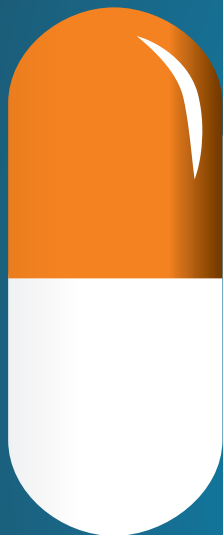


Improving technical efficiency in health spending in Africa



Hospital services purchasing in South Africa

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Acronyms and abbreviations

ALOS	average length of stay
BTR	bed turnover rate
ES	equitable share
HPTDG	Health Professions Training and Development Grant
HRG	Hospitals Revitalisation Grant
IGFR	intergovernmental fiscal relations
NGO	non-governmental organisation
NHI	national health insurance
NTSG	National Tertiary Services Grant
OCC	occupancy
OECD	Organisation for Economic Co-operation and Development
PDE	patient day equivalent
PFM	public financial management
SMR	standardised mortality rate

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1. Introduction

South Africa's government spends a considerable amount on health, both in absolute terms and relative to total government expenditure. However, compared to countries with similar levels of healthcare spending per capita, health outcomes often disappoint. Some part of this is due to differences in disease burden, not least South Africa's HIV epidemic. However, inefficiencies in healthcare expenditure also play their role.

The World Health Report 2010 rates hospital-related inefficiencies amongst the ten leading causes of health system inefficiency (WHO 2010). This case study looks into the detail of South Africa's hospital financing and performance in terms of efficiency; more precisely, it proposes and develops elements of an answer to three questions:

1. How much does South Africa actually spend on hospital care, and what are the financing mechanisms?
2. What are some of the main causes of inefficiency in hospital services?
3. What are some of the solutions to address these inefficiencies?

The main tenet of the case study concerns linking financing to hospital outputs. In section 2, we discuss how South Africa finances provinces, a system in which equitable share (ES) and conditional grants play a central role. We show that although they allow for some level of linkage between financing and outputs, the allocations remain driven largely by population. The system also implies that hospital-specific funding is *de facto* delegated to the provinces, which provide hospitals with fixed global budgets that do not reward increased productivity and efficiency. In section 3, we discuss the efficiency challenges that South African hospitals face, and demonstrate varying levels of efficiency among public hospitals. Section 4, then, discusses means of improving hospital efficiency, which revolve around linking hospital payments to hospital outputs, and giving hospitals a greater degree of autonomy. While these solutions are largely conceived independently of the public financial management (PFM) system, they require the PFM system to be reformed in order to be successful.

2. Financing hospitals in South Africa: an overview

The South African health system is made up predominantly of equally large public and private components, which together constitute about 90 per cent of the sector, and a small but growing NGO sector, which accounts for the remaining 10 per cent. The majority of the lower-income groups are served by the public sector, while the higher-income earners are served by the private sector. This case study focuses on public healthcare provision, specifically hospital services.

2.1 Budget-setting

Allocations from the national budget to the provinces consist of essentially two components: an ES and conditional grants. The national government sets the overall envelope for allocating funding to the provinces, and establishes indicative allocations by sector (health, education, etc.) and by province (the ES). It also establishes the size of conditional grants – earmarked allocations for specific purposes, including health.

Provinces then decide on how much of their ES envelope (topped up with the relatively low revenue derived locally) to use for health. From this total provincial health budget, the share of resources going to hospitals and primary healthcare is then determined.

Public hospital budgets are driven by annual adjustments to historical levels of spending, and do not take into account, for example, public sector wage increases or general inflation. They may incorporate budget responses to specific needs that arise from time to time, although hospitals frequently complain that they are required to implement new policies and priorities without additional funding (unfunded mandates). This implies that hospital financing is largely de-linked from hospital outputs and efficiency.

2.2 Allocation to provinces

The principle behind a geographical resource allocation formula is that funds should be allocated to an area in proportion to the health service needs of the resident population. Need is usually differentiated from actual utilisation to reflect the unmet needs resulting from differential access to services. The allocation of funds may also reflect policy decisions to privilege the needs of certain groups in order to promote an equitable distribution of health across the population. Most formulae usually begin with the size of the target population and then introduce other

factors that proxy the differential need for services across populations of the same size.

