



Briefing Paper:

A People's NHI in South Africa – possibilities, prospects and pitfalls

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1. Introduction - South Africa's Health and health care situation

South Africa faces a health crisis and our public health system is near collapse in many areas. The country suffers a massive burden of HIV and TB, trauma and injury, diseases affecting mothers and children, and an epidemic of non-communicable diseases, the latter rising at rates beyond the health system's ability to cope. Although we run the largest ART programme in the world, HIV incidence amongst young women is not declining and may even be increasing. Given that our health care expenditure is high as a percentage of GDP, our health outcomes are very poor compared to other countries of similar economic development. There is huge inequality between public and private health sectors, urban and rural sectors and the amounts spent on primary versus tertiary care. Most diseases in South Africa are caused by social, economic and political determinants which require inter-sectoral upstream interventions but which our policies and programmes are failing to address.

1.1 Rationale for the NHI

This crisis, and particularly the gross inequality between public and private sectors, coupled with spiralling costs in the private sector way above the rate of inflation, has prompted the recent efforts in South Africa to seek a more equitable health system through the establishment of a National Health Insurance Scheme (NHI). This has occurred at the same time as there has been a global movement towards achieving universal health coverage (UHC), incorporated as a target of goal 3 of the Sustainable Development Goals (SDG). The stated intention of the NHI in South Africa is to realise the right to comprehensive health care of good quality for everyone on the basis of need, while ensuring that no one experiences financial hardship in accessing the care they need. Comprehensive care includes promotive, preventative, curative, rehabilitative and palliative health services regardless of people's socio-economic or health status.

While the immediate origins of the NHI can be traced to a resolution of the 2009 Policy Conference of the African National Congress (ANC), health system reform has a much longer history in South Africa. In fact, the recommendations of the pre-apartheid Gluckman Commission in 1945 were the first to consider the possibility of a National Health Service for all South Africans based on a model of Community-Oriented Primary Care (COPC)¹. However, the Commission's recommendations, then far ahead of their time, fell by the way with the ascendancy to power of the National Party in 1948 and the implementation of apartheid which systematically denuded the majority of South Africans of access to services, including health services. Ironically, the experiences of COPC and the insights of the Gluckman Commission in South Africa helped to inform global understanding of a new model of health care that culminated in the Alma Ata Declaration of Primary Health Care and its adoption at the World Health Assembly in 1978².

In South Africa, following on the National Party election victory in 1948, the next 40+ years witnessed the gradual implementation of apartheid which institutionalised discrimination in health and denied any rights to health care for black South Africans. In the 1980s, as the liberation movement gained momentum, anti-apartheid formations, both inside and outside South Africa began to think more carefully about what a future health system might look like in a free and democratic South Africa. Early policy documents looked towards a National Health Service (along the line of the UK health system) as a model, though some discussion also took place on the idea of a

¹ See Harrison D. The National Health Services Commission, 1942-1944--its origins and outcome. *S Afr Med J.* 1993 Sep;83(9):679-84 and Phillips HT. The 1945 Gluckman Report and the establishment of South Africa's health centers. *Am J Public Health.* 1993 Jul;83(7):1037-9.

² Marks S. Reflections on the 1944 National Health Services Commission: A Response to Bill Freund and Anne Digby on the Gluckman Commission, *South African Historical Journal* 2014; 66:1, 169-187, DOI: 10.1080/02582473.2014.890331

Social Health Insurance in which employed workers who contributed to a social solidarity fund would be able to access care based on the membership of the fund³. The ANC Health Plan which informed the first democratic government's health vision was essentially one of a national health service funded through tax and delivered through public services.

What the new democratic government inherited in 1994 was a deeply divided health system, not only balkanised into multiple homeland systems by apartheid, with its attendant urban-rural disparities, but also an entrenched private sector sustained by private medical insurance catering for a small percentage of the population who were, in the main, whites able to purchase medical insurance. The co-existence of a private sector catering for about 16 to 20% of the population but spending close to half of all health care expenditure and a public sector catering for the rest of the population using approximately the same resources has remained a defining feature of the South African health system.

It is not just the inequalities in expenditure per capita between public and private systems but the inextricable linkage between the two sectors that is the problem. For example, skilled health personnel, particularly doctors and medical specialists, are drawn out of the public sector into the private sector because of higher salaries and easier conditions of work with the result that even when posts are available in the public sector, it is hard to fill such posts, particularly in the most marginalised rural areas. Similarly, the tax rebate given to medical aid members is an opportunity cost since the lost revenue to the fiscus is funding which potentially could bolster public sector services.

It was these ongoing inequities in the health system that led the ANC to commit to a National Health Insurance as a vehicle for fundamental health system reform in 2009. The policy envisaged an NHI funded through a solidarity mechanism where the rich cross-subsidise the poor through taxation. It was envisaged that general tax probably supplemented by an employment levy would contribute to a large funding pool, thereby constituting the NHI Fund. This fund would be used to purchase services from accredited providers in both the public and private sectors. The NHI is explicitly framed by the Minister as a vehicle to enable the realisation of health as a right and as part of the state's obligations in this regard.

The core idea of solidarity funding through tax should be supported by all concerned about the deep inequality in our health care and that poorer and sicker members of society should enjoy greater access to services without incurring financial hardship. This would not only be fair but also lead to improved economic productivity. Moreover, since the private sector houses many of the country's health resources – facilities and personnel – widening access to these resources, currently sequestered in the private sector environment - would mean that citizens who cannot now afford to utilise them, will be able to make use of a wider set of services than currently the case. It is for these reasons that the announcement of a NHI was welcomed by the labour movement and progressive civil society.

1.2 The evolution of the Policy

The first formal government policy statement on National Health Insurance (NHI) was the Green Paper on the NHI, released for public comment in 2011, which described the NHI as *“a healthcare financing mechanism that covers the whole population”* which required four simultaneous and key interventions: *“a) a complete transformation of healthcare service provision and delivery; ii) the total*

³ See Critical Health. Health and welfare in transition. A report on the Maputo Conference April 1990. Double edition August 1990, numbers 31/32.

overhaul of the entire healthcare system; iii) the radical change of administration and management; iv) provision of a comprehensive package of care underpinned by a re-engineered PHC." The Green Paper introduced the idea of a single payer (ie purchaser) of services, which would be the NHI Fund, although it did note that a *"multipayer system ... will also be explored as an alternative to the preferred single-funder, single-purchaser publicly-administered Fund."* A single-payer implies that only one agency, the NHI fund, would purchase services from providers and this monopsony (meaning a market where there is only one buyer) would enable the state as purchaser to bargain downward the price of services, thereby making many services affordable for the state to purchase. This arrangement would bring many services in reach of poor patients who would not have been able to afford to purchase them in a private market. A multipayer system, such as exists in the USA, allows many schemes to purchase services but then they also compete for members. There is no strong drive to reduce costs; rather this mechanism relies on the market to control costs, a reliance which experience has shown, is not an effective mechanism in health care.

The Green Paper also proposed that the current tax rebates allocated to subscribers to private medical schemes, would be reduced and phased out, and these monies transferred into the proposed NHI Fund. The Green Paper noted the spiralling costs and fragmented and capped benefits in the medical scheme environment and located the cause of the worsening cost-escalation and unaffordability in medical schemes in *"the uncontrolled commercialisms of health care."*

While the Green Paper identified the need to utilize the expertise from those involved in the administration and management of health insurance *"where necessary and relevant"* *"... to ensure adequate in house capacity is developed"* for the NHI, it gave no special place to medical schemes in shaping the NHI. There was no mention made of consolidating medical schemes prior to the NHI and the advisory structures envisaged for the NHI were based on skills rather than sector. There was positive engagement with the Green Paper by civil society and the trade unions and a broad Coalition of 11 Civil Society groups⁴ made a submission which was broadly supportive of the principles, but pointed to concerns about the comprehensiveness of benefits under the NHI (particularly the absence of attention to prevention), absence of provision for transport for users (particularly in rural areas), the lack of clarity on the progressivity of financing mechanisms for the NHI, possible impacts of accreditation on existing urban-rural inequities in availability of services, omission of any position on co-payments, reliance on public-private partnerships to build new academic hospitals, the risk of increased fragmentation of the health system, the risk of corruption of public funds, weak accountability mechanisms, poor mechanisms for participation, weak attention to human resources (particularly the role of Community Health Workers), lack of clarity on single-payer, potential infringement of privacy protections in the NHI information systems, the need to strengthen the public sector and discrimination against documented and undocumented migrants in terms of access to health care⁵.

