



CRITICAL HEALTH PERSPECTIVES

2022 #1 – JUNE 2022

THIS EDITION

National Health Insurance in South Africa

A brief history and critical analysis

Ms Lynn Bust, Dr James van Duuren, Dr Louis Reynolds, Prof. Leslie London, Ms Anneleen De Keukelaere

In 2022, the South African health system is in severe crisis. We are re-igniting our CHP publications with a fresh face. Our first focus will be on the massive health system reform currently pending in South Africa – National Health Insurance (NHI). We will critically analyse and unpack the South African NHI in four sequential CHP publications. The first issue is separated into two sections: the first will give a brief history and background context to National Health Insurance in South Africa. The second section will analyse the current NHI Bill of 2019, briefly breaking down its most relevant components. This will be a teaser for CHPs to come which will go into further detail, looking at the topics of financing and the private sector; governance and accountability; and community participation in the NHI policy process.

INTRODUCTION	2
HISTORY OF NHI	3
CRITICAL ANALYSIS OF BILL	4
WHAT IS MISSING?	6
CONCLUSION	7



Health for All Now!

People's Health Movement

South Africa

www.phm-sa.org   @PHMSA1

Critical Health Perspectives (CHP), published by the People's Health Movement-South Africa (PHM-SA), are short editions critically analysing the health system of South Africa. They aim to take a deeper dive into some of the health problems we currently face, scrutinising their root causes and discussing potential solutions to these complex issues. Originally started in 2005, CHPs are written by activists, academics, and experts in their field to spark debate on the most pressing issues in health today. The views expressed here do not necessarily reflect the view of all those who have identified with PHM-SA.

Introduction

“If health outcomes are to be improved the central question that needs to be asked is not how public systems are to be privatized but how existing public systems could be made truly universal. Public systems need to be reclaimed by citizens, reformed in the interest of the people and made accountable.”

Amit Sengupta, Founder and Advocate of the People’s Health Movement in India [1]

The aim to achieve Health for All through universal health coverage (UHC) is profoundly political. Health system reform has a long history in the global policy sphere, with a recent movement towards achieving UHC as a target of goal 3 of the Sustainable Development Goals. UHC implies that all people and communities have access to the promotive, preventive, curative, rehabilitative and palliative health services they need (equitable access); that the services are of sufficient quality (effective); and that the use of these services does not expose them to financial hardship (affordable) [2].

Movements towards UHC should be seen as an opportunity to build a society based on social solidarity, equity, and justice, recognising the principle of health as a human right. However, there is risk of reinterpretation of the meaning of UHC and its principles to the benefit of powerful players prioritising their profit margins.

The South African health system of today is arguably in its deepest crisis, further exacerbated by the COVID-19 pandemic. There is severe fragmentation and inequitable distribution between the public and private sectors, rural and urban areas, and primary and tertiary levels of care. In South Africa, numerous proposals to improve health care have cropped up. These have been windows of opportunity to implement real change in a failing health system. However, these have not achieved their desired outcomes in the past due to lack of political will and the power of vested interests.

In 2018, the National Health Insurance (NHI) Bill was released for public comment, with the stated intention of realising the right to comprehensive, quality health care for everyone on the basis of need, while ensuring that no one experiences financial hardship in accessing the care they need [3]. The NHI presents

itself as another window of opportunity to improve the South African health system. However, if we do not heed the lessons of the past, there is possibility that vested interests may seize this opportunity to pursue their own gains, leaving the system no better, or worse even, than before.

There have been three historical efforts of note to improve the health system in South Africa.

The first was in 1944, inspired by the concept of Community Oriented Primary Health Care (PHC) and developed under the leadership of doctors Emily and Sydney Kark. At this time, the National Health Services Commission under Dr Henry Gluckman recommended the establishment of a single tax-funded national health service for all citizens irrespective of race or class [4]. However, vested interests in the provincial governments and the private sector opposed this recommendation. Then the National Party won the 1948 election and started implementing its apartheid health system, closing the window for any opportunity for this innovative approach. Had it been implemented, South Africa would have been at the forefront of health systems thinking globally.

The second opportunity was in 1978, globally inspired by the Declaration of Alma Ata with the commitment to health as a fundamental human right, and vision of Health for All by the year 2000 [5]. The declaration was almost universally adopted, including by South Africa, and was based on the concept of comprehensive PHC which seeks to empower people through a bottom-up, community-based approach [6]. This was shortly reinterpreted globally to a narrow, ‘selective PHC’ approach which undermined the values of the original declaration, and again, the window of opportunity was lost.