In South Africa, the main needs-based mode of distribution of resources is the ES formula used to allocate resources for services provided by provinces. The formula sets out what proportion is allocated across sectors and how this will be distributed among the provinces. In 2016, the formula allocated 48 per cent to education, 27 per cent to health,¹ 16 per cent to basic services, 5 per cent to institutional requirements, 3 per cent to poverty and 1 per cent to economic activity. Once the size of the pool for the sector has been determined on the basis of this appropriation, the allocation to the province by sector is in accordance with each sector's formula determination.

2.2.1 Equitable share

The health component of the formula uses a risk-adjusted capitation index, along with the output data from public hospitals to determine how much each province receives. In theory, these two components work together to balance health needs and demands.

Once the ESs are determined, the provinces, through their provincial executive councils, determine the allocation for each of the provincial departmental functions, taking into account the priorities underpinning the division of revenue, provided that they meet their obligations to deliver the services for which they are responsible.

Following various reviews of the ES formula, the current formula takes into account the population not covered by private medical insurance and level of output from the hospitals in a district, and adjusts the provincial share by crude population structure estimates to account for the differential health risks across different population cohorts.

Table 1 presents some scenarios of how different weights would affect the appropriation to the provinces. Column 1 shows a hypothetical allocation based on provincial population only (2015/16 mid-year estimates). The next column (population with non-medical aid weighting) bases the allocation on the population not covered by medical aid, who would most probably use the public health facilities. Column 3 adjusts the non-medical aid population by crude population structure (risk-

¹ An increase from 18 per cent in 1998/99.

Table 1: Health equitable shares (current system and example scenarios)

	Population only (1)	Population with non-medical scheme weighting (2)	Risk adjusted share (3)	Current system (4)	SMR weighted (5)
Eastern Cape	12.6%	13.3%	13.4%	13.5%	13.5%
Free State	5.1%	5.3%	5.4%	5.4%	8.1%
Gauteng	24.0%	22.2%	21.9%	21.4%	20.4%
KwaZulu-Natal	19.9%	20.9%	20.8%	21.8%	23.7%
Limpopo	10.4%	10.7%	10.7%	10.4%	8.1%
Mpumalanga	7.8%	7.7%	7.8%	7.3%	8.7%
Northern Cape	2.2%	2.1%	2.1%	2.1%	2.5%
North West	6.7%	7.2%	7.2%	6.7%	7.2%
Western Cape	11.3%	10.6%	10.7%	11.3%	7.8%

Source: 2015/16 budget data and author calculations

adjusted) to reflect the varying levels of health risk across age-groups. In principle, age and sex have an impact on need, since typically the very young (under-5, particularly under-1 years), women of reproductive age and the elderly have higher relative requirements for healthcare. Yet, at a large population level, distributions often do not vary substantially. The current share (column 4) adds to the risk-adjusted share a weighting for hospital-level outputs, partly to adjust for hospitals that may be receiving patients from other regions. Lastly, an allocation based on standardised mortality rates (SMR)² is presented in column 5.

The provincial population remains the key driver of each province's share, but notable differences can be discerned when comparing the population shares with the current share. Provinces such as Gauteng and KZN that historically have had good health infrastructure proportionally receive shares lower than their share of population.

2.2.2 Conditional grants

Conditional grants³ are received by the provinces in addition to the ES to be spent on the purpose mandated by national government. These conditional grants are the main mechanism through which provinces are accountable to the national government for meeting national priorities. Currently, health conditional grants are allocated for HIV/AIDS, health professions training, hospital revitalisation and tertiary services. The latter three all directly benefit the hospital sector, but none is linked to outputs.

- *The National Tertiary Services Grant (NTSG) (R10.31 billion)*. The grant aims to compensate provinces for the supra-provincial nature of tertiary services provision and externality or spillover effects, and to provide strategic funding to enable provinces to plan, modernise, rationalise and transform the tertiary hospital service delivery platform in line with national health policy objectives, with a particular focus on improving access and equity. It, thus, has both a function in compensating provinces for the

costs (recurrent and capital) of current services provided (including cross-boundary flows) and a capital development function in helping provinces with little capacity to develop their own services.

