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UNIVERSAL HEALTH COVERAGE PATHWAYS FOR SOUTH AFRICA

A literature review informing critical policy choices report on the National Health Insurance

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ACRONYMS AND ABBREVIATIONS

Acronym/abbreviation	Full description
ANC	African National Congress
BHF	Board of Healthcare Funders
DRG	Diagnosis Related Grouper
GEMS	Government Employees Medical Scheme
FDI	Foreign Direct Investment
HMI	Health Market Inquiry
LMIC	Low-Middle Income Country
NHI	National Health Insurance
NHS	National Health System
OHSC	Office of Health Standards and Compliance
PFMA	Public Financial Management Act
PHC	Primary Health Care
SAPPF	South African Private Practitioners Forum
SEIAS	Socio Economic Impact Assessment System
SHI	Social Health Insurance
UHC	Universal Health Coverage
VAT	Value-Added Tax

EXECUTIVE SUMMARY

How did we get here? South Africa's proposed approach to achieving Universal Health Coverage (UHC) is articulated in the Draft National Health Insurance (NHI) Bill. The principles guiding the reform process, particularly in relation to equity, access and an orientation to primary health care can be traced back to the ANC Health Plan of 1994. There was an inflection point in the reform process in 2007 towards a single payer and purchaser system, away from a system that builds off existing medical scheme infrastructure. It was a change in direction that remains contentious.

How has the context changed? In the 12 years since the shift in policy direction, there have been significant contextual changes which do not appear to reflect in how policy has developed. Furthermore, the recent Health Market Inquiry process put forward a number of proposals for health system strengthening which have largely not been incorporated into the policy process.

Locally, we have experienced reduced trust in the State, a tighter fiscal space, and a more constrained health service delivery platform. Economic and health system vulnerabilities have been accentuated by Covid-19. Internationally, we have seen previously lauded UHC systems run into financial sustainability challenges, questions raised about the efficacy of strategic purchasing, and a move towards value-based contracting approaches. However, these systems have also weathered Covid-19 better than other systems, elevating the need for a more integrated and equitable system.

Why do we need reform? There is no doubt that the current health system requires substantial reform. The two-tier nature of the system is inequitable, and both the public and private sectors are fragmented and unsustainable. However, the current proposals have been met with a wide range of criticisms and concerns from across the political spectrum.

This report draws from the literature surrounding the reform process, together with insights from various interviews with critical stakeholders. The sticking points between different stakeholders in reaching consensus on the NHI Bill can be grouped into the following themes:

Theme	Key concerns
The creation of a purchaser-provider split	While there are arguments for a purchaser-provider split increasing accountability and enabling pluralistic purchasing, the evidence base for a split stimulating competition between providers is limited, particularly where there are few providers in a geographic region. There are questions about the basis of competition, and the extent of a fair playing field between the public and private sectors. The NHI Bill does not provide clear ways for transitioning to a situation where the NHI Fund will purchase from private providers in such a way as to ensure their ongoing sustainability. Negotiated payments to providers have to take into account the nature of the private environment (e.g. taxation and the need for a profit margin). The purchaser-provider split increases accountability from a top-down perspective, which should ideally be balanced with a bottom-up ability of clients to demand accountability and quality care from providers.
A single purchaser	A single purchaser is mooted on the basis of economies of scale, reducing risk pool fragmentation and strategic purchasing. However, it is not clear that a single purchaser is necessary to achieve these objectives. There is a lack of evidence relative to alternatives.

	A single purchaser creates a large pool of funds raising concerns about corruption and accountability. There are also concerns relating to the inefficiency of centralisation and a reduction in local responsiveness. A single purchaser is a monopsony creating a lack of both client-facing and provider-facing competition. The concerns about a single purchaser are amplified by a lack of trust between stakeholders.
The role of medical schemes limited to complementary cover	There remains a high degree of uncertainty in the role of medical schemes and the practicalities of providing complementary cover, particularly in the absence of an articulated benefit package. The impact on providers of being subject to a single purchaser raises the threat of a monopsony-induced brain drain. The economic ramifications of shutting down the private funding sector, including the impact on investor sentiment, are of concern. A reduced role for medical schemes is likely to result in an increase in out-of-pocket expenditure, the most inefficient form of healthcare financing. The financial and servicing pressure on the NHI Fund will be dramatically increased through the inclusion of medical scheme members. There exists no evidence to support the assumption that if you combine private sector (medical scheme) and public sector health expenditure, the amount will be equivalent to current total health expenditure- in part due to the shape of the tax instruments and the role of employer subsidies. Leakage from the system is likely to occur.
Quality assurance and quality improvement	A key concern is that the NHI Bill provides little detail as to how a high-quality health system will be achieved or monitored. The Bill lacks both process and outcome quality measures. The current low level of compliance in the public health sector raises the concern as to whether there will be enough accredited providers to provide access to care. Furthermore, there is a question as to what will happen to public facilities, and their employees, that are not accredited. The NHI Bill lacks a coherent framework for ongoing quality improvement.
Financial considerations	There are a wide range of financial concerns – most notably the absence of an accompanying financing paper. The uncertainty associated with the financial aspects cut across the lack of clarity on the inter-relationship between the benefit package and affordability, on the likely financing mechanism, and a lack of publicly available costings. The risks associated with the benefit package being dependent on available funds are noted.

Governance and accountability	There is concern about the relationship between the Minister of Health and the NHI Fund Board, and the role of the Minister across both purchasing and provider sides of the health system. The latter undermines the purchaser-provider split. The governance design is perceived to be vulnerable to corruption and poor accountability. Weaknesses across the range of health regulators (highlighted by the HMI) point to existing gaps in health system governance. Accountability is conceptualised as being in relation to clients, providers, across entities associated with the Fund and as a strategic purchaser – all four areas are found to be wanting.
Timelines and progress milestones	There are concerns about the proposed timeline being too short for successful implementation (i.e. implementation is being rushed). This is linked to a lack of detail in the timeline and a lack of clarity in the transitional arrangements. There are no benchmarks or milestones set, making accountability to timelines difficult to uphold.

We also note that a number of constitutionality issues have been raised by stakeholders. Many of these concerns relate to uncertainty or vagueness in the NHI Bill.

Clarity, trust and consensus: Questions about what will be covered, how cover will be provided and who will be covered lie at the heart of the envisaged system. While all of these are likely to be dynamic in nature, a clearer sense of the intent would facilitate constructive engagement.

The nebulous role of trust is a recurring theme. This has been exacerbated by State Capture, the failure of State-owned enterprises and poor governance of health-sector entities. The failure to build stakeholder buy-in through the reform process is apparent – this in itself raises concern about the likely conduct of a monopsony.

Despite all of this, it was apparent from our engagements with stakeholders that there are clear areas of consensus. Key to this is agreement on the principles of UHC and a commitment to increased equity. Stakeholders agree that greater levels of collaboration between the public and private sector are welcome and that primary health care (PHC) is recognised as the appropriate point of entry into the health system.

What can we do while we wait for reform? Certain key elements of the purchasing function can be strengthened prior to implementation: accreditation, health technology assessment, information system strengthening, clinical coding, levelling of professional rules across the public and private sectors, and experimentation with provider contracting are all examples. Learning sites will be essential to enable experimentation and testing of alternative service delivery models. There are numerous pragmatic impediments to innovation which will need to be interrogated and dismantled, for example, budget structures, salary determination, Public Financial Management Act (PFMA) rules etc. Similarly, certain rules of the Health Professions Council of South Africa (HPCSA) will have to be amended to allow for team-based remuneration and telehealth which will be required as part of new service delivery models.

Understaffing and low human resources for health (HRH) capacity will strengthen the notion of weak government capacity and quality, leading to lack of trust and buy-in to NHI as a concept. Ensuring that a sufficient healthcare workforce is available by the first roll-out and implementation of NHI needs to happen now, and requires continual planning and engagement to ensure future availability. Much needs to be done to improve public-sector working conditions, the absorption of the training pipeline into the system, and the ability

of doctors to work across both sectors. Task-sharing and the role of mid-level health workers need to be strengthened, and the current problems with vacancies fixed. These improvements will be critical to regaining the trust of healthcare providers.

Where to from here? This report is a precursor to a summary document laying out the critical policy choices relative to health system objectives as set out in various policy papers between 1994 and 2019, as identified in this report.

To inform a way forward, there is a need for research that is cognisant of the shortcomings of the current system – both public and private – and the advantages and disadvantages of the proposed reforms. In questioning the way forward, it is useful to conceptualise an inter-connected set of reforms, enabling thinking about a series of policy choices and the sequencing of implementation. Clearly articulated goals of the reform process can be used to create a framework against which to assess alternative reform choices and pathways (including the sequencing of the current proposed reforms).

1. INTRODUCTION

South Africa's proposed approach to achieving universal health coverage (UHC) is articulated in the draft National Health Insurance (NHI) Bill. TThe proposed reforms see the creation of a purchaser/provider split in the health system[a], the establishment of a monopsonist strategic purchaser of care, and a minimisation of the role of medical schemes. There is a substantial reconfiguration of the public system envisaged i.e. provinces become providers of care (as opposed to both purchasers and providers) with new entities created at the local level to co-ordinate the provision of care.

