov**	14.Shanty	2. Chris Hani Baragwanath Academic Hospital (CHBAH)
3. Itireleng	**3. Tladi Prov**	15.Sinqobile	3. Clinix Tshepo Thembo
4. Chiawelo	4. Meadowlands	16.Zondi	4. Dr SK Matseke Memorial
5. Zola C	**5. Moroka**	**17.Jabavu**	
	6. Zola Gateway	18.Nokhuphila	
	7. Noordgesig	19.Naledi Clinic	
	8. Mandela Sisulu	20.Diepkloof LA	
	9. Michael Maponya	**21.Tladi LA**	
	10.Elias Motsoaledi	22.Klipsruit West	
	11.Mofolo South	23.**Greenvillage**	
	12.Protea Glen	24. Slovoville	

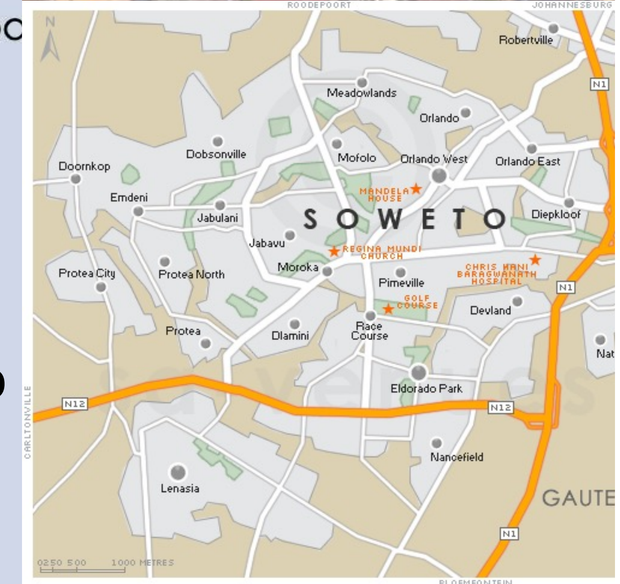
Ideal Clinic Self Assessment: 83%

KEY

Inspected and passed

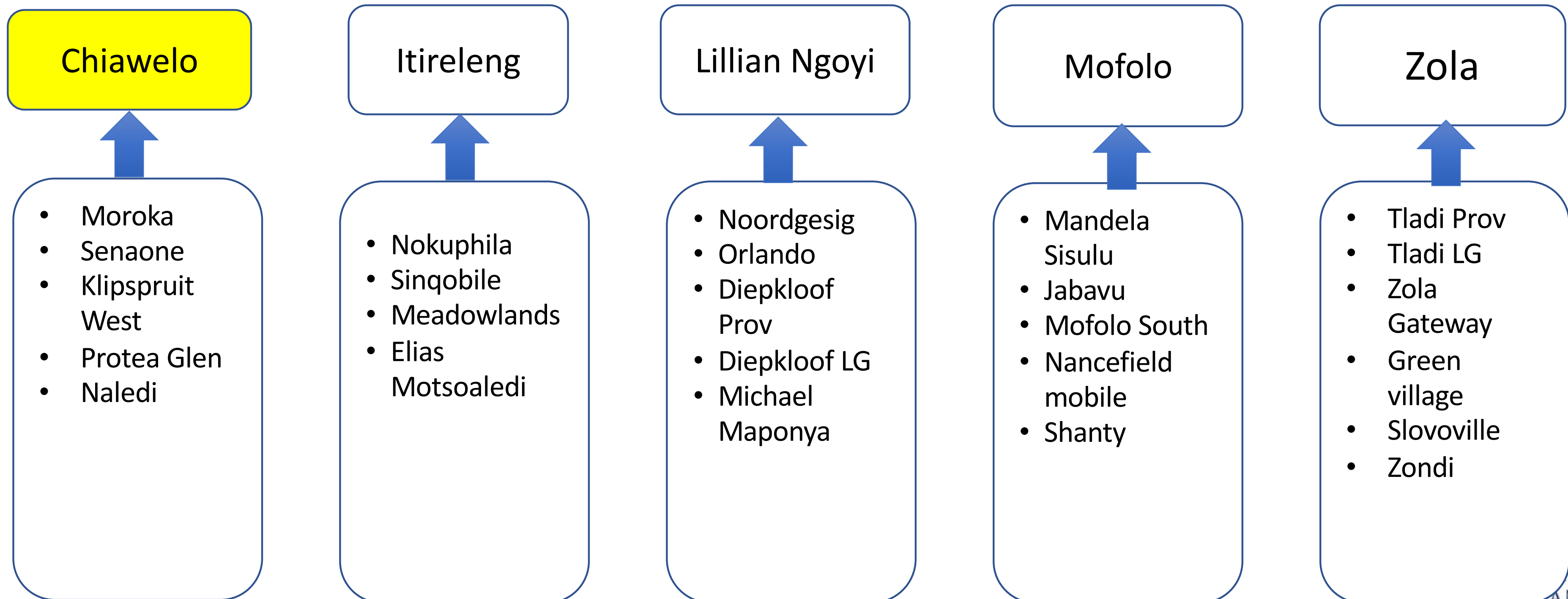
Inspected but failed

NOT Inspected



CHC Clusters

- Dr Crisp suggested smaller sized CUP vs Soweto with 1.6m



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CUP Issues

- Profiling - population / needs/ morbidity
- HPRS as NHI spine
- Define service package
- Ensure clinical governance / functional referrals
- Strengthen sub-district management
- Explore private provider contracting
- Develop shadow budgets/costing

Profiles

- Actual (vs. extrapolated) nopulation needs/morbidity data limited in LG/PG profiles and DHIM / IDP
- GDOH) catchment maps (incl. GPs -2014) 1.3sq km hexagons with DHIS/StatsSA data – not granular enough → Use wards / NDOH Data Science
- CHWs only cover 7% of clinic population with post 2020 household registration data
- CHWs mHealth planned for Mar 2023
- HPRS!