In 2015, a White Paper was released for comment, supposedly building on the inputs of stakeholders to the Green Paper and the Department's experiences in NHI pilots across the country. The 2015 document made clear that the *"NHI Fund will be the single, strategic purchaser"* and described the future of health sector funding in unequivocal terms: *"This requires that government intervenes strategically and decisively to eliminate fragmentation in funding pools which has been shown to adversely impact on the performance of the current health system."* No mention is made in the

⁴ People's Health Movement South Africa (PHM-SA), SECTION27, Treatment Action Campaign (TAC), Black Sash, Rural Health Advocacy Project (RHAP) Rural Rehab, Rural Doctor's Association of South Africa (RuDASA), Passop, EarthLife Africa, Africa Health Placements (AHP).

⁵ See <http://section27.org.za/wp-content/uploads/2011/12/NHI-Coalition-Discussion-Paper.pdf>.

White paper of any notion of establishing a contributory system (as would occur in an SHI) but it did recognize the role of medical schemes producing supplementary cover (i.e. the same benefits as would occur under an NHI) **until an NHI is in place**, whereafter medical schemes would only provide complementary cover (benefits not provided in an NHI). This White Paper made no mention of implementation task teams but did identify that one of the Work Streams set up to do preliminary planning for the NHI (number 4) was to do a review of medical schemes so as to define their future role.

In 2017, government released a further White Paper (NHI Policy White Paper) and a gazette outlining the Implementation Structures for the NHI. Although the Implementation Structures were issued with an intent to receive comment, neither gazette indicated the documents were open to comment. This White Paper reiterated government's commitment to seeing the NHI as a vehicle for realising UHC and people's right to health. However, it began to give some indication as to how the transition to the NHI would happen. Firstly, it introduced the idea that there will be "*consolidation of Government funding on medical schemes*" and it set up four permanent and four interim structures in Phase 2, including an Advisory Committee on Consolidation of Financing Arrangements. The White Paper gave no details on the composition of the committees and gave only broad Terms of Reference. For the Advisory Committee on Consolidation of Financing Arrangements, the White Paper noted that it will "advise the Minister on the strategies to be followed in consolidating current fragmented funding pools in the medical schemes environment... advise on alignment of benefits [under] ... COIDA, ODMWA, and the RAF." The White Paper further noted that Medical schemes will be consolidated to provide complementary cover, particularly schemes for state employees which will be consolidated under GEMS.

The July gazette mapped out in detail the proposed composition and roles of all the proposed committees. For the Advisory Committee on Consolidation of Financing Arrangements, it noted the role as including (a) consolidation of funding streams into 5 transitional funding arrangements; (b) Consolidation of Civil Servants Funding arrangements; (c) Introduction of Mandatory Cover and Contributions related to Formal employment; (d) other changes expanding PMBs to a more comprehensive benefit structure. Thus, rather than merely advising the Minister "on the strategies to be followed in consolidating current fragmented funding pools in the medical schemes environment," the July gazette presents a strategy already determined by these Terms of Reference. In particular, two of the elements to this strategy – namely, the consolidation of funding streams into 5 transitional funding arrangements and the introduction of mandatory medical scheme cover for those in formal employment are, as explained below, extremely problematic if the NHI is to achieve UHC. The gazette also commented that the Committee would advise of the costs of mandatory cover to be subsidized by Government. Note that the implications of such a subsidy would be enormous to the fiscus. Government would be pumping billions into the Medical Aid environment through subsidy at a time when it should be concentrating on the strengthening the public sector on whom the most vulnerable in society are dependent.

Thus, while the Green Paper of 2011 presented, in broad strokes, a vision for a single fund able to bargain the private sector costs, the July Implementation Gazette in 2017 introduces the notion of 5 divided funding streams. Additionally, when challenged over these streams, the DG for health claimed "The intention of this is to start creating a contributory system now" when contributory schemes have never been in the policy dialogue to date. Since neither the 2017 Policy White Paper nor the 2017 Implementation Gazette were effectively consulted, these changes have been introduced without opportunity to question their introduction in any consultative process.

A Civil Society outcry against the introduction of this multi-tiered system and the exclusion of civil society representatives⁶ led to a revision of the Implementation Task Teams such that it was promised that most task teams would be revised to include at least one civil society representative. But the revised Implementation Structures, most notably that of the Committee charged with the Consolidation of Financing Arrangements, retained the same Terms of Reference, such that the consolidation of medical scheme members into separate funding streams was not altered, nor was the assumption that mandatory medical aid membership among formal sector workers would be needed to build the NHI.

It cannot be said with any certainty that these changes were the direct result of private sector lobbying. However, it is common knowledge that department officials and technical advisors, in particular, those seconded to work on the NHI from the Clinton Health Access Initiative (CHAI), had a number of engagements with private sector interests through this period. The shift in emphasis from medical schemes as a sector where particular skills might be sought for specific purposes in order to build the NHI, to a sector whose own interests need to be dovetailed with that of building an NHI, and who need to be at the centre of constructing the NHI, is notable. For example, the heavy emphasis on members of the actuarial society in the implementation structures suggest a fundamental reconceptualization of the NHI as a grand medical scheme, rather than a system wide intervention to facilitate UHC.

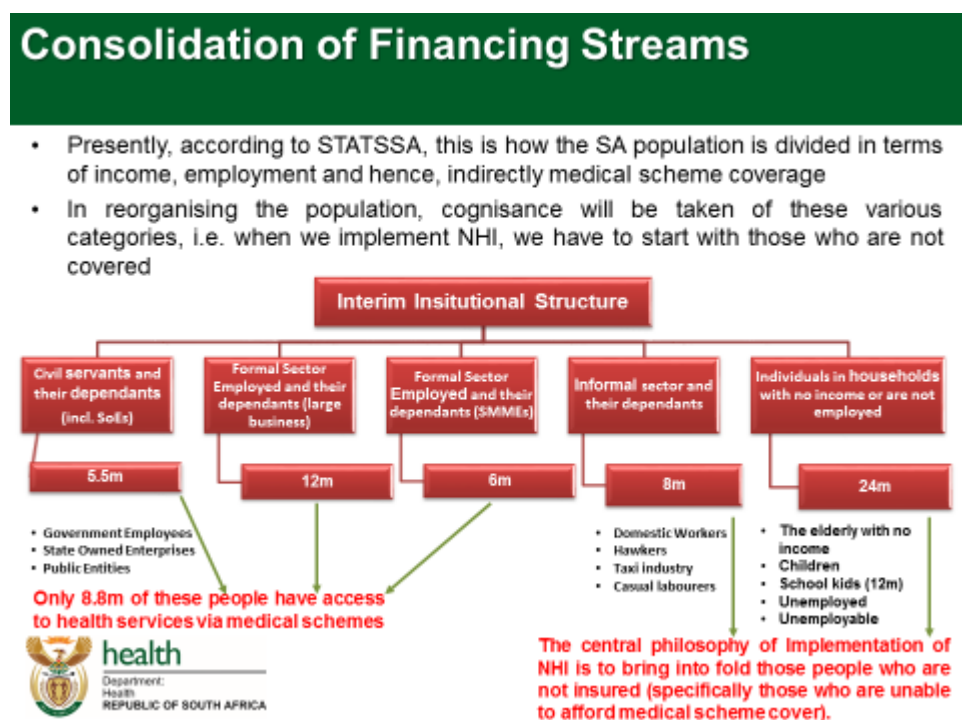
The 2018 NHI Bill consolidates many of the earlier principles introduced in the Green and White Papers. These include the separation of purchaser from provider (the NHI fund purchases services from providers who may be public, private or some mixture of both public and private); the idea of the NHI fund as the single public purchaser of health services under the NHI; an intent to ensure the equitable and fair distribution and use of health care services; sustainable and affordable access to health care services; protection against financial risk. The Bill established the NHI fund in some detail; it defines eligibility as including South African citizens and permanent residents while migrants with refugee status are given entitlements to a much smaller basket of services – emergency medical care, services for notifiable conditions and maternal and child health services at primary care level. Undocumented migrants are not entitled to any form of care under the Bill.