The policy development process underpinning the Bill has been drawn out – the Green Paper was published in 2011, the White Paper in 2017, and the first draft of the Bill in 2018. Prior to 2007, the policy trajectory was referred to as Social Health Insurance, which was a reform pathway that leveraged off existing medical scheme capacity. This pathway was abandoned in favour of a single-purchaser system. In the 12 years since the change in policy direction, there have been significant contextual changes. Locally, we have experienced reduced trust in the State, a tighter fiscal space, and a more constrained health service delivery platform. Internationally, we have seen previously lauded UHC systems run into financial sustainability challenges, questions raised about the efficacy of strategic purchasing (even in highly resourced environments), and a move towards value-based contracting approaches.

This report was written at the point in the policy process where the public submission and public hearing processes have been concluded, and those inputs now need to be considered by Parliament. It follows on from three previous reports:

- The first summarises the discussions held at a roundtable ("Towards Inclusive Healthcare") hosted by Inclusive Society Institute (ISI) in December 2019;
- The second reflects on lessons for South Africa on transitioning to UHC from the German experience; and
- The third outlines potential constitutional issues arising from the proposed reforms.

There is no doubt that the current health system requires substantial reform. The two-tier nature of the system is inequitable, and both the public and private sectors are fragmented and unsustainable. However, the current proposals have been met with a wide range of criticisms and concerns from across the political spectrum.

This report draws on conversations with a wide range of stakeholders through a roundtable discussion that took place in Johannesburg in December 2020 as well as individual stakeholder discussions before and after the roundtable. It has also been informed by the literature surrounding the financing reform process, including various NHI Bill submissions. The widely consultative process that informs this document included various stakeholders from Government, the political sphere, the private hospital sector, the medical schemes sector, doctor and specialist bodies and specific regulatory bodies. We clearly illustrate the areas of alignment and major sticking points between different stakeholders in reaching consensus on the NHI Bill.

The report begins with a brief history of UHC policy evolution (Section 3). The key health system objectives are drawn from this historical context and used to inform the thematic organisation of the rest of the document. Section 4 summarises the key remaining unresolved NHI structural and process questions. For each of the themes, we provide an overview of the critical data, the status quo and conflicting stakeholder opinions (Sections 5 to 12). In section 13, we reflect on the implications of Covid-19 for the reform process. We conclude (Section 14) with a consideration of the way forward.

[a] https://percept.co.za/category/research/nhi/

2. A BRIEF HISTORY OF NHI POLICY EVOLUTION AND KEY HEALTH SYSTEM OBJECTIVES

A clear understanding of key health system objectives is critical to assessing large-scale health reforms in South Africa. Our process of identifying key objectives involves a historical review of relevant NHI policy documents, specifically the evolution of these policies and how it birthed the most recent health reform policies. This chronological policy review will be limited to the post-apartheid period and therefore starts with the African National Congress (ANC) Health Plan of 1994[1] and continues up to the current NHI Bill of 2019.[2]

SHI and NHI: Defining concepts

Social health insurance (SHI) and national health insurance (NHI) are often used interchangeably in the relevant policies reviewed for this report. We therefore provide both a technical and conceptual description of these two terms.

As described in the Taylor Committee process in 2002[3], SHI refers to an insurance model where only those who contribute to it are entitled to its benefits. Contributors could include all taxpayers, all employed people, or defined groups in certain industries. On the other hand, NHI refers to a model where usually the same taxpayers would be the contributors but unlike SHI, everyone would be entitled to benefits. South Africa's Government Employees Medical Scheme (GEMS) is described as an SHI when the term is interpreted in its technical form.[4]

Despite the technical distinction between SHI and NHI, the use of these terms are often blurred in practice, with some technically social systems called NHI and vice versa.[5] For example, Germany's health system is known as SHI but covers the entire population. In contrast, Indonesia is implementing an NHI where initially only contributors are covered but with a long-term goal of slowly incorporating other groups.

In essence, the term adopted for a mandatory insurance – SHI or NHI – remains a question of societal preference and values.[5] Professors Diane McIntyre and Alex Van den Heever argue against using politically loaded terms like NHI or SHI and instead refer to a more neutral term like mandatory health insurance, which recognises common ground in the proposals.[6]

In South Africa, mid-1990s health reform proposals were called NHI.[1] Essentially the same proposed reform was then called SHI from around 2002.[5] In 2007, the terminology was changed back to NHI in the ANC documents emerging from the Polokwane conference[7] and has remained as such since then.[2]

2.1 ANC Health Plan of 1994

During the early 1990s, health reforms in South Africa focused on introducing mandatory health insurance. After the 1994 elections, policy initiatives that considered either SHI or NHI had its origins in the ANC Health Plan of 1994.[6]

This seminal document is underpinned by the ultimate aim of **health for all**, i.e. a measurable improvement in health outcomes for all South Africans. This aim is framed in the post-apartheid context of a fragmented health system, inequitable access to health care and the subsequent inequities in health outcomes. It therefore follows that one of the main objectives of the Health Plan was to **improve overall health system equity**. The plan asserts that a reorientation of the health system towards primary health care (PHC) is the best strategy to provide sustainable and equitable healthcare to all members of South African society.

The other key objective of the Health Plan was to **address the rapidly escalating costs in the private health sector** which rendered private health care increasingly unaffordable and reflected health system sustainability concerns. The plan described how the structure of the private health sector created incentives that prevented health for all. It envisaged a national health system (NHS) with a restructured private sector that played an important role in improving the health of the nation. It therefore viewed active cooperation between the private and public health sectors as essential to achieving health for all.

In summary, the ANC proposed working towards a comprehensive, equitable and integrated national health system based on the principles of equity, right to access and a PHC approach. The SHI proposals made by the Health Care Finance Committee of 1994 were in keeping with the aim and objectives of the ANC Health Plan.[8]

2.2 Committee of Inquiry into NHI 1995

The 1995 Commission of Inquiry[9] (also referred to as the Shisana/Broomberg Commission of Inquiry) upheld the objectives of the ANC Health Plan i.e. improving equity in the health system and addressing the cost-spiral in the private health sector. The Commission of Inquiry endorsed the objectives and proposals made in the ANC Health Plan and the Health Care Finance Committee but provided more detail on the role of medical schemes under the plan. It also strongly emphasised the strengthening of the PHC system. More specifically, it stressed that **improvement in health access, efficiency, and effectiveness** of publicly funded PHC services were urgently needed to ensure delivery of improved quality of care to all.

The Commission's report made detailed reference to **universal access** as a basic principle informing its recommendations. It defined universal access as a principle that should guarantee all permanent residents of South Africa equal access to all publicly funded PHC services and that the quality of these services should be equivalent for all users.

The Commission of Inquiry was criticised[10] because it seemed to favour the private health sector by encouraging competition between the public and private sectors when the former sector was poorly equipped to compete fairly. Serious concerns were expressed that the universal plan was not inclusive enough, thereby entrenching the existing disparities in access to healthcare. Furthermore, doubts were raised that the financial benefits of the NHI scheme would not be adequate to support the public health system.

2.3 Department of Health SHI Working Group of 1997

None of the proposals put forward in the ANC Health Plan and the Commission of Inquiry into NHI were further developed.[8] Instead, in 1997 the Department of Health (DoH) established the SHI Working Group with the stated objective of **generating additional revenue for the public health sector**.[11]

The proposals developed by the SHI Working Group formed the regulatory framework for the Medical Scheme Act in 1998. The Act aimed to regulate private health insurance as well as establish the principles of **open enrolment, community rating, prescribed minimum benefits and better governance of medical schemes**. Despite the introduction of the Act and its supporting principles, the level of coverage for the South African population remained below 16 percent.[12]

2.4 The 1997 White Paper on the Transformation of the Health System in South Africa

The 1997 White Paper on the Transformation of the Health System in South Africa put forward the main aims of restructuring the health system. These aims included developing a **single unified and comprehensive NHS to deliver quality health care to all**; ensuring **national, provincial and district levels play different but complementary roles in the health system**; increasing **access to an improved package of PHC services**, and uniting public and private sectors to promote these aims.[13]

The White Paper provides a comprehensive list of objectives to achieve the above-mentioned aims. These objectives can be condensed into two core objectives: improving **equity in the health system** and **generating additional revenue for the public health sector**.

In summary, this White Paper regards SHI as the main vehicle to increase finance for public health and proposes that an SHI scheme should be introduced. Again, the proposals to establish an SHI were not taken forward for implementation. This was mainly due to continued opposition by National Treasury.[8]

2.5 The 2002 Taylor Committee of Inquiry into Comprehensive Social Security

The Department of Social Development appointed Professor Vivienne Taylor to chair the 2002 Committee of Inquiry into Comprehensive Social Security to provide a vision for the transformation of all aspects of social security, including retirement reform and health care reform.[3] The Taylor Committee Report remains an important document and its recommendations are still being implemented. It provided the first set of policy recommendations on mandatory health insurance that explicitly called for an NHI.[8]

The broad objectives underpinning the Taylor Committee's proposals on NHI included the **provision of universal access to basic health care, ensuring social protection and solidarity** as well as **addressing the persistent issue of escalating costs in the private health sector**.[8]

More specifically, it was proposed that the universal cover should provide a minimum level of essential benefits that could be **provided by both the public and private health sectors**. The public health sector would continue to be the foundation of the overall health system, while the private health sector was envisaged as increasing levels of funding above the usual tax allocations. It was recommended, however, that private sector activity should take place in a closely regulated environment. The Committee argued that addressing the problems arising from the private health sector would **promote efficiency** in the health system.[3]

2.6 The 2002 Ministerial Task Team for Implementing SHI

To implement the Taylor Committee recommendations that would achieve an NHI in the long-term, the DoH established a Ministerial Task Team (MTT) on SHI[b]. In addition to the Taylor Committee recommendations, the MTT also considered findings from the Risk Equalisation Fund (REF) Task Group and the International Review Panel on REF. The MTT's main objectives were to ensure **affordable universal cover** and a **consistent system of cross-subsidies**.[8]

The MTT concluded that implementation of an NHI was not practical in the near future and that the focus should be redirected to planning for SHI.[14] However, the path to achieving universal coverage through the SHI model was not supported and implementation of the MTT's recommendations were stalled.[12]

2.7 The 2009 Ministerial Advisory Committee on NHI

In 2009 the Ministerial Advisory Committee was established to advise the Health Minister and DoH on health system reforms including the design and implementation of NHI.[12] The Committee's mandate was rooted in Resolution 53 which was passed at the ANC's Polokwane Conference in 2007.[7] This resolution **explicitly called for the implementation of an NHI**, stating that the NHI Fund urgently be set up using state revenue by 2014 and that the ANC should mobilise social support for the NHI and continue developing the White Paper and NHI legislation (envisioned to be finalised by 2013).