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HPRS

DHA Biometrics

Johannesburg MM	1,849,024	1,025,872
Johannesburg A SD	247,428	84,976
Johannesburg B SD	18,499	2,053
Johannesburg C SD	208,708	111,458
Johannesburg D SD	523,416	265,147
Johannesburg E SD	268,019	234,916
Johannesburg F SD	144,900	79,506
Johannesburg G SD	438,054	247,816

Total Primary Health Care facilities in City of Johannesburg Metropolitan Municipality - 1[illegible]

Status	Total
Health Patient Registration System implemented	58
Health Patient Registration System registered patients	[illegible]
Ideal Clinic status achieved	109
Ideal Clinic status achieved and Health Patient Registration System implemented	56
Ward Based Outreach Team linked	
Medicine Stock Management System implemented and functional	
Registering pregnant women on MomConnect	
Linked to Centralised Chronic Medicines Dispensing and Distribution points	
Clinic Committee established	44

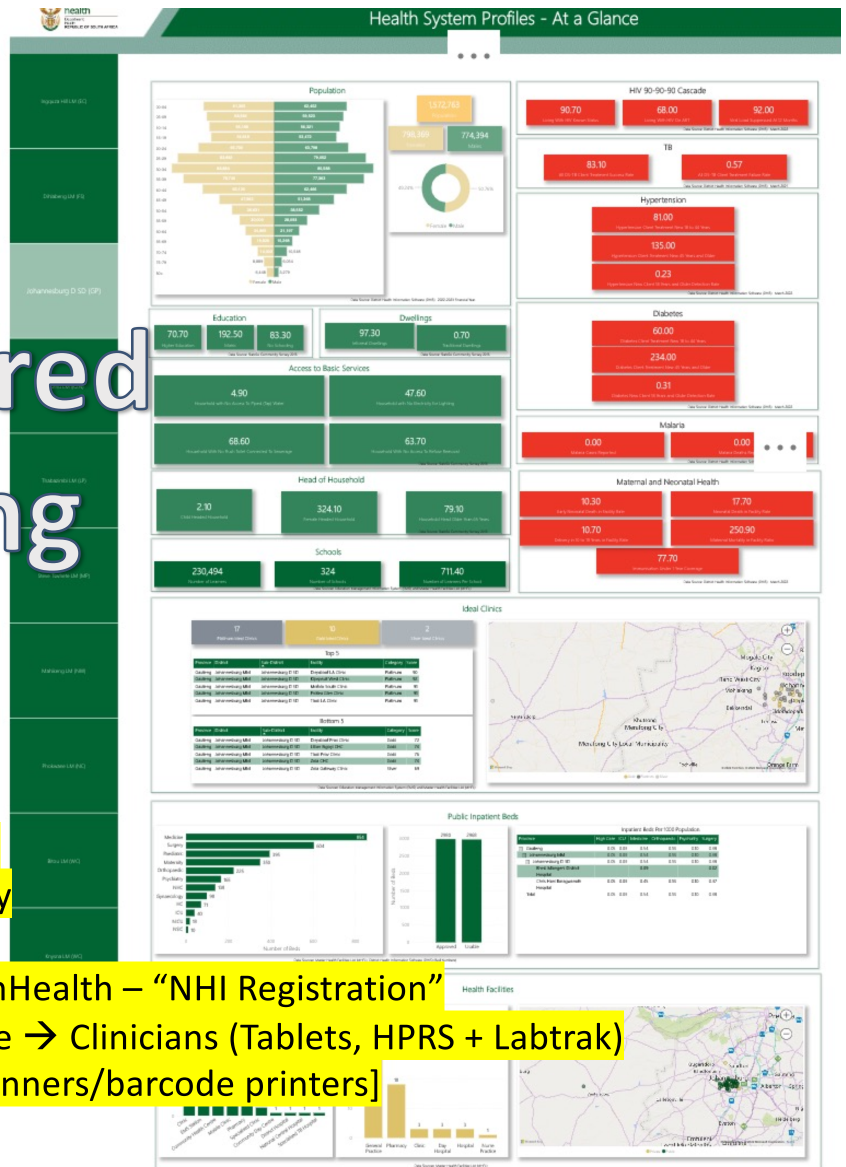
33% registered

46% visiting

GDOH Challenges
- HPRS in HIS system?
- Internet connectivity

GDOH Solutions
- Add HPRS to CHW mHealth – "NHI Registration"
- Strengthen HPRS use → Clinicians (Tablets, HPRS + Labtrak)

#NDOH Support for scanners/barcode printers]



Service Package

MDT?

Per 50 000-80 000

Clinic

Facility-based care:
Minor acute ailments, HIV/TB and other communicable diseases, non-communicable diseases, mother and child health (incl. IMCI, FP, EPI, ANC/ PNC), violence/trauma, mental health

Community-based care:
Community-level home-based care, directly-observed treatment strategy, integrated nutrition programme, community-based rehabilitation, health promotion (incl. dietary advice/exercise), social work, environmental health, school health

+ Dr

Office + Extended Hours

10 000

CHC

After Hours / 24 Hr Emergency
Shared Services
Radiology
Pharmacy
Maternity obstetric unit (MOU)
Minor procedure theatre (MMC)
Short stay beds

Large CHC

Multi-disciplinary team:
Dentistry
Optometry
Physiotherapy
Occupational Therapy
Speech Audiology
Podiatry

1 Dentist + other cadres

Progressively contract **Additional Services**

to population?