The Bill confirms the portability of services (meaning one can make use of the NHI for services no matter where one happens to be) but, at the same time, mandates the use of referral pathways under the fund if users are to have services paid for by the NHI. All users are required to be registered with a primary care provider (presumably a clinic, health centre or general practitioner) and will have to attend such a provider before being eligible for specialist care. While the 2017 Policy Paper recognised the need for the NHI to cover transport costs to services for vulnerable groups such as the disabled, elderly and rural populations, the Bill makes no provision for such support.

The Bill is also silent on the transitional funding arrangements and makes no mention of the Advisory Committee on Consolidation of Financing Arrangements or of mandating medical scheme membership amongst formal sector workers contained in the 2017 Policy Paper and Implementation Gazette. However, the Minister continues to use the idea of 5 funding streams in his presentations on the NHI and, as recently as August 2018, although the Minister asserted that there was no differentiation in how the NHI will be structured, his own powerpoint slide presentation clearly indicates a differentiated funding stream (see Figure 1 below).

⁶ See Op-Ed: Has the National Health Insurance process been captured? <http://phm-sa.org/op-ed-has-the-national-health-insurance-process-been-captured/>

Figure 1. Consolidation of Financing Streams under the NHI



1.3 Why do these changes matter?

The key question unanswered is whether these differentiated funding streams signal a differentiation in benefits. The gazetted implementation document and the press release accompanying the Bill describes five different groups of health care recipients: the unemployed, the informal sector (such as taxi industry; hawkers, domestic workers), those in formal sector employment (bigger business), those in formal sector employment (small and medium size business), and civil servants (including SOEs, Intelligence Agencies, Defence, Police Service). What is of concern is that if there are different funding streams, it implies there will be different packages of benefits for different groups. This concern is borne out by the DG's assertion that the NHI will be achieved by moving through a phase of 'contributory' schemes (Correspondence with Anele Yawa, 1st September 2017). Although this arrangement is said to be 'transitional', experience from other countries shows that it is very difficult to change such benefits packages once they have been in place for any length of time.

For example, a WHO review of global experience of different models aiming to achieve Universal Coverage⁷ found that "... where SHI schemes begin by covering the formal sector, they tend to concentrate resources on a relatively small and economically advantaged part of the population. Such schemes do not naturally "evolve" to include the rest of the population. Instead, the initially covered groups, who tend to be well organized and influential, use their power to increase their benefits and subsidies, rather than to extend the same benefits to the rest of the population." In other words, consolidating public servants separately from the rest of the population risks creating a powerful interest group able to undermine the principles of solidarity and risk sharing across different groups.

⁷ Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. Bull World Health Organ 2013; 91: 602–611

Kutzin also points out that “The unit of analysis for goals and objectives must be the population and health system as a whole. What matters is not how a particular financing scheme affects its individual members, but rather, how it influences progress towards UHC at the population level. Concern only with specific schemes is incompatible with a universal coverage approach and may even undermine UHC, particularly in terms of equity. Conversely, if a scheme is fully oriented towards system-level goals and objectives, it can further progress towards UHC. Policy and policy analysis need to shift from the scheme to the system level.” In other words, focusing on NHI as a financing mechanism only loses the population perspective that is needed to achieve UHC.

Secondly, the suggestion that the steps toward NHI will require mandating medical insurance coverage for formal sector workers is both inconsistent with UHC intentions and is a policy step not required. One can only assume it is the result of medical scheme lobbying of government. Given the crisis of affordability in private medical insurance, which has limited the ability of medical schemes to recruit new members, a development they desperately need to maintain their financial viability, a legislative mandate to force workers to take out private medical insurance is more likely to be a liferaft for medical schemes than it is to be a pathway to UHC. Rather than moving us close to equity, such a measure is likely to obstruct progress to UHC. As Kutzin points out, “There is a difference between a new insurance scheme designed for the purpose of making its members better off, and one intended to serve as an agent of change to improve equity in the use of services, service quality and financial protection for the entire population... good coverage for some people comes at the expense of the rest. The interests of the scheme(s) are in conflict with UHC objectives at the level of the entire system.” He goes on to point out that “... where SHI schemes begin by covering the formal sector, they tend to concentrate resources on a relatively small and economically advantaged part of the population. Such schemes do not naturally “evolve” to include the rest of the population. Instead, the initially covered groups, who tend to be well organized and influential, use their power to increase their benefits and subsidies, rather than to extend the same benefits to the rest of the population.”

It is notable that the Bill signals an intent to ensure in Phase 2, the “interim purchasing of personal healthcare services for vulnerable groups such as children, women, people with mental health disorders, people with disability and the elderly.” This might represent a commitment to preference those currently excluded from access. However, if such measures are to be accompanied by expanding medical aid membership of formal sector workers, it is unclear how the two strategies can be reconciled or result in UHC.

Evidence suggests that neither Mexico nor Thailand, which have gone the route of first focusing on the formally employed, “has been able to integrate the population outside the formal workforce into the pre-existing schemes.” Successful examples (Moldova, Kyrgyzstan pursued “reform from an early stage by putting payroll tax contributions and general revenue transfers into the same pool on behalf of both the formal and informal sector populations, and then using the new SHI funds to drive system-wide efficiency and equity gains through the combination of centralized pooling and output-based provider payment mechanisms.” The conception of 5 different funding streams for NHI is thus extremely dangerous and potentially undermines all that the NHI policy stands for, particularly when coupled with mandatory medical scheme coverage for the most advantaged beneficiary group. It is therefore likely that the poorest and sickest in our country will receive the most limited package of services and that this will be difficult, if not impossible to shift in future. If this occurs, it will increase already existing inequality. Kutzin concludes “what matters is how the scheme influences UHC goals at the level of the entire population. A concern only with specific schemes is not a *universal coverage*

approach. Schemes can contribute to system-wide UHC goals, but they need to be explicitly designed to do so. Otherwise, increased population coverage with health insurance can actually become a potential obstacle to progress towards UHC.”

1.4 Services provided under NHI

The details of what services are to be funded (the benefit package) are not provided. It is hoped that the benefits package will be identical for all users of NHI-funded providers although the above-mentioned ‘tiered’ system of beneficiary groups raises concerns that the benefits package will be different for different socio-economic groups. The bill does not state clearly that there will be no differentiation in the benefit packages for different groups.

A ‘Benefits Advisory Committee’ will decide what the content of these packages will be. The composition of this committee includes no community members or Civil Society representatives and is dominated by Deans of Medical Schools and representatives of provincial departments of health (9 participants each) with some private sector participation (3 members). Compared to the July gazette, the composition of this important committee has quietly dropped representatives of professional councils, the CMSA, Academic and research organizations, participants from Civil Society and Trade Unions as well as omitting mention of persons with “Operational experience of medical schemes and/or administration of medical Schemes” and “Actuarial Expert with health care benefit design experience”. The Benefits Advisory Committee will be supported by a Health Benefits Pricing Committee which also has only technocrats. None of these NHI committees provide for meaningful public participation. This will likely bias their work and decisions towards hospital-centred specialist care and a narrow biomedical approach.