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[b] Authors have been unable to source this document (Social Health Insurance Options: Financial and Fiscal Impact Assessment. Unpublished technical report to the Department of Health. June 2005.)

A broad description of the ANC proposal for an NHI system was included in the ANC's 2009 election manifesto.[15] The objectives that guided the Ministerial Advisory Committee were drawn from this manifesto and included **reducing inequalities in the health system, improving the quality of care** (in both the public and private sectors) and **increasing human resources for health care** to ensure improved health outcomes for all South Africans.

2.8 NHI Green Paper 2011

In August 2011 the DoH published the NHI Green Paper (titled: NHI in South Africa), which proclaimed that the NHI would ensure that all South Africans had **access to appropriate, affordable and quality health services**, regardless of socio-economic status.[12] It was proposed that the NHI would be phased in over a period of 14 years and would require major changes in service delivery structures, as well as administrative and management systems. The implementation of NHI was intended to bring about health systems reform that would improve service provision by **promoting equity and efficiency**. Additional guiding principles of NHI included **social solidarity** and **effectiveness**.

The NHI Green Paper offered high-level solutions to achieving the following four health system objectives: **to provide improved access to quality health services**, irrespective of employment status; **to improve equity in the health system** by pooling risks and funds to create a single fund; **to address rapidly escalating costs in the private health sector** by procuring services on behalf of the entire population and efficiently mobilising and controlling key financial resources; and **to improve health systems performance** by strengthening the under-resourced and strained public sector.

The Green Paper was broadly criticised for its lack of detail on the complete package of services, financing mechanisms, the role of private medical insurance schemes and implementation plans and processes.

2.9 NHI White Paper 2017

In 2015, the DoH released a draft of the NHI White Paper (titled: *National Health Insurance for South Africa: Towards Universal Health Coverage*).[16] Commentators indicated that few of the NHI Green Paper submissions were incorporated in the draft NHI White Paper, which appeared to be quite similar to the NHI Green Paper.

The final NHI White Paper was published in 2017.[17] The NHI White Paper states that it lays the foundation for moving South Africa towards universal health coverage by implementing NHI and establishing a unified health system. The Paper proceeds to describes how implementing NHI is based on principles of the constitutional right of citizens to have **access to quality health care services** that are delivered **equitably, affordably, efficiently, effectively, and appropriately**. Furthermore, it states that NHI is based on **social solidarity, progressive universalism, equity**, and health as a public good and a social investment.

The objective upon which NHI should be based, according to the White Paper, seems to be closely linked to the objectives of UHC: equity in access to health services, access to good quality health services, and financial risk protection. More specifically, policy trajectory of the NHI should achieve the following three objectives for all citizens: **to provide adequate financial risk protection; to provide an opportunity to equitably benefit from the health system**; and **to ensure contributions towards the funding of the health system are based on the ability to pay**. Therefore, there was some disagreement over whether the term NHI was the right choice, given that the policy expanded beyond just the financial mechanisms.

The DoH highlighted that implementation of NHI would require amendments to related legislation and enactment of new laws to ensure that there is both legislative alignment and policy consistency across government departments and spheres of government. The NHI White Paper served as the precursor to the NHI Bill.

2.10 NHI Bill 2019

The NHI Bill was tabled in parliament on the 8 August 2019[2] and remains under consideration by the National Assembly's Portfolio Committee on Health after receiving submissions via the public participation process. These submissions may inform amendments to the Bill before it is put to a vote in the National Assembly.

The NHI Bill is based on two overarching but similar principles: **universality** – all will be able to access the same essential health care benefits regardless of their financial means; and **social solidarity** – all, regardless of their socio-economic status, will benefit from a national system of health care. As stated in previous policy documents, the goal of the NHI is to move towards **universal coverage**.

The NHI Bill refers to six specific objectives that the Fund will strive to achieve

- to provide **universal protection against financial risk**;
- to ensure an **equitable distribution** of the burden of funding the universal health system;
- to ensure **equitable and fair provision and use** of health services;
- to ensure **efficiency** in service provision and administration; and
- to provide **quality** in service delivery; and to ensure **good governance** and **stewardship**.

2.11 Finding alignment across policy documentation and trajectory

Table 1 below, outlines the key objectives and principles of the policies discussed in the sections above. Note the similarities in the policies, despite the different names and parties who were involved in their drafting.

Table 1: Core policy objectives across the trajectory of UHC discussions in South Africa

Year	Policy	Objective(s)	Principle(s)
1994	ANC Health Plan (including Health Finance Committee)	1. To improve equity in the health system 2. To address escalating costs in the private health sector	1. Equity 2. Right to access 3. PHC approach
1995	Committee of Inquiry into NHI	1. To improve equity in the health system 2. To address escalating costs in the private health sector	1. Equity 2. Right to access 3. Efficiency 4. Effectiveness
1997	Department of Health SHI Working Group	1. To generate additional revenue for the public health sector	1. Open enrolment 2. Community rating 3. Prescribed minimum benefits 4. Better governance of medical schemes
1997	White Paper on the Transformation of the Health System in South Africa	1. To improve equity in the health system 2. To generate additional revenue for the public health sector	1. Equity 2. Right to access 3. Efficiency

2002	Taylor Committee of Inquiry into Comprehensive Social Security	1. To provide universal access to basic health care 2. To ensure social protection and solidarity 3. To address escalating costs in the private health sector	1. Equity 2. Right to access 3. Efficiency 4. Public/private collaboration
2002	Ministerial Task Team for Implementing SHI	1. To ensure affordable universal cover 2. To achieve a consistent system of cross-subsidisation	1. Equity 2. Affordability
2009	Ministerial Advisory Committee on NHI	1. To improve equity in the health system 2. To improve the quality of care (in public and private health sectors) 3. To increase human resources for healthcare	1. Right to access 2. Public/private collaboration
2011	NHI Green Paper	1. To provide improved access to quality health services 2. To improve equity in the health system 3. To address escalating costs in the private health sector 4. To improve health systems performance	1. Right to access 2. Equity 3. Efficiency 4. Affordability 5. Appropriateness 6. Effectiveness
2017	NHI White Paper	1. To provide adequate financial risk protection 2. To provide an opportunity to equitably benefit from the health system 3. To ensure contributions towards the funding of the health system are based on the ability to pay	1. Right to access 2. Equity 3. Efficiency 4. Affordability 5. Appropriateness 6. Effectiveness 7. Progressive universalism 8. Health as a public good and a social investment
2019	NHI Bill	1. To provide universal protection against financial risk 2. To ensure an equitable distribution of the burden of funding the universal health system 3. To ensure equitable and fair provision and use of health services 4. To ensure efficiency in service provision and administration 5. To provide quality in service delivery 6. To ensure good governance and stewardship	1. Universality 2. Social solidarity

Based on this analysis, we have identified **five** objectives that have been consistently present over the years, while South Africa has tried to move closer and closer to UHC:

1. To improve **equity** in the health system, including the sharing of resources (human and other) across the public and private health systems;
2. To address **escalating costs** in the private health sector;
3. To provide **universal access** to **quality** health care;
4. To ensure **efficiency** in service provision and administration;
5. To ensure **good governance** and **stewardship**.

These key objectives of the health reform process will be used to create a benchmark against which to assess the feasibility of various policy choices and pathways. It may also assist in guiding the sequencing of current reform proposals.

3. A SUMMARY OF KEY ISSUES IN THE NHI BILL

The ISI hosted an NHI roundtable in Johannesburg in December 2019. The purpose of the roundtable was to enable a high-level stakeholder dialogue to identify key areas of policy agreement and disagreement. Through discussion and presentation of the various viewpoints of different stakeholders, it was clear there are certain positions on the NHI Bill on which stakeholders are in agreement. However, some areas still require interrogation in order to arrive at a place of consensus. Table 2 sets out:

- The proposals where stakeholders agreed that the position taken represents the accepted or preferred route;
- Areas of uncertainty that possibly need to be revisited; and
- The proposals that are disputed, where resolution and ultimately consensus are required in order to move forward.

At this point the disputed areas outweigh the areas of alignment.