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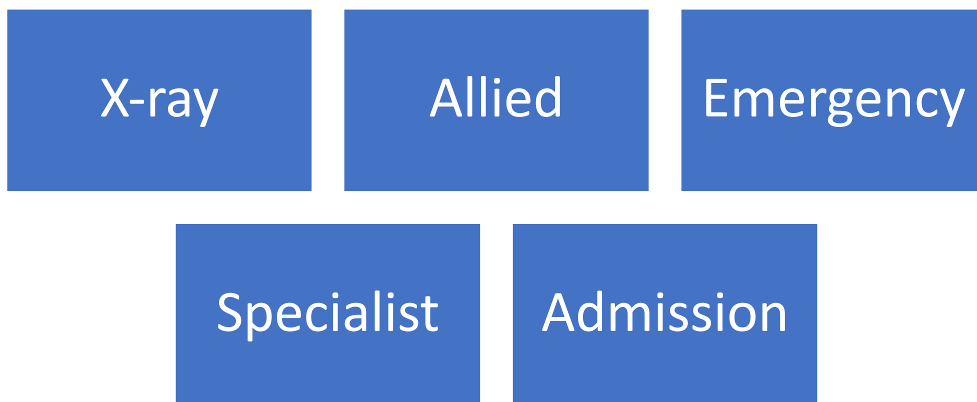
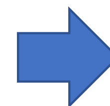
Referrals





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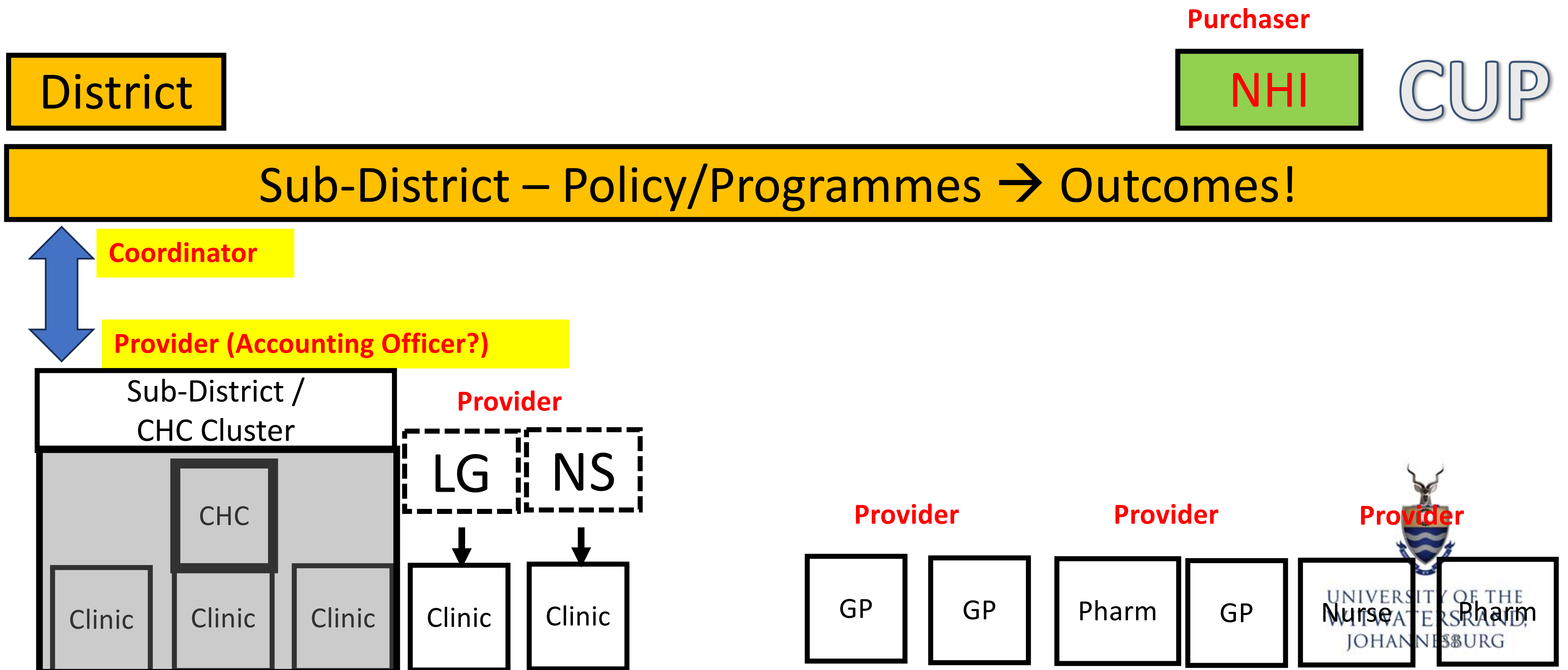
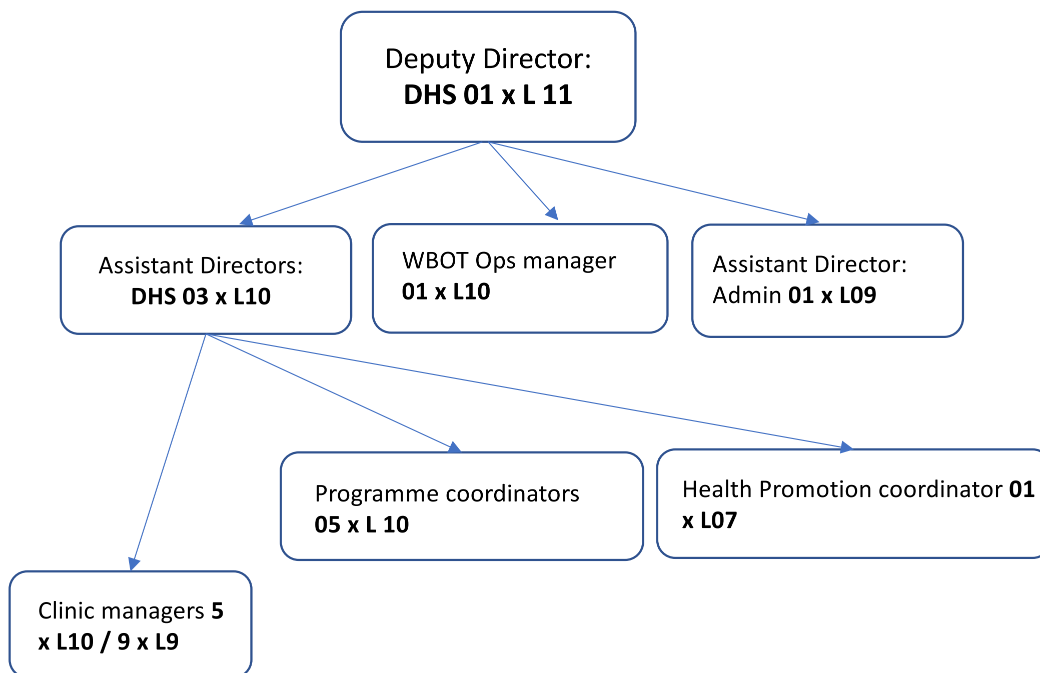
DHS re-organisation