The Ministerial Advisory Committee on Health Care Benefits will be a precursor to the Benefits Advisory Committee which will advise the Minister on priority setting. Although the composition of this structure is not specified in the Bill, the 2017 gazette discussed above proposed a composition in which senior government officials and medical scheme representatives predominated. This structure too creates a concern that the emphasis will be on facility-based clinical medicine and that primary and community-level care will be marginalized, as will prevention activities.

Only the Stakeholder Advisory Committee, a large body that merely advises the Minister, has representation from indigenous practitioners, NGOs and civil society, although they are greatly outnumbered by representatives from professional and statutory bodies. Further, as an “Advisory” Committee, it is unclear how much influence such a structure will be able to wield over the NHI and the recommendations coming from other Committees stacked with technocrats, public officials and key private sector influential.

1.5 How will NHI purchase services?

The NHI Bill states that purchasing of services is intended to be devolved to provincial and district level hospitals and at sub-district level to contracting units for primary health care (CUPs). District Health Management Offices are intended to play a coordinating role. Justifiable concern has been expressed about whether these sub-district and district entities will have the capacity to undertake the detailed and complex activities required by the bill. The mechanisms for payment of accredited service providers are vague in the Bill and it is strongly rumoured that medical schemes may be enrolled to perform this function. There is also concern that urban and private (generally better equipped) providers/facilities will be more likely to be accredited than public (generally more poorly functioning) and especially rural providers/facilities. This would risk aggravating already existing

urban/rural inequity. For example, the great majority of medical specialists and therapists of various kinds are overwhelmingly located in large metros, especially in Gauteng and Western Cape. This could effectively mean that public tax money will be used to fund a service that will likely cater preferentially for the better-off living in urban areas.

There is no explicit mechanism, structure or strategy in the Bill which explains how services will be improved in the most marginal areas, other than reliance on the inspections of the Office of Health Standards Compliance (OHSC) and the Ideal Clinic system. These are both Quality Improvement Systems developed by the Department of Health in the past few years. Preliminary reports suggest that a minority of audited public health facilities have been able to meet OHSC standards and improvements from the first to the second audits have been minimal and, in some cases, districts have gotten worse. For example, only five of the 696 hospitals and clinics that the OHSC inspected in 2017/8 achieved over 80% compliance with the national norms and standards. There is a huge silence in the bill on strategies to turn around the public sector.

Coverage under the NHI is limited to citizens and permanent residents. Documented refugees and asylum seekers will be eligible for free emergency services, care for conditions of public health importance (presumably TB, HIV and other infectious diseases) and services for paediatric and maternal conditions. Undocumented migrants are not covered at all. Services not reimbursed by the fund (i.e. not part of the defined 'package') can be paid for through medical schemes or out-of-pocket.

1.6 Financing the NHI

The Bill says very little about possible sources of funding for the NHI Fund, but there are no real options other than through taxation and an end to austerity budgets. A progressive income tax — a surcharge added to the normal income tax at an increasing percentage — would be the best option. The principle that those who can afford it pay more, while those who need more health care receive more care, also builds social solidarity. The retrogressive recent increase in VAT adds to the tax burden of poor and working-class people and exacerbates inequity in access to the social determinants of health through increased prices on some essential commodities.

There is no doubt that increases in revenue from tax are necessary to strengthen the public sector and finance the NHI. This may be difficult politically, but we believe there is room for such increases. Forslund notes that, because tax brackets have increased faster than inflation, the tax burden on the middle class and the rich has decreased substantially over the past decades. He points out that if the government had merely kept personal income tax stable since 2005/06 – by raising tax brackets strictly at the rate of inflation – personal income tax would have added more than R150 billion to the present budget. This would have made financing the NHI easier even before raising additional tax.

The alternative to tax is to borrow, which means eventually paying more and more government income towards debt servicing and away from delivering services.

1.7 Administration of the NHI Fund

The Bill makes clear that the NHI Fund will be overseen by a Board of ten persons appointed or approved by the Minister. It will be the only purchaser of health services from accredited providers – public and private – and will ensure equity and efficiency in health care. A unitary system with the National Health Insurance Fund as the single purchaser of services allows for strategic purchasing of those services that are necessary to reach defined health goals. A justifiable concern, expressed by a number of analysts and based on experience of state-owned enterprises, is the potential that exists

for this enormous fund to be looted. The oversight structures for the NHI fund outlined in the Bill are extremely thin.

1.8 Comparing the Green Paper and the Bill

Reflecting on the progression of the NHI Policy from its 2011 Green Paper and its final translation into a Bill some 7 years later (Table 1), the following observations can be made:

- Most of the concerns voiced by PHM and other Civil Society formations and Unions are still on the table.
- Some of the issues have been addressed (for example, amendments to the Medical Schemes Bill accompanying the NHI Bill propose abolition of co-payments, but these are already being contested by Medical Scheme interests; and a more extensive set of provisions aiming to prevent corruption).
- Some issues that were taken up in the 2015 White Paper appear to have been dropped in the Bill (e.g. transport for rural users).

But the fundamental concerns about the urgent needs to strengthen the public sector, develop a human resources for health plan and free up resources required for both tasks are not addressed.

2. Changes required - Strengthening the public health sector

Before the public health sector can participate in the NHI it will need to be strengthened substantially, especially in terms of its physical infrastructure and its human resource base including skills especially in leadership and governance. At district level, managers will be expected to identify population needs and appropriate services required, as well as negotiating contracts with providers in both public and private sectors. Given the parlous state of management in many districts and provinces, expecting this level of skill at district and sub-district level is unrealistic. An urgent programme to build capacity in management and leadership is a first step.

Secondly, the funding of unfilled posts, which, despite denials, have been subject to a moratorium preventing appointment of suitably qualified health workers, must be actioned urgently. Looking enviously at the health professionals in the private sector will do nothing to redress the bare facts that public sector posts are there but are not being funded due to fiscal austerity measures. These austerity measures must come to an end.

Thirdly, investment in physical infrastructure, facility refurbishment, establishment of new facilities and purchase and maintenance of equipment need to be done based on need and freed up from opportunistic tenderpreneurship that has become insidious in the health sector over the past years.

These imperatives will require strong political will and significant funds. Government has little option but to provide such funding, since the current health crisis is untenable. Although the upfront financial commitment will be large, the returns on investment are potentially even greater – as a result of savings on long-term health care, improved economic productivity of a healthier workforce, and the multiplier effect in the economy of having a larger number of employed people, especially rural women.

Linked to the above changes is the need for a plan for Human Resources for Health (HRH). The Bill specifies transitional arrangements that consist of three phases extending to 2026. The current second phase will focus on establishing institutions that will form the basis for the Fund, as well as on interim purchasing of personal health care services. Phase 3, from 2022 to 2026, will establish the necessary structures and be guided by two committees – the National Tertiary Health Services

Committee and the National Governing Body on Training and Development. These will be responsible for a Human Resources for Health (HRH) development plan.

These arrangements raise a number of concerns: firstly, an HRH plan is much more urgently required to ensure the development of a robust public health sector, especially at district level and below, so that the NHI can operate effectively and efficiently in formerly underserved areas. Awaiting Phase 3 to develop a coherent HRH plan is courting disaster given the parlous state of the public sector services. Secondly, given their unimpressive record to date in transforming health sciences education and training, it is unlikely that these structures, whose composition has been proposed to include mainly hospital-based clinicians and educators, will implement an appropriate HRH plan. For example, the critical importance of Community Health Workers or of increasing the output of institutions training nurses are unlikely to feature highly in committees whose members spend most of their time in tertiary services.