- *The Hospitals Revitalisation Grant (HRG) (R5.4 billion)*. This grant is for the physical upgrading or replacement of entire hospitals with sub-components for medical equipment, hospital management and quality improvement. Access to this grant is based on bids made by provinces to the department of health. Although bids must be backed by plans, there does not appear to be a particularly strong process for option appraisal or for the comparison of relative needs across provinces to determine priority in allocation.
- *The Health Professions Training and Development Grant (HPTDG) (R2.4 billion)*. The main objectives of this grant are to compensate provinces for additional costs of medical students in facilities, to compensate for reduced service time of qualified staff that participate in training, to compensate for reduced service time of qualified staff resulting from research activities intended as part of their normal activities (applies exclusively to specialists) and to provide for a redistributive component that could be used to develop training capacity.
- *Comprehensive HIV and AIDS and TB grant (R13.67 billion)*. The grant allocated a substantial sum to the provinces in 2015 for HIV-specific activities, including testing and counselling, antiretroviral treatment, medical male circumcision, post-exposure prophylaxis, prevention of mother-to-child transmission, and HIV and TB integration.

2.2.3 Own revenues

As a third source of revenue, provinces also raise their own finances through vehicle licensing, gambling licenses and service fees. This is a growing source of revenue, which, between 2010 and 2015 increased by an annual average of 13.4 per cent.

² 2009 data.

³ Grant amounts quoted are for the 2015/16 fiscal year.

2.3 Funding for public health services

In 2015/16, public funding for health services amounted to R149.45 billion (US\$10.5) (see Figure 1). The ES contributed 70 per cent of funding, with conditional grants and own resources making up the remainder.⁴ District health services accounted for 46 per cent of funding, of which 30 per cent was spent on clinic, community and other non-hospital services. The latter can be regarded as primary-level spending, although it is also suggested that many people obtain primary services by visiting district- and higher-level hospitals. There are no consistent international figures on the proportion allocated to primary care, but Saltman, Rico and Boerma (2006) suggest that just under 25 per cent of spending is typically allocated across Europe, which is comparable to the figure recorded in South Africa.

⁴ Provinces may top up health funding either from their own revenue or through a disproportionate allocation to health from the ES at the expense of other sectors.

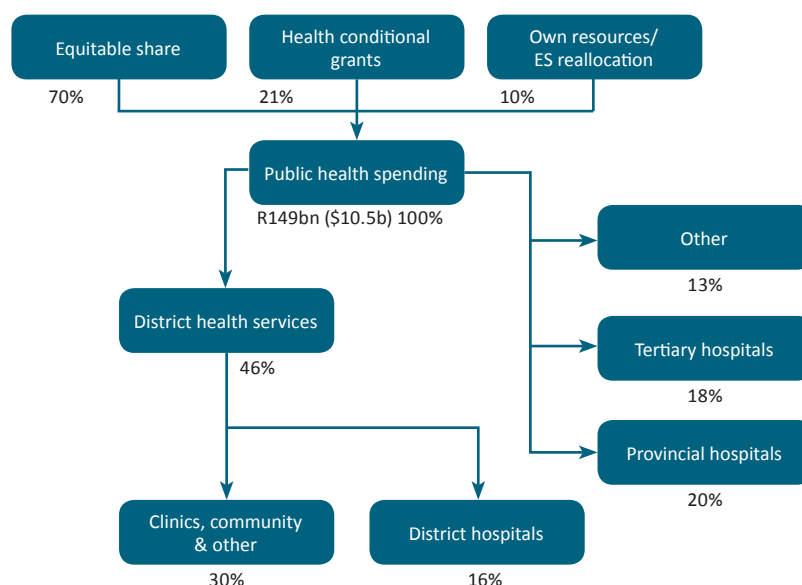
2.3.1 Spending patterns by province

Provinces fall into distinct groups with respect to hospital spending, with those that have well-developed hospital infrastructure (Cape Town, Gauteng, Kwa-Zulu Natal and Free State) devoting close to 60 per cent of public expenditure to hospitals.

Hospitals are funded using fixed global budgets, which are mainly historically determined and not linked to varying outputs levels over the year.

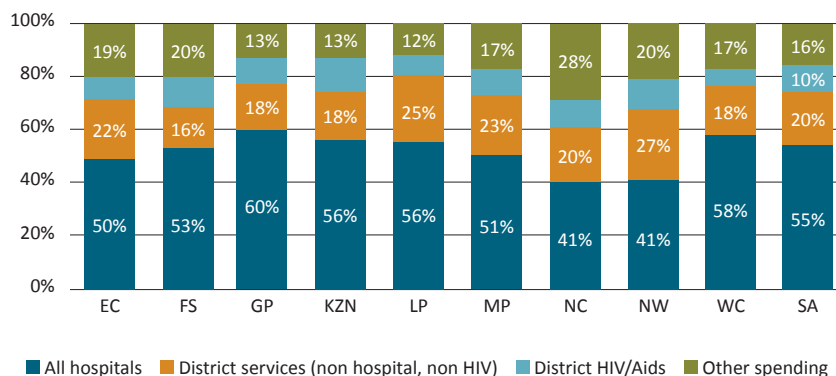
The Northern Cape and North West spend the least on hospitals, just above 40 per cent; over the past five years, improvements in hospital infrastructure in Mpumalanga, Limpopo and the Free State have seen these provinces spend just more than half of public funding on hospitals.