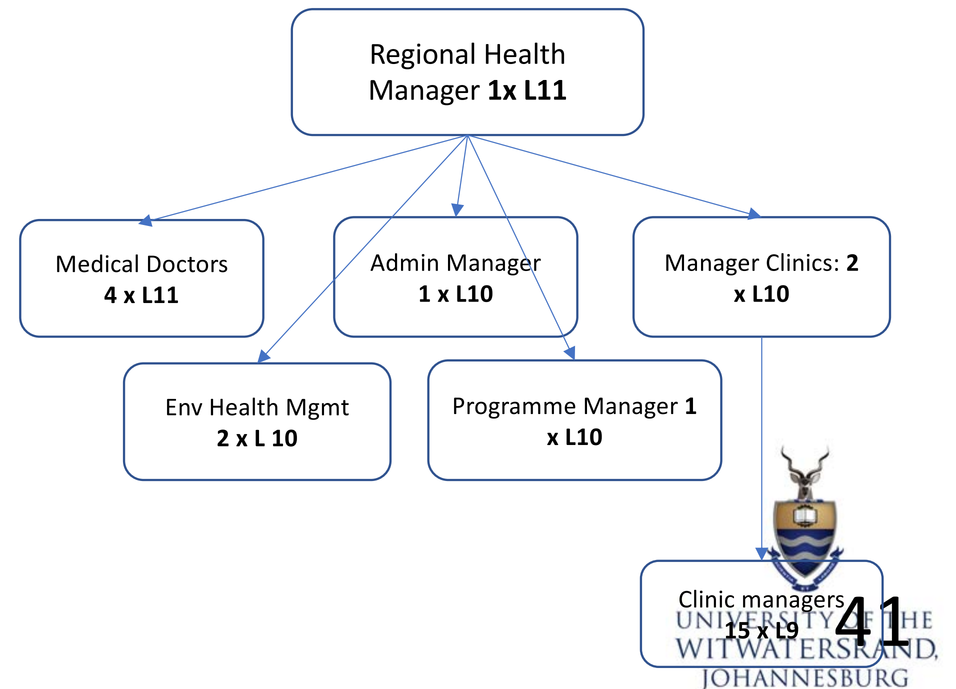


Current Sub-District D Organogram (1.6m ppl)

Provincial Sub-District D



CoJ Sub-District D



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Ideal Capacity (with provincialization)

JHD / DHMO

- 10x Cost – No add funds

Sub-District D Manager (L14)
01x Deputy Director (L11)

Who will contract as PHC Public Provider?

Director CUPs (L13)

Assistant Director (L10) per CUP to coordinate ALL Providers

Director: Finance & Cooperate Service (L13)

Director HR (L13)

Director PHC (L13)

Deputy Director: Finance (L11)

Deputy Director: Corporate (L11)

Deputy Director: IT / HIM (L11)

Deputy Director HR (11)

5 CUPS

Deputy Director PHC (L11)

Deputy Director Programmes (L11)

Deputy Director Admin (L11)

Assistant Director PHC (L10)

Assistant Director Finance (L10)

Assistant Director Corporate (L10)

Assistant Director IT/HIM (L10)

Assistant Director HR (L10)

Assistant Directors (L10)

Assistant Director General (L9)

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Private provider contracting

- GP Contracting-Out → FFS [= low FFS / overservicing / District Surgeon / apart]
- MO Sessions → Sessions [wkly clinic visits / #s / few / low pay] MO FT?
- GP Contracting-In (Tshwane) → Sessions [=FT at clinics / MO G3 with COT]
- MCWH (EPI/FP) → FFS [FP R50/Imm-IUCD-HCT R150/Other R350]
- GP Cell Care (Term) → FFS [R1500+]

- Providers identified by Clinics: 43 GPs in Soweto (but >100 in SOIPA)
- 42 private allopathic providers in Chiawelo CUP (1/5 of Soweto)
  - Senaoane (low income): 3 GPs / 2 Pharmacists
  - Protea Glen (mid income): 11 GPs / 2 Dentists / 7 Pharmacists / 1 Psychologist / 5 Optometrists

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Private provider contracting

- GP?
- Nurse Clinics: Unjani / Alma
- Pharmacy Clinics: Clicks, Dischem, Alpha Pharm
- Hospitals?

Accountable Doctor?