3. Global Experience

3.1 Some Case Studies: The UK, Colombia and Costa Rica

The United Kingdom National Health Service (NHS) serves as the archetypal model of a tax funded, centrally planned health care system delivered through employed staff⁸. It was established in 1948 in a time of post-War austerity and provides comprehensive services, largely funded from general taxation with little or no co-payments. Financial protection against the costs of health care under the NHI is therefore very strong. Despite many changes over time, including separation of purchasers from providers, and efforts to dismantle some of the NHS commitment to quality public services by recent UK governments, the NHS enjoys very strong public support. According to the King's Fund, "the NHS remains a treasured national institution that is a key part of the British national identity. The public is unwavering in its support for the underlying principles of the NHS and consistently prioritises the health service for extra government funding, above other public services like education and welfare⁹." This level of public 'ownership' of a health care institution has much to do with the recognition that it plays a key role in protecting the most vulnerable and a willingness to contribute to taxes to a solidarity-based mechanism that provides health care to all.

Colombia introduced compulsory health insurance in the early 1990s but involving two distinct funding and service pools. In doing so, it was following the well-trodden US model of a mixed economy in health, with more than 130 competing public and private health insurance companies following the "managed care" model of its northern neighbour¹⁰. A Contributory Regime (CR) covered all formal sector employees and their dependents while a Subsidized Regime (SR) covered all others. The insurance system was premised on a managed competition model where private health insurance was supposed to foster efficiency, quality, and cost containment. There was no single payer as multiple health plans were supposed to compete in an environment where a variety of arrangements of health care delivery existed which included contracting with individual public and private health care providers¹¹.

The consequence of this mixed-market model was that while coverage was slowly boosted in statistical terms, the quality of care between the two sectors was separate by a chasm so large that

⁸ See <https://openknowledge.worldbank.org/handle/10986/29183>

⁹ See <https://www.kingsfund.org.uk/publications/public-satisfaction-nhs-2017>

¹⁰ Webster PC. Health in Colombia: a system in crisis. *CMAJ : Canadian Medical Association Journal*. 2012;184(6):E289-E290. doi:10.1503/cmaj.109-4124.

¹¹ See <https://openknowledge.worldbank.org/handle/10986/13285>

care under the SR was effectively no care at all for some of the most marginalised. Thus, “It allowed Colombian politicians to repeatedly boast that the system was steadily enrolling larger and larger numbers of people” and to claim, by 2010, that 97% of the population had coverage by health insurance. Yet the experience on the ground was that patients were often turned away under the SR, or failed to get any access to care even though formally insured. So bad was the crisis that a Colombian court had to order the government to act, which it did by requiring that the publicly subsidised insurance offer the same level of care as contributory schemes. Government labelled the huge health inequities in the country a “social emergency” so that it was able to implement changes needed to the financing of public health services. However, regulatory authorities lacked the legal apparatus and the workforce to enforce the law. The system remained plagued by runaway pharmaceutical costs, widespread insurance fraud and bribery¹². Despite some progress in legal measures, large groups of the population still face access barriers due to lack of integrated networks of services, even to some basic primary health care services. A 2014 comparison of access to health care in Colombia and Brazil showed that despite two decades of reforms intended to improve equity in access to health care, inequities persist in both countries, largely related to the design of their health systems in which health insurance plays a key role in segmenting health systems¹³.

The Costa Rican health system has long been held up as a ‘success’ story, generating relatively good health indicators at relatively low cost. Universal health coverage in Costa Rica is provided through a single national health insurance program which dates back to major health system reforms undertaken in the mid 1990’s¹⁴. A Single Social Security fund (CCSS) receives contributions from all individuals employed in the formal sector (in the form of a 15 percent mandatory payroll tax or which employees contribute about one-third) while poorer households are covered by government contributions raised through taxation of luxury goods, liquor, beer, soda, and other imported goods. The CCSS manages the funds as a single pool which directs resources to the administrative and health care units through line item budgets rather than through a purchaser-provider split. Expenditure on health by household income is highly progressive with the poorest 20 percent of the population (who receive 4.7 percent of national income), receiving almost 30 percent of health expenditures while the wealthiest 20 percent of families (who earn 48 percent of national income) receive 11.1 percent of social security resources. Part of the success of the Costa Rican system has been its prioritisation of primary care and the adoption of a programme involving multidisciplinary teams serving geographically defined populations with an emphasis on the four critical functions of primary health care: first-contact access, comprehensiveness, continuity, and coordination¹⁵.

3.2 Consolidating global experience

The World Health Organisation’s review of UHC and NHI based on reviewing international experience identified 3 broad tasks required of countries wanting to move towards Universal Coverage¹⁶. These include (a) raising sufficient funds; (b) reducing reliance on direct payments to finance services; and (c) improved efficiency and equity. As the WHO report points out, these steps can and have been successfully pursued by a range of countries of different levels of economic development and wealth.

¹² See BMJ 2012;344:e802 at <https://www.bmj.com/content/344/bmj.e802.full>

¹³ See Garcia-Subirats et al, 2014 at <https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-13-10>

¹⁴ See <https://openknowledge.worldbank.org/handle/10986/13279>

¹⁵ See Pesec et al in Health Affairs 2017; 36(3): 531–538

¹⁶ World Health Organisation. 2010. World Health Report 2010. Health system financing: the path to Universal Coverage. WHO: Geneva. At <http://www.who.int/whr/2010/en/>

(a) Raising sufficient funds for UHC

The WHO report identified three main routes to raising the resources necessary for UHC - increasing the efficiency of revenue collection, reprioritising government budgets so that health receives its fair share and innovative financing mechanisms (such as increasing taxes on air tickets, foreign exchange transactions and tobacco; diaspora bonds (sold to expatriates); and solidarity levies on a range of products and services. The WHO report suggests that, for example, raising taxes on alcohol to 40% of the retail price could reduce consumption levels by more than 10%, while more than tripling tax revenues for selected Low-Income Countries. However, it does caution that any tax needs to be carefully evaluated for distortionary and unintended consequences and will be opposed by vested interests. Additionally, development assistance may play an important role for LMICs. All these modalities are open to the South African government as it approaches its NHI planning.

(b) Abolishing direct payments to finance services

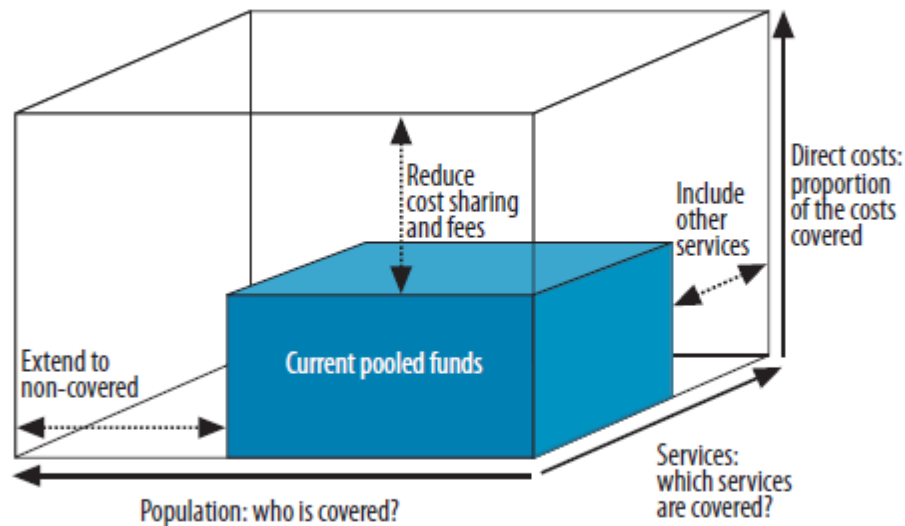
A central tenet of UHC is the need to avoid users suffering financial hardship as a result of seeking care for illness or being deterred from using services by direct costs imposed at the point of service. Getting around this problem requires some mix of risk-pooling and prepayment. Those too poor need to be subsidised by government, while all other pre-payments must be mandatory, otherwise the rich and healthy opt out, leaving insufficient funding to cover the needs of the poor and sick.

Secondly, pools that provide benefits for small defined groups are neither viable in the long run, nor efficient, since multiple pools require different administrations and information systems. Such systems also militate against equity, since pools for relatively wealthy people will provide high levels of benefits and members will resist cross-subsidizing poorer, less healthy people. It is possible that multiple funds could achieve cross-subsidisation but that requires high levels of political will and technical and administrative capacities and is dependent on enforcement.