Figure 1: Public funding flows for health (2015/16)



Source: IGFR spending files, 2016 (<http://www.treasury.gov.za/publications/igfr/default.aspx>)

Figure 2: Public health spending by level and province (2015/16)



Source: IGFR spending files, 2016 (<http://www.treasury.gov.za/publications/igfr/default.aspx>)

3. (In)efficiencies in health spending

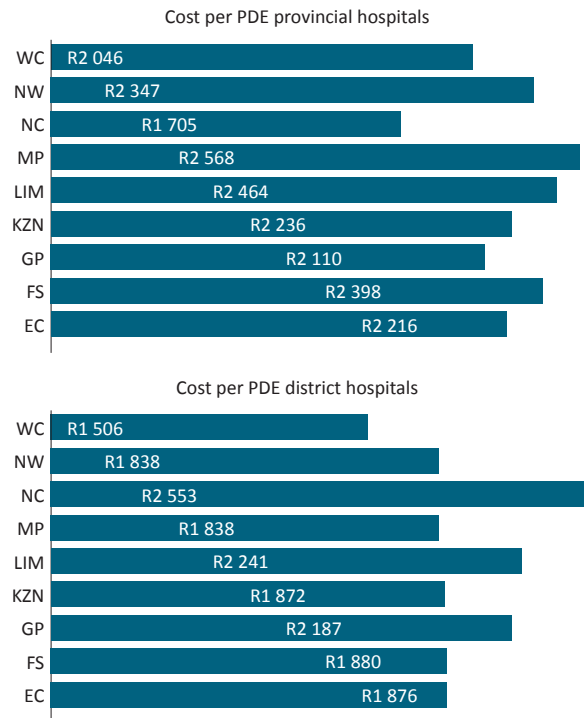
As is the case with many other countries, the efficiency of health spending in South Africa is under scrutiny, and there is evidence of inefficiency in the sector, in general, but also specifically in the hospitals. In Gauteng, the provincial treasury (in collaboration with the national treasury and health department) undertook an extensive investigation of reasons for financial imbalance (GDHSD 2009). This led to a report detailing areas where managerial deficiencies were causing waste. A number of inefficiencies, including the following, were identified:

- public procurement and contract management that leads to poor value for money with higher prices than those paid in the private sector despite the supposed advantage of public bulk procurement;⁵
- weaknesses in supply chain management, with stocks of supplies in central stores not being distributed, resulting in facilities resorting to emergency local purchasing of the same items;
- leakages (resulting from corrupt practices) of medicines and other supplies;
- a weak referral system that results in patients that could be treated at lower and cheaper levels of the system being referred too early or entering hospitals through self-referral.
- poor payroll administration, presence of ghost workers and not using registers to record that staff are actually working during the hours for which they are paid;
- Excessive and uncontrolled use of overtime and agency workers (regular workers often have an expectation about levels of overtime in their contracts that cannot be controlled by hospital management);
- Use of private ambulances despite the proximity of public ambulances (often housed within the hospital).

⁵ Poor planning, perhaps based on lack of information regarding local needs, appears to account for at least some of this loss. The Gauteng report, for example, cites an instance of one hospital allowing a contract for out-sourced catering that built in a management charge based on 350 patients per day, whereas the maximum number of patients ever accommodated was 289.

While a detailed efficiency analysis was not conducted, a quick assessment of the cost of care by level begins to show the degrees of variation in spending efficiency, as measured by per patient day equivalent (PDE). The efficiency indicator links financial information with service-related data from hospital admissions and outpatients.⁶

Figure 3: Expenditure trends by level of care and province



Source: Department of Health

⁶ The indicator value is calculated by dividing the total expenditure of the hospital by the patient day equivalent (PDE). The PDE itself is calculated by adding the number of inpatients plus 1/2 of day patients plus 1/3 of outpatient and emergency room visits. The results are then aggregated across the provinces for district and provincial data.