News / Legal Brief

Amendments to the Ethical Rules – a step in which direction?

Dec 7,2023

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Private provider contracting

GENERAL PRACTICE INSPECTION TOOL
DISCUSSION DOCUMENT DRAFT 3

- Domain 1: User Rights
- Domain 2: Clinical Governance and Clinical Care
- Domain 3: Clinical Support Services
- Domain 4: Governance and Support Services
- Domain 5: Facilities and Infrastructure

Domain 1: = Chapter

Sub-domain 2: = Regulation he

Standard 3: = Sub-regulation

Criterion 1: = Sub-regulation

Measures

1.
2.
3.

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Private provider contracting

Service Package

- Service Package includes (Clinic with Dr/ GP with 'Clinic team')
  - Unlimited Free Consultation
  - PHC elements of SA guidelines by team incl. accountable doctor (teamwork/COPC)
  - Office-hour visits at Health Establishment
  - Extended hours visits in complexes of 50-80 000 (17h00-21h00/Sat/Sun)
  - Preventive Services e.g., immunisations, family planning, pap smears, antenatal/postnatal care – from JHD Pharmacy (current)
  - Medicines (extended EML) – from JHD Pharm (manage risks)
  - Investigations (extended ELL) - use NHLS (manage risks)
  - Office Procedure List (81 from NHRPL to limit hospital referrals)
  - Commitment to 4 Principles

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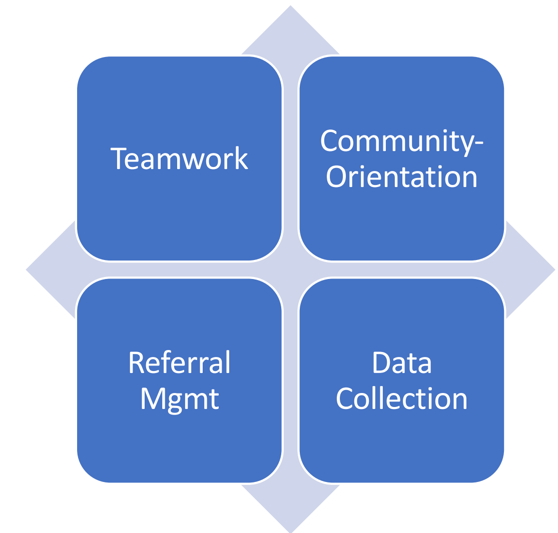
Private provider contracting



- STRENGTHEN TEAMWORK
  - Include nurses, CHWs, pharmacy assistant
- STRENGTHEN COMMUNITY-ORIENTATION
  - Profile and actively manage panel population (with own CHWs)
  - Practice with strong records, links to CHWs and appointments
  - Engage panel population leaders / patient reps mthly
  - Use information for targeted health promotion
  - No discrimination between NHI and non-NHI (back and front sections)

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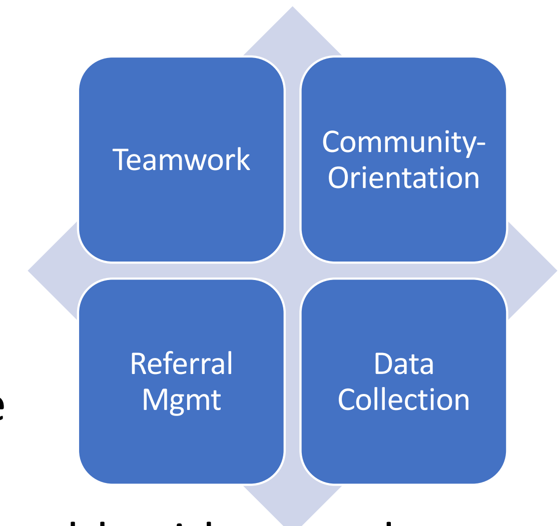
Private provider contracting



- STRENGTHEN REFERRALS
  - Set up NHI Referral Network using Vula for public service
  - Peer review system for referrals + visits, meds, labs etc.
  - Progressively include private specialists-hospitals/allied health with more data
  - Train all doctors in PG Diploma Family Medicine
- STRENGTHEN DATA COLLECTION
  - Strong performance management
  - Initially Payment Management Systems + EDI / Audit systems
  - Progressively move to Electronic Health Record (EHR) data

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Private provider contracting

- Registrations / Enrolment
  - Health Establishment/Facility Registry
  - Provider Registry
  - Health Patient Registry System
    - HPRS connection
- Panels
  - 2500
  - 10000

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Payment system range

Line-item Budget

- Africa
- Per facility
- Demand-driven [=salary]
- Paid in advance
- Benefit - simple
- System Risk - unresponsive
- Provider risk - low

Capitation

- UK
- Per person per year / (Per capita)
- Need-driven (risk-adjusted
- Paid in advance
- Benefit – admin simple / responsive
- System Risk - underservice / over-referral
- Provider risk high

Fee for Service

- Private/USA
- Per visit
- Demand-driven
- Paid shortly after
- Admin claims-based
- Benefit - responsive
- System Risk - overservice
- Provider risk low

Performance Payment

- UK / Rwanda
- Per performance
- Performance-driven
- Paid after while
- Admin data-based
- Benefit- performance
- System Risk – data challenges
- Provider risk medium