Table 2: Areas of alignment and contention

Accepted - preferred route	Uncertain - possibly revisit	Disputed - consensus required
1. There is a need for UHC, due to inequity between health systems	1. Choice of a ***single*** purchaser and payer	1. Timelines and progress milestones
2. Wide engagement on the Bill is required to shape an effective health system and to build buy-in	2. The creation of a purchaser-provider split	2. The role of medical schemes/the private health financing sector: supplementary or complementary?
3. Greater levels of collaboration between the public and private sector is welcomed	3. The view that the NHI Board be appointed by the Minister of Health, and the CEO of the Board appointed by the Board	3. Quality assurance and quality improvement mechanisms
4. Primary health care is recognised as the appropriate point of entry into the health system		4. The extent of pluralistic purchasing
		5. Reimbursement mechanisms for providers
		6. Fiscal controls and affordability (what are we buying)?
		7. Governance mechanisms
		8. Accountability mechanisms
		9. Who to cover: refugees and undocumented migrants
		10. Constitutionality issues not captured by the above

In the following sections, we unpack these areas of misalignment, to illustrate from where the disagreements arise. This will help to inform further engagement.

4. THE PURCHASER-PROVIDER SPLIT

4.1 Rationale behind a purchaser-provider split

The NHI Bill18 outlines that the purchasing and provision of health care services will become two distinct and separate functions, performed by different entities: the former will be the responsibility of the NHI Fund alone, which will contract directly with both public and private providers. Provision of services will be the responsibility of the providers themselves and the district health authorities. The provinces currently play the roles of both purchaser and provider. A purchaser-provider split with the NHI Fund as the single purchaser was first proposed in the NHI Green Paper of 2011.[12] It is important to note that the creation of a purchaser-provider split is not necessarily linked to the creation of a single purchaser.

The creation of a purchaser is intended to support more strategic purchasing.[19] This includes determining who to purchase from (putting in place both accreditation and contracting requirements), what to purchase (the design of a benefit package) and on what basis to purchase (including the development of payment mechanisms to enable provider payment).[19] A purchaser-provider split has the potential to generate multiple benefits:

- The suggested purchaser-provider split is expected to **increase accountability of healthcare providers**, by creating a distance between the Fund, as the sole purchaser, and the various providers with which it contracts.[19] The NHI Bill specifies two ways in which such accountability can be driven: through enforcing minimum quality standards for providers and reimbursing providers based on the quality of care provided (determined by measurable outcomes).[18]
- Additionally, the purchaser-provider split is theorised to increase **competition among providers**, driving innovation and efficiency, as providers attempt to improve quality and/or decrease costs so as to remain competitive.[19]
- If the Fund institutes price ceilings, as is expected, providers won't be able to compete on price. The idea is that this would force competition based on quality.[20]
- Lastly, the proposed purchaser-provider split also has the potential to increase access to **private sector resources**.[19] In other words, the creation of a purchaser would enable pluralistic purchasing – purchasing from both public and private providers. The current procurement paradigm limits the extent to which this is possible. The extent of health resources in the private sector translates to a potential increase in access to quality health services under the NHI,[21] with the Fund being able to purchase services from a wider set of providers.

4.2 Sticking points around the proposed purchaser-provider split

A number of potential concerns have been raised about whether the foreseen benefits of a purchaser-provider split are likely to be realised in South Africa:

- Evidence from other countries (such as England) has shown that there are often not enough health care providers in a given geographic area for the benefits of competition to materialise.[19] In South Africa, where many regions have very few health resources available, this is likely to be the case.
- It will be vital to ensure that appropriate quality measures are strongly enforced by the Fund in order to avoid competition based on unimportant aspects of health care provision, such as the aesthetics of facilities.[19]
- To enable competition across the public and private sectors, consideration will need to be given to the structural differences across the two sectors (for example, VAT applies only in the private sector) that may hinder fairness in their ability to compete with one another.[19]
- The purchaser-provider split increases accountability from a top-down perspective, which should be balanced with a bottom-up ability of clients to demand accountability and quality care from providers.[19]

5. THE *SINGLE* PURCHASER

5.1 Rationale behind the choice for a single purchaser

The NHI Bill[18] states (page 7, section 2) that the NHI Fund will serve as the sole purchaser of health care services under the NHI:

"The purpose of this Act is to establish and maintain a National Health Insurance Fund in the Republic funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services by (a) ***serving as the single purchaser and single payer of health care services*** *in order to ensure the equitable and fair distribution and use of health care services [...]"[18]*

The choice for a **centralised pool of funds** was borne out of the current fragmentation of health care funding pools in the South African health system – both between public and private sector, and within each sector. The aim is to create one integrated fund that can ensure **equity** in spending for all South Africans.

The NHI Bill states that the NHI Fund will serve as the "single purchaser and payer"[18] in order to r**educe the cost of health care while simultaneously improving quality of care**, through economies of scale and more strategic purchasing.[19] Shifting to a single purchaser even within the public sector alone is expected to improve equity between provinces by allowing provinces to deliver more services than historical budgets may have allowed.[19]

All NHI policy papers (since the Green Paper of 2011) have indicated that the NHI Fund will serve as the single purchaser of health care services. However, previous conceptualisations of NHI were based on multi-purchaser models, expanding on the medical scheme environment.[22] This has therefore been a notable change in the policy as it essentially changes the role of provincial departments of health and limits the role of medical scheme administrators and managed care organisations.

5.2 Sticking points around a single purchaser

Concerns have been raised around the rationale for a single purchaser: the NHI Bill does not explicitly state or explain why a single purchaser is preferable to several purchasers.[23] The NHI Bill emphasises the main issue to be "fragmentation of health care fund pools in the South African health system"[18], which are proposed to be addressed through the development of an integrated pool for funding.[23] Previous official documents relating to the NHI also tend to focus on the pooling function, providing little rationale or evidence in favour of a purchaser-provider split (with a single purchaser) in the South African context.[23] There are alternative mechanisms to ensure equitable funding that do not require a single purchaser, for example, risk equalisation mechanisms, needs-based budgeting, and the implementation of capitation and Diagnosis Related Groupers (DRGs).

Professor Alex van den Heever argues that no evidence is provided in the Bill as to which aspects of the proposed health system reform and the current problems experienced in the health system necessitate a single purchaser.[23] In other words, can economies of scale and strategic purchasing be achieved without the creation of the NHI Fund? The State currently purchases pharmaceuticals at a national level, for example. The health component of the Provincial Equitable Share formula provides an opportunity to improve equity between provinces, and an equivalent mechanism at district level would further this equity. DRGs, as a means for directing funding towards hospital events, could also be implemented without a central fund, as could health technology assessment and other dimensions of strategic purchasing.

As mentioned, having a single purchaser creates a monopsony, which, in the case of an entity as large as the NHI Fund, raises concerns around both efficiency and corruption. The Fund will have complete market power through its sole control of purchasing health

care services and many argue that this will impede on provider autonomy and bargaining power.[19] Furthermore, the Bill lacks clarity around the costs of administration of such a large, centralised purchasing mechanism.[24] If the management of the Fund does become corrupted, there is the risk of a reduction in the availability of health care funds.

While the concept of a single purchaser (with the State as the single purchaser) is no longer new within the NHI discussion space,[25] there are still major concerns around the concept. Firstly, the NHI Bill does not explicitly state or explain any problems directly relating to the need for a single purchaser, nor provide any evidence as to why a single purchaser would be preferable to other options in the South African context.[23] Based on this lack of evidence, the most recent investigation of health systems purchasing and pooling problems in the South African context is considered: the Health Market Inquiry (HMI) report published by the Competition Commission, based on the private sector.[23] In contrast to the proposal of a single purchaser in the NHI, the **HMI recommends that the number of purchasers should increase** and that purchasing should remain a decentralised function.[26] However, a centralised risk-adjustment scheme is recommended to improve the fragmentation of pools and equity across pools.[26] Although the HMI calls for more purchasers, this would differ from the current private sector context where each scheme has its own risk pool. This is an important distinction, both in terms of equity and the basis of competition between purchasers. The incentive would be to compete on the basis of quality and not on the basis of risk selection i.e. cherry picking.

The centralisation of the purchasing process could come at the expense of a **decrease in responsiveness to local needs and adaptability**, as well as an increase in lengthy bureaucratic processes, due to the centralisation of the Fund at the national level.[19] These issues are particularly pertinent, given the size and scope of the health system.[27] In contrast to the proposed centralisation under NHI, the majority of countries are moving towards decentralising financial management functions, so as to enable critical financial decision-making to happen more locally.[27] While the benefits of economies of scale may be clear in some aspects of the health system, the importance of local relevance may outweigh these benefits in others.[19] To allow for increased local responsiveness, the NHI Bill has proposed local-level contracting units for primary health care, which will choose the combination of services and providers best suited to the relevant population.[27] The German experience, where purchasing functions are largely centralised at a national level (with some purchasing at a state level) demonstrates that various compromises between national and local levels, achieved through constructive conversation between stakeholders, need to be made in order for the system to work.[28] Germany has selected a multi-funder approach with multiple public insurance schemes that are able to be responsive to local-level needs while still benefitting from risk pooling at a national level.[28]

In the proposed single purchaser model for the NHI, there is **no room for competition between purchasers**. This raises the concern of purchaser complacency, through the elimination of the potential benefits of such competition, both in relation to clients of the health system and health care providers. The benefits include improved service levels, improvements in the ability to purchase on the basis of value, the impact of strategic purchasing interventions and attempts to secure contracts with providers.[19] This lack of competition also removes incentives for efficient administration in the provision of and access to health care.[27] A single purchaser could, therefore, create an imbalance in the relationship between providers and the purchaser, as well as between clients and the purchaser, owing to the elimination of choice.[27]

The Fund is reliant on a trusting relationship between the State and providers. Providers (public and private) will become heavily dependent on the fairness, rationality and effectiveness of the Fund[19], and vice-versa, the Fund will become heavily reliant on providers.[19] One of the risks driving the choice of a single purchaser, is the concern that providers would not choose to contract with the NHI Fund, given historical mistrust between the public and private health sectors. To prevent this, the Fund will need to build **trust and credibility with providers**.[19]

Figure 1: Sticking points around having a single purchaser

6. THE ROLE OF MEDICAL SCHEMES LIMITED TO COMPLEMENTARY COVER

6.1 What does the NHI Bill state about the role of medical schemes?

The medical schemes referenced in the Bill include medical schemes registered in terms of the Medical Schemes Act 1998 (Act No 131 of 1998) and any voluntary private health insurance scheme.