As illustrated in Figure 3, the median cost per PDE at district hospitals is around R1 800, and five of the nine provinces hover around this mark. However, the Western Cape has an average cost per PDE that is nearly 17 per cent lower than the median. Other provinces (Northern Cape, Limpopo and Gauteng) have much higher costs per PDE, nearly 40 per cent higher than the median. Assuming on average the same case mix and cost base, this range in cost indicates that some district hospitals are much more efficient than others. Similar deductions can be derived from the juxtaposed provincial hospital data.

The relative performance of the facilities can also be assessed using a Lasso diagram. This compares the productivity of facilities based both on bed-occupancy (horizontal axis) and bed turnover rate.

Bed occupancy measures the percentage utilisation of the beds that a particular hospital has over a period of one year. It is calculated using the following formula: $bed\ occupancy = inpatient\ days / total\ bed\ days$. This is the most common ratio employed to assess the efficiency of hospitals. In general, a hospital with a higher occupancy ratio is more efficient in the utilisation of its resources than one with a lower occupancy ratio.

The turnover ratio is a measure of productivity of hospital beds and represents the number of patients treated per bed in a defined period of time (usually a year). It is calculated as follows: $bed\ turnover\ rate = total\ admissions / number\ of\ beds$. In general, the higher the bed turnover rate, the more efficient the hospital.

The Lasso diagram (Figure 4, Figure 6) is divided into four quadrants based on mean values of bed occupancy and turnover. The first quadrant (I) groups the district hospitals with below-average bed occupancy and bed turnover rates. Most of the district hospitals are in this quadrant. These hospitals have the capacity to admit more patients. The second quadrant (II)

contains the district hospitals with below-average bed occupancy but above-average bed turnover rates. The third quadrant (III) represents district hospitals with above-average bed occupancy and turnover rates, indicating overcrowding. Almost one-third of the facilities are in this quadrant and most of these have an average length of stay (ALOS) below the mean, indicating that patients are treated quickly in those facilities. However, this does not guarantee efficiency, as many of the patients might have been admitted unnecessarily. Quadrant IV has district hospitals with above-average bed occupancy and below-average throughput. ALOS is longer in these hospitals.

The Western Cape and Gauteng are the best performers at district level, while the Eastern Cape and KwaZulu-Natal do not appear to perform well.

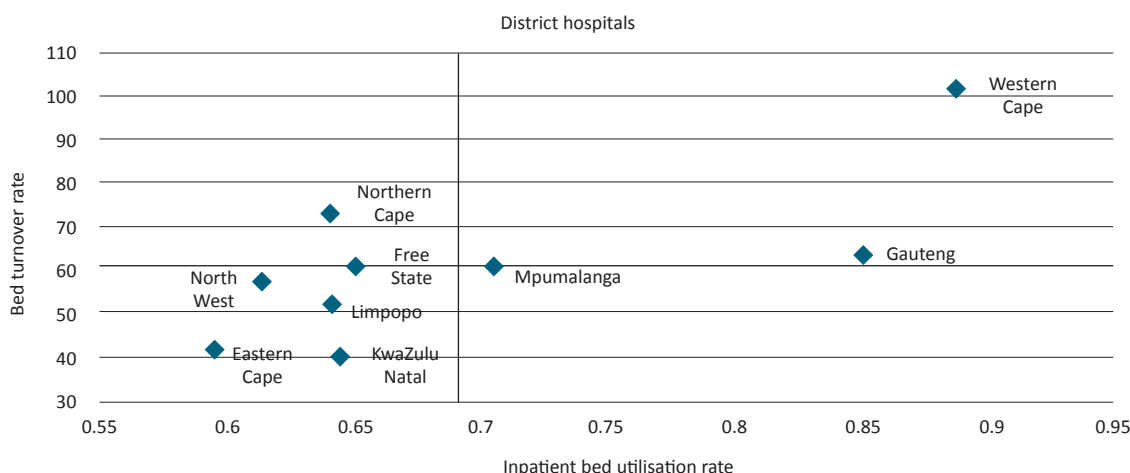
Provincial hospitals (see Figure 5, Figure 6) generally perform better than the district hospitals, with more hospitals within the acceptable efficiency range (Western Cape, Northern Cape and Gauteng) and a number of provinces with average (rather than poor) performance (compared to poor).