Ultimately, the success of progress towards UHC depends on expanding access along three domains: Population coverage, Service coverage and the proportion of costs of services met from pooled funds (see overlay Figure 2 below). As the 2010 WHO report notes “To get closer to universal coverage, the country would need to extend coverage to more people, offer more services and/or pay a greater part of the cost.”

Figure 2: Three dimensions to consider when moving towards universal coverage (WHO, 2010)

Fig. 1. Three dimensions to consider when moving towards universal coverage



Source: Adapted from (9, 10).

(c) Improving efficiency and equity

Ensuring resources are used efficiently and in ways that promote, or at least, do not impair equity, is critical. Reducing unnecessary usage and therefore expenditures of medicine, using them more appropriately, proper supply chain management, improving quality control on medicines, and use of cheaper but equally effective generics are said to be likely to save up to 5% of health expenditures. Other strategies include maximising the use and benefits of health technologies, improving health service efficiencies, reducing medical errors, motivating health workers, eliminating waste, preventing and prosecuting corruption and matching services to need. Incentives to reduce over-utilisation need to be examined to ensure they do not exacerbate inequities.

All of the above strategies are applicable in the South African context and have been considered to some degree in the preliminary work and workstreams informing the development of the NHI.

4. Civil Society views

As one might expect, a number of private sector organisations have pushed an agenda promoting market ideology in their submissions on the NHI White Paper. These include the Free Market Foundation, the South African Institute of Race Relations, the Helen Suzman Foundation, the South African Private Practitioners Forum (SAPPF), the Hospital Association of South Africa, Afribusines, Life Healthcare and other smaller consultancies and health industry businesses. While they have slightly different emphases in their critiques, many of the arguments are broadly similar and revolve around:

- unaffordability of the NHI and questioning the cost estimations as inadequate or ‘thumbsuck’;
- an ideological hostility to the private sector claimed to be unfounded in evidence;
- market forces are the key to improving efficiency and accountability and helping to hold down unit costs
- promotion of an SHI and/or segmented markets involving different kinds of medical schemes for different earners;
- promotion of the the sale of affordable health insurance products would help low-income households to access private health care;
- promotion of public-private partnerships in which private compete, on price and functionality, for contracts to run public facilities;
- remove legal obstacles to establishing private medical schools and nursing colleges;
- state vouchers to enable poor families to purchase medical scheme coverage
- public sector mismanagement and corruption
- collapse of the medical scheme industry if reduced to providing only ‘top-up’ cover
- driving of medical professionals overseas

Three organisations (SAIRR, Free Market Foundation and SAPPF) also made use of the opportunity to submit to the Davis Inquiry into tax reform to comment on questions of NHI funding. Many of these arguments have been picked up and repeated in the press, particularly in the business-related papers. At the centre of these arguments is the core notion that the private sector should be deregulated and works best with an expanded market, with state concentrating on the indigent, unable to access private care through the market.

Then, a set of submissions reflect the perspectives and interests of **professional groups**. These include the Pharmaceutical Association of South Africa, the Dental Association of South Africa, the Genetic Alliance, Genetic Counsellors of South Africa (GC-SA) as a focus group of the Southern African Society of Human Genetics, the Psychological Society of South Africa, the South African Society of Psychiatrists, the South African Medical Association, the South African Society for Physiotherapy, and the Radiological Society of South Africa.

The kinds of arguments put forward could be grouped into the following categories:

- Contestation over scope of practice. For example, the Pharmaceutical Association of South Africa, speaking on behalf of pharmacists in South Africa, argued vehemently that “Pharmaceutical services must be provided by persons duly qualified, accredited and experienced, as certified by the Pharmacy Council. The involvement of the lay (non-pharmacy-trained) person in medicines services should not take place, not even in the name of shortages of skills or medicines distribution concerns in this field...” Exactly the converse is argued in the DENOSA submission where it is argued that licensing of nurses to dispense should be made simpler and easier, not more difficult. Similar kinds of turf-defining or turf-claiming arguments were made by professional groups (for example, nurses should be seen as the main professional driving PHC; and that CHW scope of practice must be defined so that their roles in re-engineered PHC does not adversely impact on nurses). However, some professions adopted the opposite position, recommending establishment of a mid-level category of psychological professionals called registered counsellors to deliver front line mental health care at primary care level.

- Expanding the influence of professional associations in shaping the NHI. For example, that associations should be involved in determining the package of services relating to their profession
- Inclusion of each distinct professional group in the NHI service packages on all levels of care (e.g. physiotherapy, genetic counseling in personal services, community psychiatry into the Ward Based Outreach Teams, psychologists included in the Integrated School Health Programme (ISHP) and District Clinical Specialist Teams (DCSTs) and in general health promotion and disease prevention activities under the NHI)
- Lobbying for posts for their professional group (e.g. physiotherapy; genetic counsellors, psychologist, dentists, dental specialists)
- For those professional associations embedded in the private sector (e.g. radiology, dentistry), some of the arguments mimic private sector interests:
 - promotion of public-private partnerships
 - calling for an equitable and fair approach to accreditation
 - rejection that the private sector is, in any way, inefficient or inequitable. For example, the Dental Association of South Africa argued that the private sector “provides excellent quality healthcare that is highly regarded on an international scale.” Given that 95% of dental professionals work in the private sector, such claims are not surprising.
 - presenting the private sector as having to bail out the public sector and carry an increasing patient load because of public sector services collapsing.
 - private sector health professional training
- Concerns about multiple governance challenges, especially in the public sector, namely: corruption; poor management at various levels (aggravated by a lack of accountability), a notable lack of implementation of existing policies, regulations and guidelines, and a lack of proper evaluation and monitoring.

Strangely enough, most professional associations except one, failed to comment on health and safety hazards affecting health workers or on the mental health of health care staff. One might have expected such organisations to represent their members’ interests within a future NHI and, given high level of nosocomial transmission of TB and other occupational health risks (e.g. shiftwork, violence, injuries, etc), surfaced the need for the HR policies of the NHI to ensure better safety and health conditions for staff. Also, relatively little in the professional associations’ submissions foregrounded prevention (except in mental health) since most professionals are involved in clinical curative or rehabilitative services. The interests of the associations therefore largely reflect the positionality of their members in the health care system as providers of curative care, whether in public or private. From a Trade Union perspective, there is a lot more that could be done for health care workers, particularly from the perspective of health and safety.

Some interesting comments emerge from the submission on the NHI White Paper by the South African Medical Association:

- While the poor quality of care in the public sector requires urgent redress, the Association also notes that there are quality deficiencies in the private health sector that are equally critical but less-publicised;
- Strategies to retain health professionals in under-served areas should be a priority, and freezing of posts in the public sector must come to an end;
- Enhance capacity to train doctors locally rather than secure doctors through bilateral programme

The third cluster of positions on the NHI are those articulated in submissions on the 2015 NHI White Paper and those in a series of opinions published by Spotlight on the 2018 Bill made by NGOs and Civil Society Groups. These are analysed below, primarily focusing on the 2018 Spotlight pieces but referring to the set of 2015 submissions by a range of CSOs.

Section 27, the Rural Health Advocacy Project and PHM-SA have all adopted cautionary responses to the Bill, while expressing support for the principles that underpin the NHI related to equity and redress (including the financial protections afforded to users, without cost at the point of care).

At the root of the shared caution is the concern that the National Department of Health continues to ignore the substantive crisis in the South African health system, doing little to redress the problems of frozen posts, medicine stock-outs, collapse of infrastructure and mismanagement. Section 27's position is that the Minister of Health appears wedded to the idea that unlocking the resources sequestered in the private are what is needed to solve the problems of the public sector. Whilst the maldistribution of resources between public and private health systems undoubtedly compounds the crisis in the public system, fixing the financing of health care will not address the failures to deliver quality services in the public sector. All three organisations have made it clear that an urgent response to the declining state of public health sector services must be a priority if the NHI is to stand a chance of achieving equitable quality health care for all.