The role of medical schemes is outlined in section 33 of the NHI Bill. This section was not included in the prior version of the Bill (from June 2018) and its inclusion has been contentious.

Section 33 of the NHI Bill states: "Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund."

6.2 Concerns with the role of medical schemes

The inclusion of Section 33 in the NHI Bill has led to a great deal of uncertainty around the role medical schemes will play once the NHI has been implemented. The ISI roundtable meeting in November 2019 highlighted the dissatisfaction with this addition to the Bill. Medical schemes have stated their intent to fight the clause on its constitutionality.[25]

Given that the Bill does not specify the **benefit package**, it is hard for schemes to know the extent of the services they would still be able to deliver under the NHI. It is also anticipated that the NHI benefit package will change over time raising pragmatic concerns around ongoing required changes to the corresponding medical scheme packages. It is also unclear precisely how complementary is defined in relation to referral pathways, clinical protocols, formularies, provider choice and waiting times.

The Helen Suzman Foundation[29] highlighted confusion on whether the 'complementary cover' would only be relevant for those who choose to opt into NHI (individuals or providers). This is an unlikely interpretation given the Bill's intention to collapse the current two-tiered system. However, other stakeholders expressed similar confusion in classifying 'complementary cover' and there is widespread frustration at the vagueness of the role of medical schemes.[30 29 23 25]

The Bill and supporting documentation fail to provide justification for the inclusion of Section 33, which has led stakeholders to make assumptions about the rationale and present their arguments against this assumed rational:

- Section 33 may be intended to deal with **maldistribution of provider resources** across the private and public sectors. However, it is argued that a key challenge regarding resources is a lack of funding in the public sector together with poor working conditions, which contribute to pushing health care providers into the private sector. This links to the monopsony concern raised in relation to a single purchaser. Moving all health care to the NHI is expected to lead to a reduction in income for private hospitals, private doctors, and pharmaceutical companies, among others. This could lead to job losses and decreases in tax revenue. Many in the private sector do not believe that the agreed upon tariffs will be acceptable, even with the increase in volume.[25] This may result in a 'brain drain', with health care workers choosing to leave South Africa for other countries offering a higher earning potential.
- Section 33 may be intended to redirect existing medical scheme funds into the NHI Fund, or at least replace household contributions to medical schemes with increased taxation directed to the NHI Fund. The former is unlikely as scheme funds belong to their members, 25 i.e. this is not legally possible.

- There is no connection between prohibiting private schemes and implementing an NHI that is **tax funded**. The individuals who would make use of medical schemes post NHI implementation would still be contributing toward the NHI Fund through tax (i.e. a duplicative system is possible, where contributions to the NHI Fund are compulsory, but membership is not).
- The inclusion of Section 33, without sharing the evidence driving the decision, negatively affects **investor sentiment**.

A key concern from a UHC perspective is that preventing medical schemes from providing cover could increase out-of-pocket expenses thereby reducing access and driving inequality.[25]

It is argued that the inclusion of Section 33 will adversely impact both the health care system and economy.

The economic consequences include the direct impact on the private health care funding industry. There is also the second order impact on health care providers in relation to reduced revenue, and there may be foreign direct investment (FDI) and multinational implications due to limitations on access to private cover and care.

The inclusion of Section 33 increases the **burden on the State** by forcing those who can afford to fund themselves to transfer to the NHI – these are typically clients with a high degree of agency and an expectation of higher levels of utilisation. While this pressure on the NHI Fund may drive system improvements, the pressure could also have negative implications. Furthermore, scheme members are generally older, which makes them a more expensive cohort of individuals, given the relationship between age and non-communicable diseases such as diabetes. By including more people, and a 'riskier' group of people, the Fund will require more money to successfully purchase the necessary care. The increase in clients for the State will place further burden on both the purchasing and provision side.

A potential solution for the dilemma of expensive older clients in the Fund is the opt out system followed in Germany. Individuals are able to opt out of public health insurance funds before the age of 55.[28] Once they have reached the age of 55 they are not allowed to join public insurance funds anymore. This is used as a way of encouraging people to belong to statutory sickness funds rather than private insurance schemes at younger ages and contribute when their health need is not as high yet.

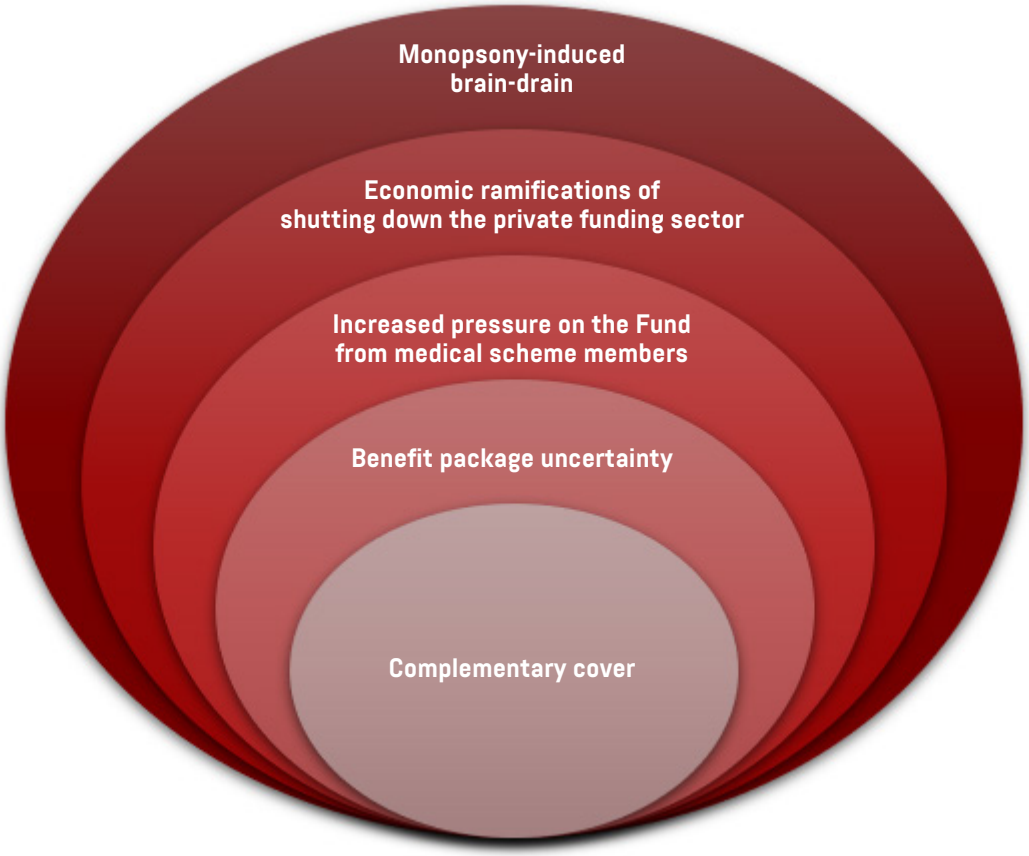
Given the shortage of human resources for health in the country, many have expressed concern that the system would not cope with the demand for care under a complementary cover set up, particularly as some private providers may choose to emigrate or leave their professions rather than accept regulation by the NHI Fund.

Many stakeholders feel that it would be more sensible to allow those who can afford to pay for private health care to do so, while still mandating that they contribute to the NHI Fund. This is aligned with the approach used in the United Kingdom, where there is a successful National Health Service alongside an active private health insurance sector.[25]

Stakeholders largely agree that medical schemes need intervention as their current operations were not aligned with the goal of UHC. However, the role of medical schemes presented in the latest NHI Bill fails to consider the **numerous measures that the HMI report recommended** to strengthen the private health care sector. The recommendations are referenced by most stakeholders as less drastic actions to take in the first steps in moving towards UHC. Although there is acknowledgement that private health sector costs are far too high, the HMI's solutions include more closely regulating pricing, strengthening social solidarity mechanisms and increasing the incentives for strategic purchasing rather than significantly reducing the role of the sector.

The combined effect of these factors is therefore a questioning of Government's ability to implement UHC without the involvement of the private sector. Stakeholders see the move to NHI as an opportunity to focus on successfully regulating the private sector rather than banishing it.[23 29 30]

Figure 2: Concerns related to Section 33



7. QUALITY ASSURANCE AND QUALITY IMPROVEMENT MECHANISMS

7.1 What does the NHI Bill say about accreditation and quality?

The NHI Bill positions the accreditation of health service providers as a mechanism to ensure the quality of health services provided. The Bill states that accreditation of health service providers includes **certification from the Office of Health Standards Compliance (OHSC)** (page 21, section 39): "In order to be accredited by the Fund, a health care service provider or health establishment, as the case may be, must (a) be in possession of and produce proof of certification by the Office of Health Standards Compliance and proof of registration by a recognised statutory health professional council, as the case may be."