Higher occupancy for similar throughput implies longer lengths of stay in hospital. It could be plausibly argued that longer lengths of stay are indicative of a more complex case mix. Increasing complexity may also account for the increase in real cost per patient discussed above. It is also possible, however, that patients are being kept in hospital unnecessarily or that discharge is being delayed because of unsatisfactory community arrangements for follow-up care.

There are a few diagnostic implications for improving efficiency based on the Lasso diagram.

The summary efficiency analysis above shows differential levels of efficiency between hospitals. In this section, we have seen that hospital funding does not necessarily provide an incentive framework to improve efficiency levels. In the next section we discuss some of the solutions.

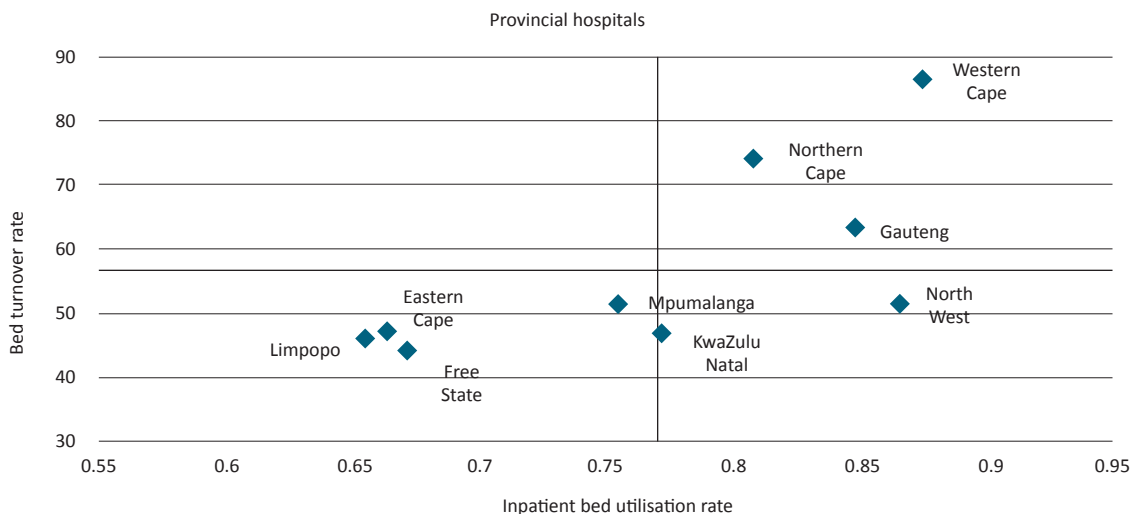
Figure 4: Lasso diagram of district hospital productivity⁷



Source: IFGR (2014), National Treasury and own calculations (see <http://www.treasury.gov.za/publications/igfr/default.aspx>)

⁷ Estimated as (occupancy rate*number of days in a year)/ALOS.

Figure 5: Lasso diagram of provincial hospital productivity



Source: IFGR (2014), National Treasury and own calculations (see <http://www.treasury.gov.za/publications/igfr/default.aspx>)

Figure 6: Lasso diagram and implications for hospitals

<p>Quadrant II: Low OCC, High BTR</p> <p>Surplus available beds, unnecessary hospitalisation or use of beds for purposes such as monitoring patients lead to prolonged patient stay and high rate of normal deliveries</p> <p>Recommendations</p> <ul style="list-style-type: none"> • Activating specialist and outpatient clinics for hospitals • Improving hospital management techniques 	<p>Quadrant III: High OCC, High BTR</p> <p>Acceptable efficiency performance with low unused capacity</p> <p>Recommendations</p> <ul style="list-style-type: none"> • Managers should continue improving efficiency as there is no upper limit to efficiency • Conform to current admission and hospital stay standards
<p>Quadrant I: Low OCC, Low BTR</p> <p>Oversupply of beds, low demand compared to approved capacity and potential demand and less need for hospitalisation</p> <p>Recommendations</p> <ul style="list-style-type: none"> • Merging of wards or transfer of services to associated clinics • Improving quality of services and the referral system • Limiting hospitalisation services through reduction of services • Ceasing any hospital expansion in the interim • Running diagnostics to identify and correct factors driving inefficiency 	<p>Quadrant IV: High OCC, Low BTR</p> <p>May be a high rate of patient services, admission of chronic patients, and unnecessarily long stays</p> <p>Recommendations</p> <ul style="list-style-type: none"> • Proper planning and use of modern management techniques, or providing new services and use of advanced medical technologies and equipment

4. The solution: developing appropriate health financing mechanisms

These causes of inefficiency identified suggest a number of prerequisites for change. Experience of health system reform worldwide suggests that reform of hospital financing needs to focus on four main interlinked areas (Ensor, Kruger & Lievens 2009):

1. realistic costing of hospital services and allocation across geographical areas, based on need and ability to deliver services;
2. active purchasing of services from providers;
3. decentralised facility management; and
4. activity-based provider payments.