The second key commonality is the agreement that weak governance, poor management and absent leadership lie at the root of the dysfunctional health system. This is compounded by problems of cadre deployment and party factionalism manifesting in provincial health services, with associated opportunities for theft and corruption. Unless corruption is rooted out and decision-making freed from vested political interests, the health system will continue to lurch from one crisis to the next, from one province under administration to another.

The three Civil Society organisations have also raised the lack of clarity around the relationship between the core elements of the health system (the provincial health administrations, the District management, and the to-be-created Contacting Units for Primary Care) and the NHI Fund. The core functions of the Department of Health risk being consumed in the vortex of funding directed to personal curative care through the NHI fund. Prevention is hardly mentioned in the Bill and the key stewardship role of the Department of Health for population health, through the District Health System, appears to be even further marginalised by the preoccupation of the NHI with hospital care, tertiary services and packages of benefits dominated by curative care.

Urgent action is needed on human resources – to unfreeze critical posts, with particular attention to equity – and to accelerate the implementation of the CHW policy.

Further, the lack of meaningful public participation (which includes some of the processes of developing the policy such as the sleight of hand in pre-empting the strategy for consolidation of interim financing arrangements) in the determination of benefits and in shaping the NHI is a serious flaw. The nature of the membership of committees suggests a bias towards hospital-centred specialist care and a narrow biomedical approach. The inclusion of civil society and labour on these committees is essential. Their proceedings should also be open and transparent, and accountable to the Minister and Parliament. In particular, they must be accountable for the reasonableness of their choices of the benefits they include in the package. The reasoning behind their choices should be open to public scrutiny, including the evidence upon which they are based, how they apply in local contexts and what impact it has on equity in access to health care.

Amongst the NGOs and CSOs that made submissions on the 2015 NHI White Paper, some of these submissions supported the issues raised between Section 27, RHAP and PHM. For example, the SA NCD Alliance¹⁷ noted that “citizens are excluded from direct “ownership” of the health system and remain part of the ongoing commoditization” inherent in reducing the NHI to a grand insurance scheme in which users are regarded as consumers of services rather than rights-holding citizens with entitlements and responsibilities. Emphasis was placed on services that are responsive to needs and which are accountable. The Alliance also highlighted the institutional weaknesses in the prevention framework advanced by the Policy, arguing that much more needs to be done and much sooner to make the National Health Commission (one of the implementation structures proposed) effective for prevention.

The Rural Health Partner Network¹⁸, comprising a consortium of 9 organisations focused on rural health needs, raised similar concerns regarding the urgent need for a Human Resources for Health (HRH) plan and the need for the NHI to take specific account of “rural health contexts and the challenges that these contexts pose for service delivery and access for patients.”

A third set of organisations linked to protections for migrants’ rights¹⁹ argued against the discriminatory provisions in the NHI Policy (carried through into the Bill) pointing out how they were in contradiction to global best practice and in fact represented a regression of rights currently provided under current laws.

Lastly, besides the professional organisations which made submissions, there were trade unions in the health sector that made important submissions: The Democratic Nurses Association of South Africa (DENOSA), the South African Medical Association (SAMA) and the Independent Municipal & Allied Trade Union (IMATU).

DENOSA recognised the importance of including CHWs in the NHI and the requisite attention needed to their scope of practice in relation to nurses’ roles. In fact, HRH with particular attention to upgrading of nurse training to address competencies needed for NHI formed a large part of their submission. DENOSA also signalled concern for a greater emphasis on prevention and suspicion of PPPs (DENOSA indicated it does not support involvement of the private sector in provision, administration, management and monitoring of NHI services).

The SAMA position on the NHI is quite eclectic, having to span a membership that is both public sector-employed and private sector-based. To the extent that the SAMA submission recognises that quality deficiencies exist in both the public and private health sectors; that choice of provider is not sacrosanct (and is not a human rights trump card); ‘laments’ the drain of human resources from public to private sectors; supports the abolition of co-payments; calls for strengthening prevention skills in the training of health professionals; and insists on zero tolerance of corruption, SAMA’s positions can be quite progressive. Areas which may bring it into conflict

¹⁷ The South African NCD Alliance includes the Cancer Society of SA, Diabetes Foundation SA, The Heart and Stroke Foundation of SA and PHANGO.

¹⁸ Rural Health Partner Network comprises including Rural Health Advocacy Project, Rural Doctors Association of Southern Africa, Rural Rehab South Africa, UKZN Centre for Rural Health, Wits Centre for Rural Health, Ukwanda Centre for Rural Health (Stellenbosch University), University of Cape Town: PHC Directorate, Professional Association of Clinical Associates in South Africa, Africa Health Placements.

¹⁹ Submission by the Joburg Migrant Health Forum (Consortium for Refugees and Migrants in South Africa (CoRMSA), Jesuit Refugee Service (JRS), the International Organisation for Migration (IOM), the African Centre for Migration and Society (ACMS), SECTION27, Sonke Gender Justice, Nazareth House, Amnesty International SA, Solidarity Centre, Lawyers for Human Rights (LHR), MIWUSA and concerned academics from the Faculty of Health Sciences at Wits University; also submission by the Scalabrini Centre

with other CSOs include the fact that the SAMA provides qualified support for public-private partnerships and focuses almost entirely on doctors in its comments on strengthening the human resource base of the health sector.

IMATU is a non-aligned trade union in the municipal sector. IMATU's submission focused on retaining freedom of choice of practitioner, a position contrary to the NHI and not easily reconcilable with an equity perspective. Its view about the health system was a rather simplistic notion that the NDOH should "first fix problems in public sector healthcare and bring down costs of private healthcare before commencing the NHI" and a that "urgent interventions is required" because "Private healthcare is becoming more and more unaffordable." In those latter comments, IMATU is broadly in line with other comments from civil society but it is clearly more sympathetic to mixed systems as it argues for retention of medical schemes "... as a safety valve in case the NHI fails to get off the ground or function effectively" and makes choice of provider and minimisation of the tax burden their main concern. In that sense, their views diverge from the more progressive labour elements.

Notably, COSATU have not publicly commented on any of the NHI policies but did issue a statement on 30 August 2017²⁰ critical of the corporate capture of the NHI represented in the private-sector dominated implementation structures. The statement drew attention to a "private-sector driven agenda through the back door" which would "prop-up the profit-driven medical scheme industry through "mandatory membership and cover for all individuals in formal employment".

It is therefore clear there is a wide range of Civil Society positions on the NHI and much scope to think about broadening joint Civil Society action towards "a People's NHI."

²⁰ See <http://www.cosatu.org.za/show.php?ID=13090>

5. The Ideal Policy – a People’s NHI

PHM and other CSOs have been developing a national campaign for a health system that places people above profits, consistent with PSI’s policy theme. The demand for a PEOPLE’S NHI is linked to PHM’s vision of health as a right and to recognising the full spectrum of political, economic and social determinants of health. In short, a People’s NHI²¹ should ensure community participation, prioritise equity, develop a health system that is Pro-public, supported by a Single Payer, providing universal benefits equally to all and based on Social Solidarity through public Mobilisation (see box below).