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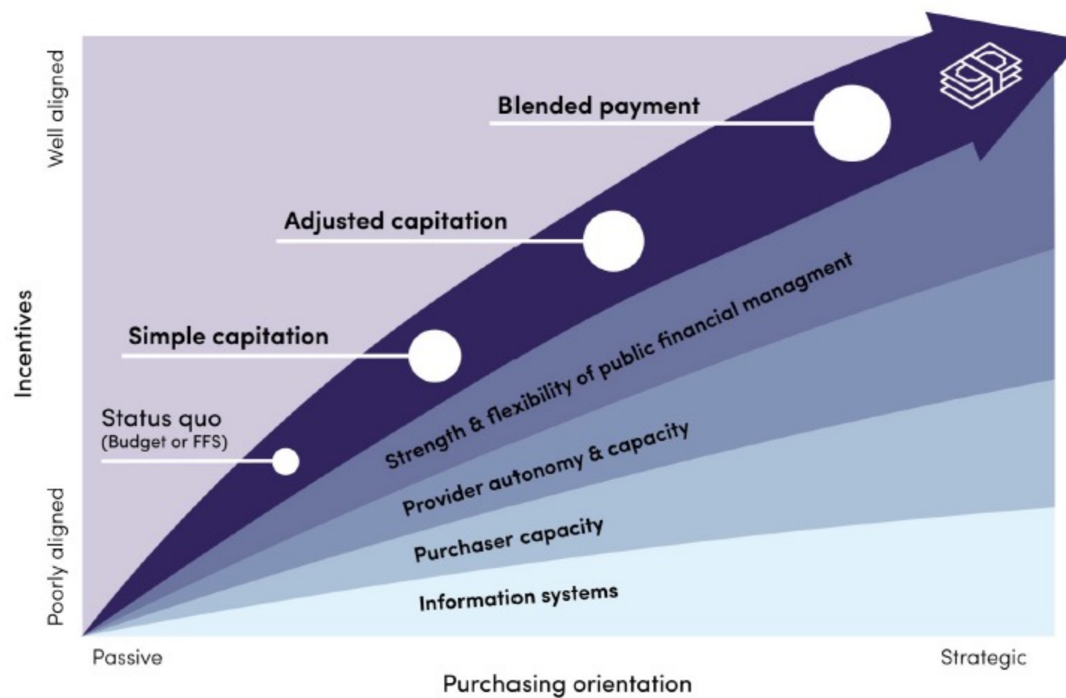
Payment continuum

Pathway to a more strategic provider payment system



Adjustment Tables

- Age
- Gender
- Socio-Economic Status
- Morbidity

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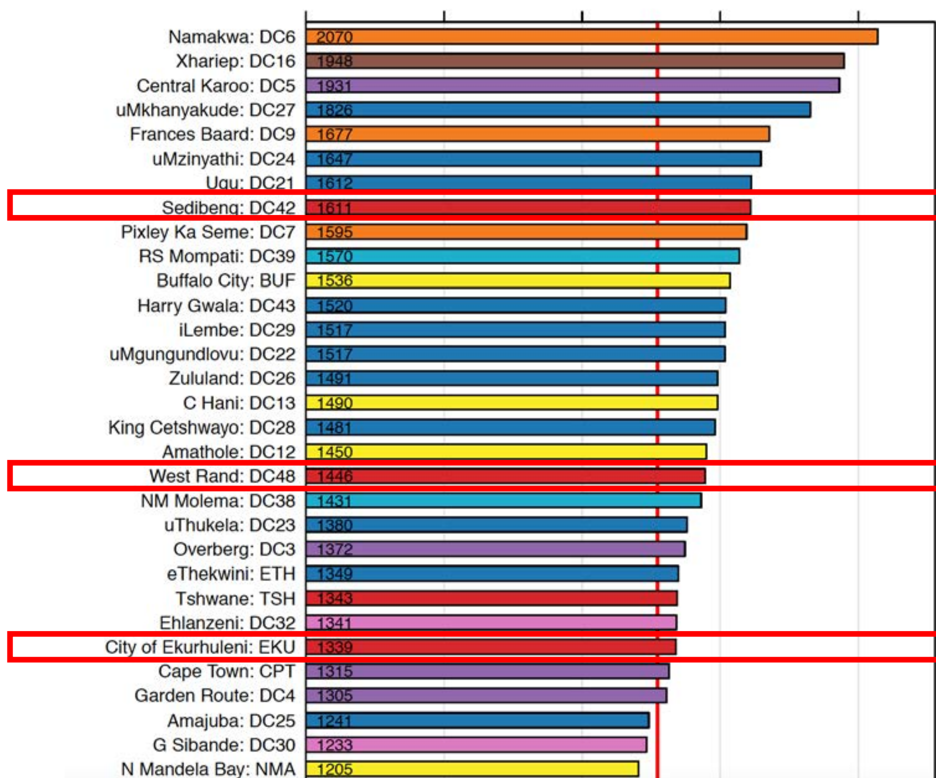
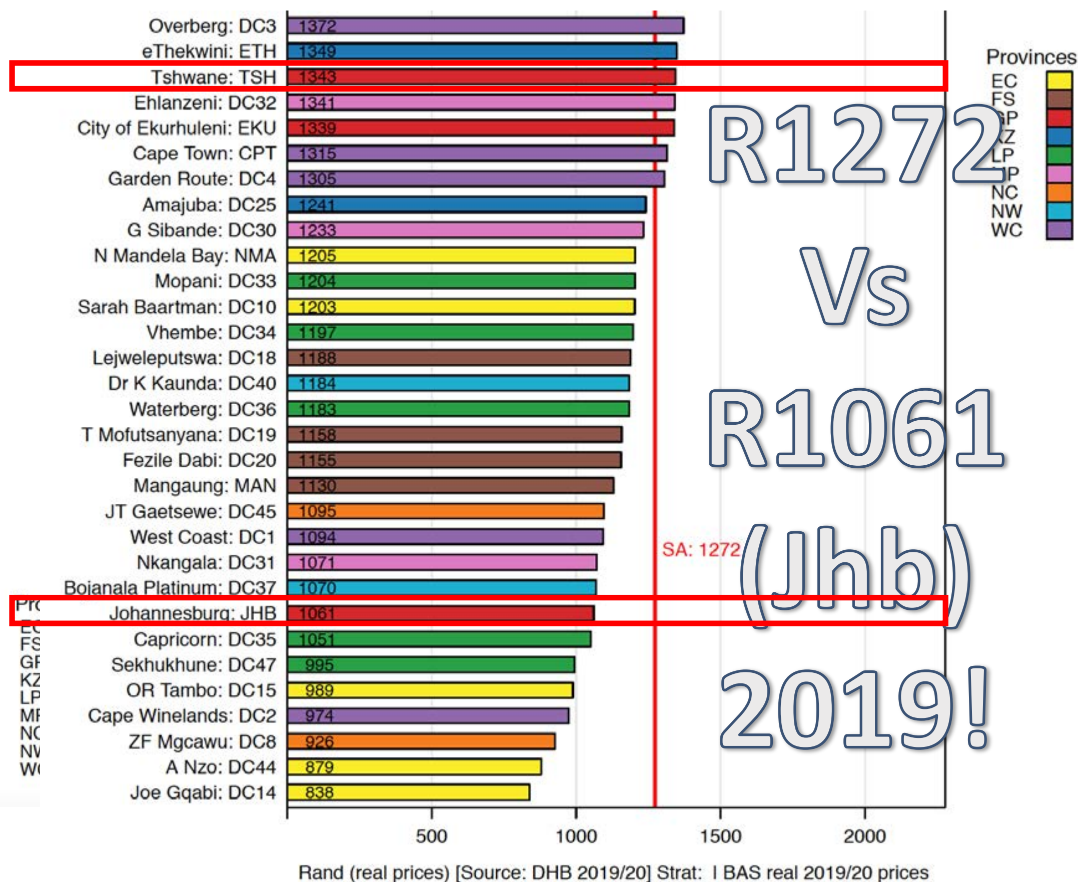
Costs