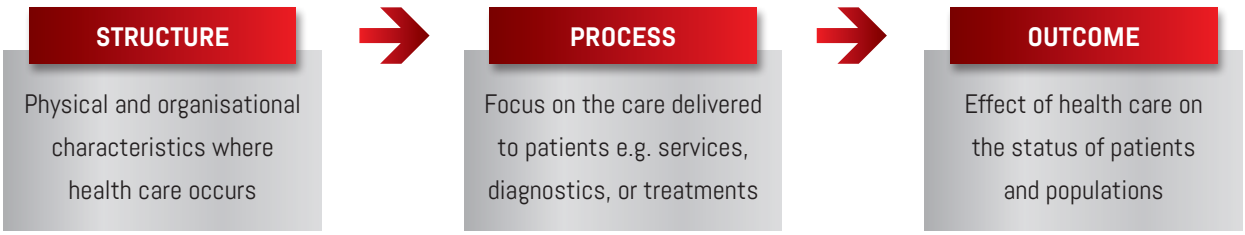
The NHI Bill then goes on to explain that the first phase of implementation will **improve quality** through certification (page 47, section 2.2.1): "The intermediate preparatory phase involves improving the quality of the health system by first certifying the health facilities to ensure they meet the requirements of the Office of Health Standards Compliance."

The Bill also makes some reference to purchasing care (it refers to contracting) from accredited public and private providers (page 20, section 37.1.2(b-c): "A contracting unit for primary health care… must assist the fund to b) identify accredited public and private health care service providers at primary care facilities; c) manage contracts entered into with accredited health care service providers, health establishments and suppliers in the relevant sub-district in the prescribed manner and subject to the prescribed conditions". Furthermore, in the Schedule to the Bill a "provider payment" is defined as "payment to providers in a way that creates appropriate incentives for efficiency in the provision of quality and accessible health care services using a uniform reimbursement strategy". However, there is no detail provided on how the creation of these incentives is envisaged to take place.

7.2 How to measure quality

The measurement of quality of health services is a complex undertaking, owing to the multi-dimensionality and depth of the concept of quality itself. It is therefore useful to differentiate which aspects of quality are being measured, and by which measures. Quality measurements can be broadly grouped as structural measures, process measures and outcome measures as per Donabedian's framework (Figure 3).[31]

Figure 3: Donabedian's quality framework[31]



The certification of health facilities by the OHSC (which is one of the prerequisites for provider accreditation as per the NHI Bill) ensures that facilities meet a minimum set of requirements, through measuring the **structural** aspects.[32] Given their tangibility, structural aspects are the easiest to measure and assess but they lend themselves to less frequent assessment. While structural quality serves as a necessary foundation for the provision of quality care, it is not sufficient on its own to reflect the quality of care delivered.[32]

Accreditation is only one aspect of quality measurement. Accreditation is generally a static process. Quality measurement can be used in a more ongoing way by using the data created when interacting with the health system as part of the measurement toolkit. Therefore, a purchaser is able to relatively quickly pick up where there have been episodes of poor quality (for example, by analysing the occurrence of bed sores in hospitalised patients) and intervene timeously.

Accreditation processes can also be costly, given that assessors would need to visit facilities semi-regularly to ensure compliance. The other process and outcome measures provide a more efficient way to measure quality between assessments. Linking reimbursement to quality measures can also help to improve quality. If the NHI Fund is seen to value quality and is able to quickly pick up and intervene where there are quality issues, it could also help the provider space to self-regulate to ensure their continued contracting with the Fund.[32]

7.3 Concerns surrounding the proposed quality measurement

Various NHI submissions have raised concerns around the accreditation of providers and the implications thereof on quality of health services. A key concern is that while the NHI Bill highlights the need to ensure quality health care, it **provides little detail** as to how this will be achieved[33] or monitored.[24] The lack of process quality measures, with regard to treatment guidelines and protocols, was a common complaint.[24] Many feel the Bill also fails to acknowledge the complexity of ensuring and improving quality.[33]

There is also concern that a large number of public health facilities will not meet the certification requirements of the OHSC, based on the OHSC 2016/17 Annual Inspection Report which found only seven of the 696 investigated facilities achieved scores of 80 percent (the benchmark score for compliance) or more.[23] The low level of compliance in the public sector raises the concern as to whether there will be enough accredited providers to deliver the care envisaged by the NHI, since the Fund can only contract with accredited providers.[32] An insufficient number of accredited providers will result in over-burdening of facilities that are contracted by the NHI, and is likely to translate to decreased quality of care as a result.[34] This also poses a threat to access to health care, which will be reduced if many existing facilities are not contracted by the Fund, especially in rural areas where there may only be one health facility for a large geographic region.[33,35]

Furthermore, there is a question as to what will happen to public facilities, and their employees, that are not accredited.[33] Stakeholders have also questioned whether the OHSC has sufficient budget and personnel to routinely investigate and monitor compliance to certify all the health facilities in the country.[33]

The Department has attempted to answer this by stating that the non-compliant facilities will be supported to become compliant. However, public health facilities should technically already be providing quality care and therefore the Department's ability to ensure this, within a relatively short time frame, is questionable. Using certification to improve quality relies on the fear of not being certified to incentivise providers to improve quality. However, they may lack the necessary skills and tools to improve quality and may need to be supported through this process. The NHI Bill lacks a coherent framework for ongoing quality improvement.

8. FINANCIAL CONSIDERATIONS: WHAT ARE WE BUYING, AND CAN WE AFFORD IT?

8.1 What does the NHI Bill say about affordability?

The Bill makes mention of affordability only once, as a consideration for what the NHI Fund can purchase. The Minister of Health at the time made it clear that the NDoH was leaving the financial aspects to the National Treasury. The National Treasury was due to release a financing paper in support of the draft NHI Bill, that would detail the fiscal space available for NHI and the mechanism for revenue collection. Unfortunately, to date, the financing paper has still not been released.

As mentioned in previous sections, the Bill does not include any detail on the benefit package. It states that the Benefits Advisory Committee, in consultation with the Minister and the NHI Fund Board would be responsible for determining the final package.

8.2 What are we buying?

The lack of detail has made it impossible for stakeholders to comment on the benefits package and whether what we are 'buying' is appropriate or sufficient for the need. This came up in most submissions on the Bill and in our stakeholder interviews. Notably, it also came up in the Davis Tax Committee report of 2017, which analysed the 2017 NHI White Paper. In that report, the committee was clear that affordability cannot be measured without details of what is included in the package.[36]

However, in the University of Witwatersrand's School of Public Health NHI Bill submission, the authors argue that it may not be necessary to detail the benefit package. Instead it is recommended that the NDoH work on a 'negative list' of services that will definitely be excluded.[37] This is the method used in Thailand, on which South Africa has in many ways based its NHI policy. This would help medical schemes to begin to know what their complementary cover might include and will also give citizens and stakeholders a better idea of what services the NHI Fund is aiming to purchase. Furthermore, a sentinel book focusing on benefit package design and funding has emphasised the need for the benefits package to be a living document.[38] By writing into the Bill the specific package, the Government may prevent innovation and learning as the NHI takes off.

Of keen concern then is the process for determining the benefit package. It is worth noting that the Bill does not currently link the benefit package process to the budget setting and affordability process nor the provider negotiation and reimbursement processes. The Bill also makes mention of a Health Technology Assessment unit, that will assist in cost-effectiveness decision-making to ensure affordability.[18] This body would ultimately inform what can be included in the benefits package. Transparency on how the HTA will assess cost-effectiveness would also assist to build support for the Benefits Advisory Committee.

The lack of a benefits package to interrogate has remained a sticking point for almost all stakeholders. It has also inflamed discussions around the complementary cover clause for medical schemes.

8.3 Can we afford it?

In 2017, the DPME conducted an impact assessment on the NHI White Paper.[39] Although the document references some more recent work by the NDoH supported by PWC, the majority of the costs still derive from the original Green Paper costing in 2011. This is problematic as the financial picture in South Africa has shifted dramatically since then. PWC has estimated that ~R3.6 billion is needed to implement the infrastructure and personnel-related costs for NHI implementation over six years for the 'base scenario'. There is,

however, no detail on what the base scenario includes and the NDoH has subsequently distanced itself from this costing as it was not based on sufficient evidence.[23]

Most submissions also focused heavily on affordability. In one of our stakeholder interviews, it was emphasised that irrespective of what the State includes in the benefit package, the final available services will have to be in line with the available funding envelope. This could create a liability for the NDoH, where users are able to litigate against the State if they do not provide the services outlined in policy documentation, or if there is a contraction is services over time. This is further incentive to include a 'negative list' only, to prevent this scenario. Alternatively, a detailed and pre-costed package is required to ensure that the package is within the affordability parameters.

The costs associated with the Fund should not be considered only a single-year time frame, or even over the short term. Long-term projections and stress-testing are necessary. The reimbursement mechanisms used for providers are relevant for consideration of longer-term costs. For example, a system like DRG's allocates funds for every hospital admission. If hospital admission rates were to rise, so to would the financial obligation of the Fund.

The fact that the financing paper still has not been released has also alerted stakeholders to perceived tension between the NDoH and National Treasury, bringing up further worries that the Bill has not been costed. The DPME impact analysis outlines five different scenarios (see Table 4) for revenue collection (with a stated preference for Scenario B).

