Percept NHI Policy Brief Series:

Matching Supply & Need

Health resources include health workers (like doctors, nurses, physiotherapists and community caregivers); health facilities (like hospitals, clinics and pharmacies); health supplies (like medicines, x-ray machines and bandages); and infrastructure (like ambulances, hospital beds and consultation rooms). These resources are not equitably divided across South Africa: the people and places with the greatest health needs often have the fewest resources. Understanding how we can better use and share health resources is crucial to the NHI's success. By understanding need, we can ensure health resources are delivered to the right people in the right places. But to do this, those health resources also need to be available, with enough flexibility to reorganise themselves.

What resources are available?

The **public** system consists of a large number of primary healthcare (PHC) facilities and a hospital platform at varying levels of complexity (ranging from district hospitals to central hospitals). The vast majority of staff are employed on a full-time basis. Community-based and PHC services are free, irrespective of income. Hospital services are subsidised depending on a financial means test, with majority of the population paying no fees to receive hospital-based care. The fees that are billed are most often not recovered because of deficits in systems, skills and incentives to do so.

Private providers (particularly specialists and hospitals) tend to be concentrated in major metropolitan/urban areas, although access in underserved regions has been increasing in recent years. Patients tend to engage with a higher level of healthcare worker in the private sector – this is because gatekeeping and referral pathways are weak. Care tends to be less well co-ordinated in the private sector with each provider engaging separately. For example, PHC sees patients moving between doctors, dentists, optometrists, pharmacies and pathology labs – as opposed to accessing all of these services under one roof. This drives up cost in the private sector.

Where are the available resources?

Public sector: The majority of facilities were built during the Apartheid era and therefore the spatial planning reflects the racial segregation of the time. South Africa has for the most part only

maintained existing hospitals, for reasons varying from limited budget to poor planning, which has resulted in this skewed picture of access across the provinces.

Private sector: The insured population has better access to both facilities and to healthcare workers than the uninsured population. For example, there are approximately 390 beds per 100K insured population, while only 190 per 100K uninsured population in the public sector. Looking at the availability of surgical beds in particular in each sector, there are 4.5 times as many beds in the private sector on a per capita basis. In the private sector, resources are better matched to where the insured populations live and work because there is a financial incentive and more flexibility to do so.

Combining public and private resources: South Africa is currently operating two health systems that only partially overlap (both in terms of clients using both systems, and in terms of health workers working across both). The envisaged NHI reforms aim to integrate the two to allow both public and private providers to serve the entire population. It is likely that, given the shortages in human-resources-for-health, that even pooling all resources may still not be adequate for the need, particularly given the metropolitan slant to the location of private providers.

Understanding misalignment between supply & need

Poor planning and coordination: At the moment, we do not effectively plan to manage South Africa's health resources. There is no organisation collecting the right information to advise on where health resources are needed and in what amounts. Sometimes the information itself is not available (either in the public or private sector), making it difficult to design a system that sends health resources where they're needed.

Public and private sectors will need to collaborate on planning to achieve the 'whole system' approach.

Inflexibilities in public sector financing: Public healthcare budgets are planned in three-year cycles, with very little room for change. Small changes can be made on a yearly basis, and only if there is an urgent need. When budget plans are set, planners are often guided by past budgets rather than the needs and priorities of the time.

Insufficient data: Apart from TB and HIV cases, we have very little information about individual patients in the public sector. Without regularly-collected, individual-level information, one cannot form a good picture of what the needs are, or match resources where they're needed. Private sector medical schemes have this information, but not aggregated for the industry. **In order to function as**

it is intended to, the Fund will need comprehensive data, the ability to interpret it in terms of health needs and a sound decision-making apparatus to transform evidence into action.

Medicolegal and defensive medicine: Both the public and private health sectors are facing a crisis of medicolegal claims against them. In the public sector, these claims are made against the provincial department of health, rather than individual health workers. But in the private sector, health providers have to take out expensive malpractice insurance. This affects private healthcare in a few important ways: 1) providers might avoid certain high-risk professions, leaving those needs unmet, 2) healthcare prices go up, as providers try to cover the costs of insurance; and 3) to avoid legal claims and cover their bases, providers might perform unnecessary tests or procedures to cover their bases, making healthcare even more expensive.

Hospi-centric private sector benefit packages: In the private sector, services covered by medical schemes are more likely to be accessed. This means that service is organised around what is demanded (shaped by what is covered), rather than what is needed.

Some of the ways to close the gap

Designing benefits to support need: The Draft NHI Bill (2019) suggests a Benefits Advisory Committee to help design the package of health services that citizens are entitled to under the NHI. The committee is intended to be responsible for designing treatment plans and benefits that will give South Africans the most value for money and improve health – no small task. Designing one, holistic benefit package that draws on both public and private resources to deliver care would allow South Africans access to the most effective care, without providers having to be concerned about whether an individual can pay.

Purchasing from the private sector: It is intended for the NHI Fund to be able to contract private providers and, in doing so, widen access to the supply. This is dependent on the ability of the two sectors to negotiate fair prices, using the promise of volumes to offset the decrease in price.

Contracting for value: The main way that health resources for the NHI are likely to be reorganised is through new ways of contracting providers that encourage efficient, quality care. Designing the right payment system is crucial, and should reward providers that reorganise resources towards people's needs, while keeping healthcare effective and affordable.

Task sharing: In some cases, there may not be enough health workers, or the right types of health workers, to meet healthcare needs. One way of addressing this is to change the scope of practice of who does what. This means moving some of the responsibilities of higher-level staff to lower-level staff, i.e. from doctors to nurses, or nurses to community health workers.

Non-traditional places of care: Providing critical care in hospitals is very resource-intensive. Some procedures, and types of care, can be delivered in other, more affordable facilities, like day hospitals. For primary health, community health workers can also shift care from clinics into homes. The Fund should be flexible enough to allow and encourage providers to shift care to different settings.

Smart, creative use of resources: Technology can help us find new and smarter ways of using health resources effectively. This means having policy that is flexible enough to adapt to fast-paced change. One large healthcare purchaser, with a lot of rules and processes, can slow or shut down new ideas. Policy should create room for testing and rolling out new health technology for patients' benefit.

Small-scale experimentation and regular policy adaptation: It can be difficult to make sure that a health system is always changing and improving. Making changes across the whole system can fail because the changes are ambitious, or because local contexts are not considered. Instead, we should start by experimenting at the local level — exploring new and better ways of matching health resources to need. Policy needs to be flexible enough to test and incorporate these new methods.