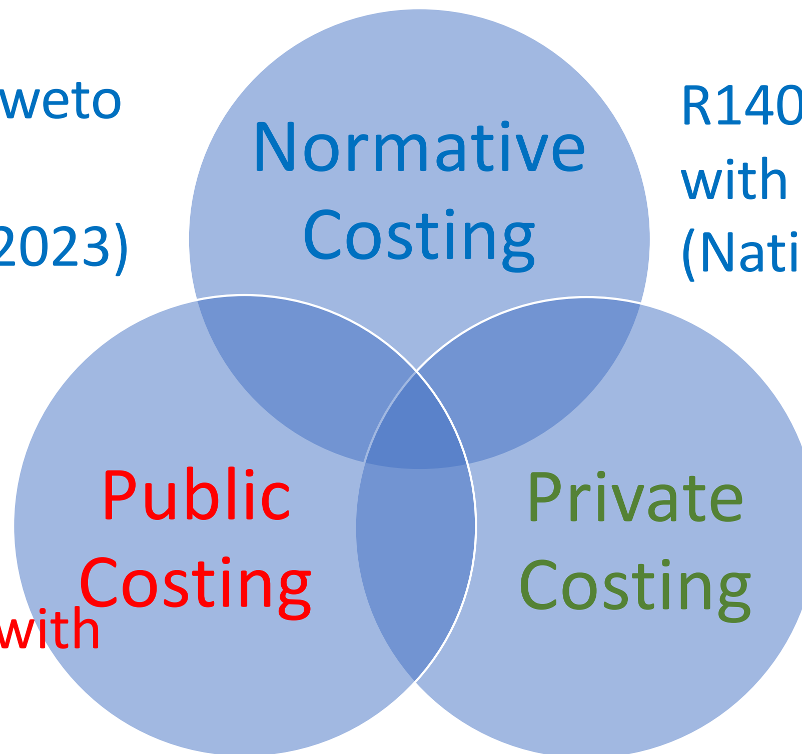
Figure 9: Provincial and local government PHC expenditure per capita (uninsured population) by district, 2019/20 (Rand, real prices)





Private provider contracting

R2017 per capita in Soweto
with 2 visits pppy
(Soweto Clinic Mgmt, 2023)



R1400 per capita in Soweto
with 4 visits pppy
(National Treasury, 2018)

R1272 per capita in SA with
2 visits pppy
(DHB 2019/2020)

R1220 per capita in SA wi
4 visits pppy
(Keycare, 2018)

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Utilisation by Practice Size

		Acute/Chronic				FP etc.
	Utilisation	1	2	4	6	1
Practice						
2500		10	20	40	60	10
10000		40	80	160	240	40