4.1 Realistic costing and allocation of resources

At the national level, the two primary financing policy concerns are how much to allocate for public hospital (and other) services and how to distribute the funding.

- *Geographical location.* The current ES formula is a relatively simple way of targeting resources according to an approximation, and the formula has been revised recently to adjust allocations for age, while the NTSG has been revised to deal better with cross-boundary flows
- *Costs of care.* Although comparisons with funding requirements of public systems in other countries provide a strong case for boosting funding for the public sector, the concern of many is that systemic inefficiencies in resource use could mean that extra funding is squandered. An approach is needed that ensures a well-costed allocation for the sector while, at the same time, putting mechanisms in place that help the system to use current and additional funding more effectively.

4.2 Developing an active purchaser of services

Devolved provider governance and activity-led (hospital outputs) reimbursement requires different purchaser functions. In a vertically integrated planner-provider system, the 'purchaser' is responsible for performance, managing constituent units using bureaucratic controls (Figueras, Robinson & Jakubowski 2005). Two aspects of the conversion

from integrated planner-provider to purchaser are important.

First, there are the technical skills required to manage the process of purchasing. This includes the more sophisticated methods of contracting through the gathering of information on current practice of service provision reflected in the case mix and costs of services' development of budgets and payment regimes based on actual workload, as well as the details of contracting that specify volumes and quality indicators.

The second aspect concerns the actual process of converting a public administrator into an active purchaser of services. This is potentially the most difficult aspect of the process. There is relatively little clear international or local guidance as to how this process should be effected, although several countries have achieved a transformation in functions. The process requires a transformation in how the provincial health department is run, with a knock-on impact on the types of staff skill required (Light 1998).

4.3 Governance of providers

Decentralised governance of providers is increasingly seen as an essential step towards the improvement of public service delivery. Local managers are more likely to understand the local context and respond appropriately in a timely manner than are decision-makers at a higher level. However, the benefit of local management can only be realised if sufficient freedom is granted to local managers to make decisions (Holt & Murphy 2007). While there is some advantage to granting freedom to utilise non-staffing budgets in a flexible manner, it is probably only by giving control over staffing that such freedoms can be fully realised.⁸

Aligning incentives to encourage improved productivity is an important concomitant to these freedoms. If facilities continue to receive fixed global budgets, then motivated managers might still utilise new freedoms to deliver improved productivity. New reimbursement systems that link activity to payment can help

⁸ It is worth noting that the 'Hospital Strategy' developed in 1996 made similar recommendations for the decentralisation of power to health facilities (Monitor Company et al. 1997).

to make these signals clearer.⁹ In practice, use may be made of the four main forms of public sector governance permitting different degrees of management autonomy in South Africa: government agencies, public entities, government enterprises and government business enterprises.

4.4 Reimbursement of providers

Beginning to link financial allocation to activities is an important part of the process of providing more local control and autonomy over services. It also permits providers to benefit from improved productivity and constitutes an important lever for the purchaser in influencing provider practice.

Two important tendencies in reimbursement practice in OECD countries are apparent.

First, most countries have adopted, or are in the process of adopting, systems of provider payment that are based on case-mix adjusted activity. Second, cash-limited budgets remain an important dimension of control, even when activity-based systems are introduced (Hurst 1991). Global budgets for facilities need to embody a realistic expectation of both the cost of services and the level of activity that can be delivered.

⁹ The issue here is not that providers always require financial incentives to improve productivity. Intrinsic motivations to perform well, combined with extrinsic non-financial incentives, such as a more stimulating and pleasant working environment, can be sufficient to stimulate improvements. Financial incentives can help to reinforce the behaviours of intrinsically motivated staff by providing clearer signals about the type of service that should receive greatest priority, while helping staff that are more dependent on financial motivations to perform effectively.