The key elements of an NHI that would make it a People’s NHI are therefore:

1. Funding through a Single-Payer system that does not seek to accommodate medical schemes as essential to the success of the NHI; rather, the NHI should draw on medical scheme expertise where it is needed but not hand the NHI tiller to the private sector.
2. A financing system based on cross-subsidisation of the poor and ill by the rich and healthy through a progressive tax-based funding mechanism.
3. A benefits package that is comprehensive, including not only personal curative services, but preventive, promotive and rehabilitative services; without differentiation on the basis of a so-called funding stream. All NHI beneficiaries are entitled to the same services. Benefits decided in a transparent process in which community and worker voice is not marginalised. Decisions on benefits should be able to account for reasoning behind their choices and should be open to public scrutiny, including the evidence upon which they are based and how they apply in local contexts.
4. A strong public sector – particularly in rural and underserved areas, where critical posts are not left unfilled; where procurement systems work efficiently in the interest of patient care;

²¹ See <http://phm-sa.org/nhi-bill-welcome-but-flawed/>

where infrastructure is maintained and serviced; where the purchase of equipment is free of nepotism and vested interests; where quality improvement monitoring systems generate findings that are actually used to improve patient care, particularly in districts and sub-districts serving the poorest and most marginalised populations;

5. A coherent unified health system able to deliver primary health care through a strong district health system where the Department of Health exercises an appropriate stewardship role.
6. A health system staffed by sufficient numbers of appropriately trained, adequately paid and well supported and motivated staff at all levels - from community health workers to specialised medical services. This implies modernisation of human resource management systems in the public sector and improved conditions of service and pay for health care workers.
7. A Human Resources for Health plan that is developed by a wide range of stakeholders who have the whole system in mind rather than their own sectoral interests. The plan should ensure the development of a robust public health sector, especially at district level and below, so that the NHI can operate effectively and efficiently in formerly underserved areas.
8. A health system managed by staff with strong management and leadership skills, able to create spaces for reflection and learning so that the health system can be responsive. Staff responsible for decisions related to purchasing health services are sufficiently skilled to understand system needs rather than respond in the short-term to supplier pressure or user demand.
9. A health system free of corruption and maladministration, able to take effective, fair and timeous action to correct abuses and violations, and based on sound financial planning and management and on effective monitoring systems.
10. Services provided by a mix of public and private providers on the basis of population need, rather than supply driven health care.
11. Investment in strong community participation structures including health committees and hospital boards at local level, but aggregated up the system to district, provincial and national level, so that community voice and the voice of civil society broadly can input to shaping the NHI as a whole.
12. NHI structures to be disentangled from vested interests by equitable representation of different sectors on committees such that those whose private interests depend on particular forms of health care delivery do not get to exercise influence over policy decisions on which their profits depend.
13. Right from the start, the design of the NHI should be focused on promoting equity for the whole health system. The needs of medical schemes should not come uppermost. While the transition period should accommodate those who are on medical insurance to move to an NHI, strategic decision on future direction should not be made on the basis of preserving medical schemes at all cost.
14. A health system that preferences the needs of the most vulnerable – including rural populations, children, elderly, women, refugees, persons with disability, LGBTI persons and those with mental health problems.
15. A health system that translates the Right to Health into reality.

Table 1. Comparison 2011 NHI Green Paper to 2018 NHI Bill

2011 Green Paper on the NHI	2018 NHI Bill
<u>SERVICES</u>	
Lack of attention to prevention within benefits	Unchanged In Phase 2, it is envisaged that preventive services will be paid for but since the focus is on personal services only, this is a very limited form of prevention
Absence of provision for transport for users particularly in rural areas Progressivity of funding mechanisms not clear Impacts of accreditation on existing urban-rural inequities in availability of services	Was introduced to 2015 NHI policy but omitted from the Bill – no mention at all Bill does not comment on how NHI will be funded – Minister says it is Treasury’s prerogative Not addressed
<u>FINANCING</u>	
Omission of any position on co-payments	No co-payments permitted under amendments to the Medical Schemes Act 2018
Lack of clarity on single-payer	Bill is unequivocal that there will be a single purchaser but the Minister’s Press Conference still talks of 5 funding streams
<u>DESIGN</u>	
Public-private partnerships to build new academic hospitals Risk of increased fragmentation of the health system	Not mentioned in the Bill Not addressed in the Bill: <ul style="list-style-type: none"> • Tertiary Services/Central Hospitals are no longer to be managed by the provinces but will report directly to Pretoria as “semi-autonomous” units • Lack of clarity on relationship of NHI Fund, District Management, Contracting Units for PHC and core NDoH functions
The need to strengthen the public sector	All three phases said to be concerned with ‘health system strengthening’ initiatives but no detail provided. No mention of funding frozen posts; no infrastructure plan; reliance on the OHSC and Ideal Clinic to improve service quality and more recent Draft Quality Improvement Plan Aug 2018
Weak attention to human resources (particularly role of CHWs)	Sets up a National Governing Body on Training and Development to recommend policy on human resource development; focused on medical personnel (interns, community service and registrars); membership not defined but previously dominated by tertiary and specialist bodies; no mention of CHWs or nursing training. Two reps from tertiary training institutions are included on the Stakeholder Committee

GOVERNANCE

Risk of corruption of public funds

Some detail on how to control possible corruption: creates an investigating unit, mandates declaration of conflicts of interest and provides that committee members must not “expose himself or herself to any situation in which the risk of a conflict of interest between his or her official responsibilities and private interests may arise or use his or her position ... for self-enrichment or to improperly benefit any other person.”

Accountability weak

Board is accountable to Parliament – not clear if lessons have been learnt from the current malaise of SOEs

Poor mechanisms for participation

No community level accountability envisaged
Bill creates a single stakeholder committee in which CSOs are vastly outnumbered and no community-level participation is envisaged, no mention of Health Committees or Hospital Boards

HUMAN RIGHTS ISSUES

Potential infringement of privacy protections in the NHI information systems

Right of user to privacy noted; disclosure requires their written permission unless for clinical care, for quality improvement or by law,

Discrimination against migrants in terms of access to health care

Still limits services for documented migrants and refugees, no services for undocumented migrants

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Resources:

1. NHI Bill Press releases
SAMA press release: <https://www.samedical.org/cmsuploader/viewarticle/708>
PHM SA press release: <http://phm-sa.org/phm-sa-demands-health-equity-for-all-now/>
PHM SA in Cape Times: Let's Unite Behind a Universal Health Service that Caters to All Equally - Cape Times press coverage of PHM-SA Statement on the National Health Insurance Bill: <https://www.facebook.com/PHMSA1/posts/2051932361514508> and <https://www.pressreader.com/south-africa/cape-times/20180625/281878709103385>
RHAP press release: <https://www.spotlightnsp.co.za/2018/06/29/nhi-bill-so-near-yet-so-far/>
S27 Press release: <https://www.spotlightnsp.co.za/2018/06/26/section27-nhi-bill-is-not-the-path-to-universal-health-coverage/>
PHM SA : <https://www.spotlightnsp.co.za/2018/07/05/the-national-health-insurance-bill-welcome-but-flawed/>
Kerry Cullinan: <https://www.spotlightnsp.co.za/2018/07/02/nhi-its-not-just-about-the-money/>
Laetitia Rispel: NHI: <https://www.spotlightnsp.co.za/2018/06/29/nhi-sas-universal-health-care-plan-falls-short-of-fixing-an-ailing-system/>
Louis Reynolds: <http://wwmp.org.za/elitsha/2018/07/04/the-national-health-insurance-nhi-bill-the-view-of-phm-sa/>

2. General NHI articles

PHM SA website with all NHI back ground information: <http://phm-sa.org/national-health-insurance-nhi/>

Section 27 website: www. <http://section27.org.za/>

RHAP website: www. <http://rhap.org.za/>

TAC website: <https://tac.org.za/campaigns/national-health-insurance-nhi/>

Business live: <https://www.businesslive.co.za/bd/national/2018-06-21-nhi-bill-gazetted-paving-way-for-nhi-fund/>

Briefing of MoH: https://www.youtube.com/watch?v=fl_nwe_Yz-l

The NHI Bill: http://www.gpwonline.co.za/Gazettes/Gazettes/41725_21-6_Health.pdf

Medical aid members getting a raw deal, Competition Commission finds after lengthy probe: <https://www.health24.com/News/sas-private-healthcare-not-competitive-20180705>

Foundation for Human Rights: https://fhr.org.za/index.php/download_file/view/1227/3698/

3. Department of Health NHI Website (20 NHI documents or more):

<http://www.health.gov.za/index.php/2014-03-17-09-09-38/strategic-documents/category/383-national-health-insurance>