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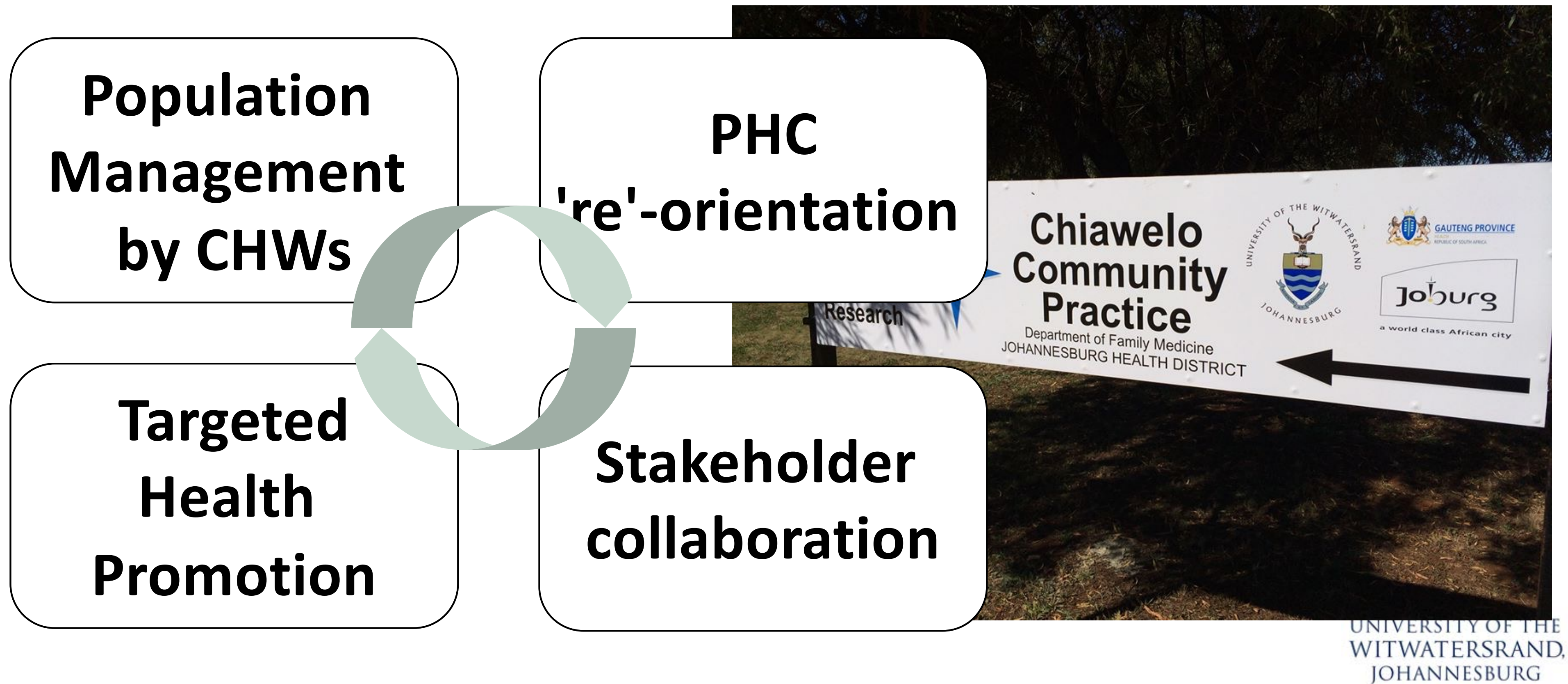
Community Oriented Primary Care (COPC)



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Still in discussion

GGT2030
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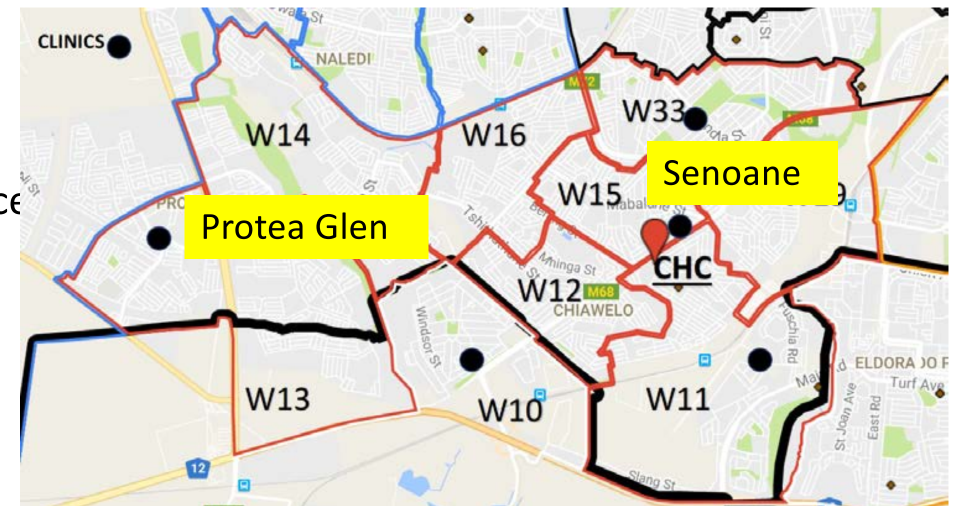
Proposal (with R6-8m from NDOH for 2023/2024)

Test contracting to improve access and double budget for two public clinics (low/middle income) ±R70m for ±120 000 ppl

- **Senaoane Clinic** (45 000 in W15/16) [very low income] → Contract current [3 GPs?] + new providers [for 22500 ppl @ ±R1200ppy = R27m]
- **Protea Glen Clinic** (69 000 in W13/14) [civil service / middle income/MA] → Contract current [11 GPs?] + new providers [for 34 500 ppl @ ± R1200ppy = R41.4m]

WAY FORWARD:

- Contract third party (e.g., FPD/WHC) based on agreed admin contract (incl. support clinic shadow budgeting / changes)
- Open call for provider contracting in specific wards based on agreed provider contract/pricing



GAUTENG
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

GGT2030
GROWING GAUTENG TOGETHER

Way forward for Districts

- Monthly education/education on NHI [NHI Champion]
- Monthly reports on
  - Ideal Clinic Readiness **[QA]**
  - HPRS registration/visit progress [HIS]
  - Internet / Hardware / Permissions / Use of Labtrak on HPRS **[IT]**
  - CHC Clusters formation (with all providers) + Clinical Governance Mtgs **[Sub-District Managers / Family Physicians]**
  - MCWH / COVID Contracting **[MCWH/Public Health]**
  - CHC Cluster Profiles / APP Indicators **[NHI Champion]**
  - District-wide private sector engagements **[NHI Champion]**
  - Develop test sites for contracting providers **[NHI Champion]**

Thank you
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I serve with a
Smile