5. Discussion

Increasing the autonomy of hospitals is a necessary reform to enhance the benefits of activity-based payment and budgeting, and the ministry of finance would be central in facilitating this. Autonomy could take a number of possible forms; possibly through the adoption of a level-1 public entity/government sub-component that extends limited autonomy to providers with regard to staffing, procurement and management of resources, and a level-2 corporatised organisation that places the governance of the facility in the hands of a board that determines both day-to-day management and organisational strategy. PFM regulations would have to accommodate these entities through a review of current governance provisions and appropriate amendments.

If hospitals were to become fully autonomous, with responsibility to allocate resources, then PFM needs to harden the link between resources and results for all hospitals, with an increasing emphasis on outcomes and a call for greater efficiency. PFM regulations would then also be compelled to allow budget managers to redeploy efficiency savings.

Possible reform measures that can be tracked through the budget cycle process include:

- a review of performance assessment tools at hospital level to ensure that they are linked to outputs;
- the development of standardised service agreements with all hospitals, with clear alignment between resources and expected results; and
- an improvement in budget ownership by allowing greater flexibility in allocating resources within budget limits

Hospital funding reform then also needs to be brought in line with the ongoing efforts to set up a national health insurance (NHI) scheme in South Africa. There are several challenges in implementing an NHI, the first of which, the long-term nature of the NHI reforms, especially when implemented in a context of growing public discontent about basic service provision, makes investment choices on some key changes politically unpopular because they are costly but do not show immediately observable results to the electorate. The challenge, then, is to maintain momentum and investment in all key areas that need unblocking for the NHI to remain on track, when there are competing, more immediate demands.

Second, the NHI is a ‘whole-of-sector’ reform that will require some rationalisation across the health system regarding the availability of services based on needs. However, until the NHI is fully rolled out, certain populations may remain underserved by the health system, pending detailed analyses and roll-out of services that now need to be extended within a national setting.

Third, ownership of the reform process is difficult to manage, as the NHI requires more co-ordination between the ministries of health and finance, as well as with the private sector and NGOs. Issues of ‘turf’ often arise, and there may be a tendency for actors to require a larger budget for reforms that they have insufficient capacity to implement.

6. Group work

Discussion question 1: Can you identify the ways in which the current funding system links hospital funding to outputs/activities? Do you think the incentives embedded in the current funding system are strong enough to improve hospital efficiency?

Discussion question 2: Do you think the PFM regulations in South Africa need to be changed to make the reforms described in Section 4 happen? What would be the main changes required?

Role play

Participants will divide into 4 groups and prepare to arguments to support the following statements:

- Group 1: “Historical line-item budgeting for hospitals is preferable to active purchasing in South Africa.”
- Group 2: “Active purchasing for hospitals is preferable to historical line-item budgeting in South Africa.”
- Group 3: “Hospital financing reform towards strategic purchasing is notoriously complex, yet full implementation can be achieved within a three-year time-window providing there’s strong leadership and political will.”
- Group 4: “Hospital financing reform towards strategic purchasing is notoriously complex, and barring some examples, it takes makes much longer than three years to make significant progress in this area.”

The arguments will be presented in plenary. This will be followed by an anonymous voting to see who won between Groups 1 and 2 and also between Groups 3 and 4.

References

- Ensor T, Kruger J & Lievens T (2009) *Note on international experience of financing hospitals*. Oxford: Oxford Policy Management, prepared for National Treasury, RSA.
- Figueras J, Robinson R & Jakubowski E (2005) *Purchasing to improve health systems performance*. Maidenhead: Open University Press.
- GDHSD (Gauteng Department of Health and Social Development) (2009). *Report on cost-cutting and reprioritisation of the 2009/10 Gauteng department of health budget*. Johannesburg: GDHSD.
- Holt KV & Murphy M (2007) Public hospitals in South Africa: Stressed Institutions, disempowered management. In Buhlungu S (ed.) *State of the nation: South Africa 2007*. Pretoria: HSRC Press.
- Hurst J (1991) Reforming health care in seven European nations. *Health Affairs*, Fall 1991: 7-21.
- Light DW (1998) Is NHS purchasing serious? An American perspective. *BMJ* 316(7126): 217–220.
- Monitor Company, HPI, Centre for Health Policy, & NALEDI (1997) *Hospital strategy project*. Johannesburg: Funded by the European Union through the Department for Health.
- Saltman RB, Rico A & Boerma W (2006) *Primary care in the driver's seat? Organisational reform in European primary care*. Maidenhead: Open University Press.
- WHO (World Health Organisation) (2010) World health report. *Health systems financing: The path to universal coverage*. Geneva: WHO.