Table 3: Tax scenarios[39]

	Year	Payroll tax	Surcharge on taxable income	Increase in value-added tax
Scenario A: Surcharge on taxable income, VAT increase and payroll tax	2016/17 2018/19 2022/23 2023/24 2024/25	0.5% 0.5% 1.0% 1.0% 1.0%	0.5% 0.5% 1.0% 1.0% 1.0%	0.0% 0.5% 0.5% 1.0% 1.0%
Scenario B: Payroll tax and surcharge on taxable income	2016/17 2019/20 2022/23 2025/26	0.5% 1.0% 1.5% 2.0%	0.5% 1.0% 1.5% 2.0%	
Scenario C: Surcharge on taxable income and VAT increase	2016/17 2018/19 2019/20 2020/21 2022/23 2024/25 2025/26		0.5% 0.5% 1.0% 1.0% 1.5% 1.5% 2.0%	 0.5% 0.5% 1.0% 1.0% 1.5% 1.5%
Scenario D: Payroll tax and VAT increase	201617 2017/18 2019/20 2022/23 2024/25 2025/26	0.5% 0.5% 1.0% 1.5% 1.5% 2.0%		 0.5% 0.5% 1.0% 1.5% 1.5%
Scenario E: Surcharge on taxable income	2016/17 2017/18 2019/20 2021/22 2022/23 2023/24 2024/25 2025/26		0.5% 1.0% 1.5% 2.0% 2.5% 3.0% 3.5% 4.0%	

The Davis Tax Committee also outlined several options for revenue collection but still concluded with the finding that the scenarios for revenue collection outlined in the NHI White Paper (2017), would be insufficient to fund the NHI, thereby concluding that the NHI policy, as it was written in the White Paper, was unaffordable.[36] The use of general taxes and personal income tax has also been wide-

ly disputed as insufficient and overly punitive given the small tax base.[23] Professor van den Heever's Bill submission further outlines the concern that no detailed financial feasibility assessment has been done since the 2011 Green Paper.

Given South Africa's current fiscal climate, including the ramifications locally and globally of the Covid-19 pandemic, stakeholders expressed grave concern over whether the NHI is achievable and particularly, whether it is achievable by 2025/26. The University of Witwatersrand submission cautions that if user expectations are not managed, the Fund may overspend on its budget, threatening its financial sustainability. A negative spiral has occurred in other lower- and middle-income countries (LMIC) where providers refuse to deliver care to registered patients, because they are not reimbursed or cannot rely on being reimbursed timeously. Essentially, this scenario would result in providers losing confidence in the Fund. Therefore, the submission calls for an implementation time frame that allows for gradual phasing in to build trust and for the development of an information system to safeguard quality and efficient provider payment.

One stakeholder we interviewed for this report suggested that the State could, in the meantime, contract in some services from the private sector without much system reform, to bolster quality and availability in the public sector. This is meant to happen as part of Phase II of the NHI implementation. The lack of movement on this front has also made stakeholders more doubtful of the State's ability to be a single, centralised, purchaser of health care services.

Until the financing paper is released, questions of affordability will remain. In the absence of a benefit package, the finance paper would have to come from a top-down approach, outlining the funds that could be available for the NHI under the most palatable revenue collection scenario. It would then be up to the NDoH and the Benefits Advisory Committee to cost and prioritise which services it can reliably offer, within the given financial envelope. This would then need to be tested against current benefits offered in the largely free-at-the-point-of-use public health system.

8.4 Who to cover? Refugees and undocumented migrants

The inclusion or exclusion of undocumented migrants and refugees has been a standing concern since the 2011 Green paper was circulated. As a way to curb costs, Government has suggested limited access for refugees and temporary residents. This has caused concern given South Africa's Constitution, which allows for health care for all within its borders, irrespective of status. The move to exclude refugees and undocumented migrants would require a change to the Constitution,[40] which is unlikely. Section27 also notes that by excluding these populations from sexual and reproductive health care and HIV prevention and management services, South Africa is placing population health at risk.

The DPME impact assessment offers a potential solution by suggesting a contingency fund for undocumented migrants and refugees. It suggests engagement with SADC countries and the African Union. The DPME assessment involved multiple stakeholders, and there was widespread agreement that these population groups should be covered within the NHI.

9. GOVERNANCE AND ACCOUNTABILITY

The themes of governance and accountability were repeatedly raised in various NHI submissions and in interviews with stakeholders. Although the themes are related, here we discuss them separately and interpret governance arrangements as dealing with the structures that will govern the NHI Fund and its operations, while accountability refers to feedback, choice and incentive mechanisms that will ensure the NHI Fund and its providers are kept accountable to various stakeholder groupings.

9.1 Governance

Fund governance was a common concern in Bill submissions and stakeholder engagements. In particular, many are worried about the relationship between the Minister of Health and the NHI Fund Board. The Bill currently states that the Minister will be ultimately responsible for selecting the Board and has the powers to dissolve the Board if s/he feels they are not performing. This creates a concern around the potential for corruption and poor accountability under this set up. The University of Witwatersrand submission also highlighted that the NHI reform is to institute a purchaser-provider split. The Minister would likely play a coordinating role between these two arms. Therefore, the Minister should not have a vested interest in either arm, in order to play a neutral arbiter role ensuring that the NHI meets its policy objectives.[37] The submission by Section27 and the TAC supports this point, calling for an oversight mechanism to safeguard the Fund from nefarious activity.[40] The history of State Capture in South Africa unfortunately has made many stakeholders suspect of centrally controlled, large government funds.

A final key consideration highlighted by one of the stakeholders is that the results of the HMI report indicate that the state has failed to adequately regulate the private sector, despite it being a policy goal since the early 1990s. Weaknesses across the range of health regulators point to existing gaps in health system governance, and weaken trust in the likelihood of the Fund being well governed.

9.2 Accountability

There are several concerns related to accountability within the NHI, we detail these, together with stakeholder-suggested remedies in Table 4 below.

Table 4: Accountability in the NHI

Area	Concern	Proposed solutions
Providers	Need to ensure providers are accountable to clients and the Fund for the provision of quality care	• Quality measures are instituted to monitor structure, process, and outcome measures for providers • Contracting with providers on the basis of value • Some degree of provider choice
Accountability across NHI-related organisations (e.g. Fund, CuPs etc)	The University of Witwatersrand drew out the complexity of the various organisations listed within the Bill and how they all relate to one another; their submission cautions against structures that are not clear and mixed lines of reporting that can result in inertia in large bureaucracies[37]	A regulatory framework is drawn up, outlining roles and responsibilities for each of the organisations; the organisational design should be considered through a governance and accountability lens, with an honest accounting for current weaknesses in health sector regulatory bodies

Clients	The centralisation of purchasing will further disempower clients and move the system further from decentralisation	• Inclusion of civil society and health care users in the advisory committees • Amendment of National Health Act (31(2)(a)(iv)) to include health care clients into District Health Council • The Fund should publish information about provider performance and health outcomes and utilisation statistics (the HMI's recommendation around an OMRO is supported) • The creation of a client ombudsperson to pronounce on cases where patient rights may have been violated
Purchaser	The purchaser (NHI Fund) is under all the usual regulatory mechanisms (PFMA etc) that other Government bodies are; this has not worked to manage or prevent corruption and as such is insufficient for the Fund	Suggestion that the Fund is held to extraordinary accountability measures beyond just the usual audit requirements; suggestion that the AGSA works to determine some non-financial metrics on which to base performance, alongside the financial metrics

10. TIMELINES AND PROGRESS MILESTONES

10.1 What does the NHI Bill state about timelines?

The NHI policy papers (Green, White, and draft Bill) all speak of the rollout of NHI taking place over phases. In the draft Bill, the initial phase (2012-2017) was viewed as the testing phase of health systems strengthening initiatives, while the current phase 2 (2017-2022) is the phase during which supporting legislation has to be developed, the foundations of the Fund have to be established and interim purchasing of health services for vulnerable groups (e.g. women, children and the disabled) has to take place. Lastly, in the final phase (2022-2026), additional resource mobilisation by the Fund may start (e.g. contribution collection from salaried employees), and the Fund will start to purchase services from providers (the Bill refers to 'selective contracting of services from private providers').[18]

10.2 What are some of the objections raised?

Six NHI submissions were considered (TAC, Section27, SAPPF, Helen Suzman Foundation, FW De Klerk Foundation and Professor van den Heever's submission) and all six highlighted an objection to the proposed timeline. Largely, these objections related to the **timeline being too short for successful implementation**. Many of the necessary steps and considerations to achieve the timelines are not included in the latest Bill. The Helen Suzman Foundation highlighted that the State has previously failed to timeously implement a simpler initiative: the payment of social grants by SASSA in 2017. This does not instil confidence in the State and their ability to implement NHI.

There is concern that the **implementation of the NHI is being rushed**. Section27[40] and the TAC[41] were also particularly concerned that the Government was continuing into phase 2 before there had been any publicly available assessment of the success of the initial phase.[41] Further, there appear to be **no benchmarks or milestones set**, making it difficult for external bodies to hold Government accountable. The FW De Klerk Foundation[30] also raises concern on the **lack of feedback from the initial phase**. The initial phase (2012 to 2017) planned to include activities in preparation to implement NHI such as strengthening the health system. There were lessons to be drawn from this phase and recommendations were provided based on an evaluation of this phase. However, the Bill does not mention how it will implement the recommendations and it does not acknowledge the existence of the initial phase which both hinders the ability to draw lessons from the initial phase/pilot but also creates confusion.

Another salient concern was the **lack of detail in the timeline** – the Bill often defaults to providing the Minister with the power to decide on the detail at a later stage. A further criticism is around the **lack of clarity in the transitional arrangements** presented in the Bill.[42] For example, it is stated that interim purchasing of personal health services for vulnerable groups will occur in the current phase yet there is no mention of which legal framework the purchasing will occur under nor when such a framework will be established. Similarly, the transitional arrangements outlined for the final phase are vague and fail to provide meaningful detail. The Helen Suzman Foundation[29] states that the lack of detail in the implementation plan allows the minister to decide on when the publication of necessary regulations will occur and effectively construct their own timeline.

Lastly, there is doubt that enough public health facilities will be fully accredited by the OHSC in the provided implementation timeframe in order to deliver meaningful access to quality care. Given the current weaknesses in the public sector and infrastructure, the low level of resourcing of the OHSC and the lack of a quality improvement framework, this may lead to insufficient capacity to rollout the NHI or an NHI reliant on sub-optimal providers. This threatens support for the reform.

Van den Heever[23] supports the notion that the proposed institutional framework cannot be achieved in the given timeframe, labelling the Bill unjustifiably optimistic and over-ambitious.

All stakeholders agreed that the timeline for the NHI implementation was too short for the massive system re-organisation it requires.

10.3 How can we prepare the way for NHI?

Strengthen the purchasing function while enabling innovation in service delivery: It is possible to strengthen the purchasing function in the short term in the public and private sectors. Certain key elements of the purchasing function can be strengthened prior to implementation: accreditation, health technology assessment, information system strengthening, clinical coding, levelling of professional rules across the public and private sectors and experimentation with provider contracting are all examples.

The current budget structure limits innovation in public service delivery. Learning sites will be essential to enable experimentation and testing of alternative service delivery models. This can be done ahead of full implementation. There are numerous pragmatic impediments to innovation which will need to be interrogated and dismantled – budget structures, salary determination, Public Financial Management Act (PFMA) rules etc. Similar to the strengthening of the purchasing function, certain rules of the HPCSA will also have to be amended to allow for team-based remuneration and telehealth that will be required as part of new models.

Invest in people now: Reflection on years of provision of universal health coverage by the UK's NHS has shown that getting the human resources right is critical to the success of UHC (Friebel et al. 2018). South Africa's last Human Resources for Health (HRH) Strategy in 2011 (Department of Health 2011) was never comprehensively implemented. The development of a clear human resources operational plan was articulated as an outcome of the Presidential Health Summit that took place in October 2018 (Gonzalez 2018). HRH shortages have been noted in terms of doctors (GPs), specialists, nurses and dentists. Ensuring a sufficient healthcare workforce is available by the time of the first roll-out and implementation of NHI is something that must happen now already and requires continual planning and engagement to ensure future availability. Under-staffing and low HRH capacity will strengthen the notion of weak government capacity and quality, leading to lack of trust and buy-in to NHI as a concept.

Much needs to be done to improve public-sector working conditions, the absorption of the training pipeline into the system, and the ability of doctors to work across both sectors. Task-sharing and the role of mid-level health workers need to be strengthened, and the current problems with vacancies fixed. These improvements will be critical to regaining the trust of healthcare providers.

Take stakeholders along on the journey: The German process of transitioning to UHC has shown how important it is to take all critical stakeholders along on the journey.[28] Significant trust can be built by being responsive to the needs of stakeholders and involving them in the transition process. In Germany, it was found that a medium-term process of working intensely with important stakeholder groups supported a transition process. An independent research group worked closely for a period of three years with key health system stakeholders to arrive at consensus outcomes and ideas on the changes required.[28] Six books were published from this engagement. It meant the perspectives of all stakeholders were captured and shared in a public way.[28]

11. POTENTIAL CONSTITUTIONALITY ISSUES RAISED BY THE NHI BILL

The ISI produced a separate report[43] that focuses only on the constitutionality issues that may arise from this Bill. Many of the concerns raised relate to areas of uncertainty in the draft Bill, and, depending on the implementation of the Bill, constitutional issues may arise at a later stage. Note that further legal input is required to engage with whether the issues outlined below are meaningful concerns, or not.

Many stakeholders have questioned the constitutionality of Section 33 of the draft NHI Bill, in particular.

For brevity in this report, we only include those issues foremost in stakeholder engagements and in various NHI submissions. [30 25 29 23]

1. Section 18 of the Bill of Rights guarantees every person to the right to freedom of association. It is argued that requiring all citizens to fall under the NHI may be limiting one's right to decide who to associate with.
2. Entrenched in section 12(2)(b) of the Constitution is the right to bodily and psychological integrity. It is argued that the freedom to choose health care services is tied to this right.
3. Section 25 of the Bill of Rights speaks to the right to property and it is argued that the inclusion of Section 33 in the NHI Bill may be infringing on this right.
4. Section 27(1) of the Constitution speaks to the right to access to health care. Government may not hinder individuals from themselves giving effect to this right. Section 33 of the NHI Bill may therefore be infringing on this right by reducing access to health care for some.
5. By taking away substitutive or duplicative medical scheme cover and thereby forcing individuals to register to become users of the NHI Fund, the State is argued to be potentially infringing on "the most basic contours" of a person's life "through coercion".
6. Section 36 of the Constitution states that rights in the Bill of Rights may be limited if the limitation is reasonable and justifiable. This includes taking into consideration the relationship between the limitation and its purpose and consideration of less restrictive means to the purpose, among other considerations. Stakeholders suggest that the Bill will fall short of this clause due to the inadequate justification and lack of evidence of considerations of other measures to achieving UHC.

12. LEARNINGS FROM THE COVID-19 PANDEMIC FOR NHI

South Africa is likely to fare worse than the Global North as a result of Covid-19 because our health system and economy are both more fragile, we have fewer health workers, and access to health care in rural parts of the country is poor. The pressure on the health system impacts not just on patients but on health workers too. Weak leadership is made visible because it exacerbates the situation by not being sufficiently responsive and clear.

Covid-19 has highlighted the weaknesses in both the public and private health system, and driven home the need for UHC in South Africa. In our engagements with one stakeholder they expressed a desire for an integrated health system and argued that Covid-19 should make the need for such a system very clear. Systems that have functional UHC, like Germany, have managed to weather the Covid-19 storm better than those without UHC or with weak health systems.

Covid-19 has also given us a glimpse of what is possible for health system reform: rapid innovation in digital access to health, the deployment of community health workers to accelerate our response, home delivery of medicines in the public sector and private sector doctors willing to roll up their sleeves for the public good.

The centrality of stewardship is beyond question. There are many things that would have made our health system more resilient but were missing because of lackadaisical regulation and oversight. Examples include the lack of progressive telehealth regulations and the absence of risk-based capital regulations for medical schemes. Other elements of the health system have also been highlighted through the pandemic. A gross under investment in technology has resulted in difficulties with patient management across facilities and sectors (for example, electronic patient records) and the availability of tracking and tracing technology to curb the spread of Covid-19. Manual and paper-based systems have fallen over with high patient volumes, and this is critical to improve before instituting a nation-wide system.

Covid-19 has highlighted some of the contracting capabilities that we need to build as we move toward NHI. For example, agreement on tariffs for Covid-19 patients to be treated in private hospitals was challenging albeit eventually reached. Covid-19 has provided an opportunity for NDoH and Treasury to ensure that provider reimbursement is timeous and fair during this period. Dealt with appropriately, this could go a long way to building trust between the sectors.

However, most pressing on everyone's mind is the way in which Covid-19 has decimated economies around the globe. This has further weakened stakeholders' belief that the NHI is an affordable option for South Africa. Given the increased reliance on loan funding, it is likely that South Africa will come under increased lender scrutiny around the financial sustainability of major policy changes.

During the pandemic, medical schemes came together to discuss how their reserves could be used to ensure care during an unusually high utilisation period. The WHO has asked how the NHI Fund plans to ensure there are enough reserves to allow for the same kind of security.

As we continue to weather the storm, no doubt there will be more lessons and more opportunities to practice some of the mechanisms that the NHI and the NHI Fund plan to rollout. If done well, this could provide the experience needed to build trust and confidence in NHI reforms.

13. THE WAY FORWARD

This report is a precursor to a summary document laying out the critical policy choices relative to health system objectives as set out in various policy papers between 1994 and 2019, as identified in this report. The intention of this report was to provide an overview of various critical issues and concerns stakeholders have raised with regards to the NHI Bill. Arguments for and against certain positions taken in the bill were presented. The report ended with reflections on how the Covid-19 pandemic is already shaping the future of NHI.

Critical interrogation of key sticking points between stakeholders is required in order to not only question the way forward proposed by the NHI Bill, but to also find a practical road ahead that can take all critical stakeholders along on the journey. There is a need for research to inform a way forward that is cognisant of the shortcomings of the current system, both public and private, and the advantages and disadvantages of the proposed reforms. In questioning the way forward, it is useful to conceptualise an inter-connected set of reforms – enabling thinking about a series of policy choices and the sequencing of implementation. Clearly articulated goals of the reform process can be used to create a framework against which to assess alternative reform choices and pathways (including the sequencing of the current proposed reforms). This will help to clarify the costs and benefits of different choices and provide clear guidance on the way forward.

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