Finally, in 1994, the Reconstruction and Development Programme and the African National Congress (ANC) national health plan for South Africa provided a vision of a unified national health system incorporating public and private sectors, and the provision of equitable health care services [7, 8]. The health plan did not last long, as policies shifted to neoliberal approaches such as the Growth, Employment and Redistribution policy which implic-

itly emphasised private health care and removed the vision of a national health plan [9].

In all three of these windows of opportunity, there was great potential to implement real change towards Health for All. However, they were captured by powerful players and lacked political motivation, thus achieving no real change in the system. These lessons should be heeded when considering the NHI today.

History of NHI

The current efforts to establish an NHI scheme in South Africa have been prompted by the health system crisis with gross inequality between the public and private sectors, and spiralling costs in the private sector way above the rate of inflation [10]. The immediate origins of the NHI policy can be traced back to 2009 with the resolution of a policy congress of the ANC. The first formal government policy statement on NHI was the Green Paper, released in 2011 for public comment which envisioned provision of a comprehensive package of care underpinned by re-engineered PHC. The Green Paper introduced ideas such as a single payer system, implying that only one agency, the NHI Fund, would purchase services from providers. A single payer makes services more affordable as the state is able to bargain down prices, and prevent the private sector from overcharging. It also proposed tax rebates allocated to members of private medical schemes would be phased out, transferring the money to the proposed NHI Fund.

In 2015, an NHI White Paper was released for comment which stated the need for government to act to eliminate fragmentation in funding pools shown to adversely impact the performance of the current health system. This document recognised the role of medical schemes to provide supplementary cover (the same benefits that would occur under an NHI) until the NHI is in place, after which they would provide complementary cover (benefits not provided in an NHI). In 2017, a second White Paper was released for comment together with a gazette outlining the Implementation Structures for the NHI. This provided further detail on the consolidation of financing arrangements for the NHI, including consolidation of funding schemes into 5 transitional funding arrangements which oppose the equity principle of NHI (see financing below for further explanation). There was a concerning shift in the policy documents from medical schemes as a sector with particular skills that might be of value for specific purposes in order to build the NHI, to a sector who needs to be at the centre of constructing the NHI, with their own interests protected. This indicates the potential of corporate capture which should be monitored closely in future.

In 2018, the NHI Bill was released which consolidates some of the principles in the earlier policy documents. The core of NHI is the separation of purchaser from provider, in other words the NHI Fund purchases services from providers who may be public, private or some mixture of both. The following principles were outlined in the Bill, and the CHPs will further unpack these principles:

- **a single public purchaser** of health services, the NHI Fund: PHM strongly supports
- **equitable and fair distribution and use** of health care services: PHM strongly supports
- **sustainable and affordable access** to health care services: PHM strongly supports
- **protection against financial risk**: PHM strongly supports
- **eligibility limited to South African citizens and permanent residents**: PHM strongly opposed
- **mandated use of referral pathways**

Since 2020, the COVID-19 pandemic shifted prioritisation away from NHI in South Africa, but work has continued toward it in the background. The

pandemic has been a reminder of the vast inequities that exist in the current South African health system, and that fragmentation in the health system made it impossible to respond in an agile way. It was also a reminder of the social determinants of health, and the inequitable impact on the poor and vulnerable in society as a reminder that the current system is not working. Several lessons could be learnt to help design a better health system with equal access to health care. For example, the centralised procurement of vaccines and contracting of doctors might be similar to arrangements under the NHI [11]. On the other hand, instances of extreme corruption in South Africa were revealed during the pandemic and alert us to the threat of

corruption with a centralised fund for the NHI – a threat that must be prevented. For centralised procurement to be successful, strong governance and accountability mechanisms need to be established. A national health service built on social solidarity and collaboration to deliver the goods and services essential for health could go a long way to improve preparedness for the next pandemic and build resilience in the health system.

PHM calls for a People-Centered NHI where community participation is central, equity is fundamental, and a one-payer system finances a pro-public health system. We need to mobilise for an NHI for everyone and everywhere based on social solidarity and universality.

Critical analysis of Bill

The principles outlined in the NHI Bill as it stands can be lauded such as equity, social solidarity, and health care as a human right and public good. However, there are several sections of the Bill which are extremely problematic if the desired goal of the NHI is to achieve UHC. We give a brief overview of some of the issues raised in the Bill, but will discuss these in further detail in future CHPs.

FINANCING

The sources of income for the NHI Fund are vague and ambiguous. Funding will supposedly come from four sources: general tax revenue; reallocation of funding for medical scheme tax credits; payroll tax; and surcharge on personal income tax. The Bill does not go into much further detail. Regressive taxation such as VAT, or a surcharge on salaries or flat rate increase income tax can have a deleterious effect and entrench inequality. Rather, in support of the social solidarity principle of NHI, progressive taxation is needed such as an incremental increase in income tax rates, an increase in company tax, or a salary exempted financial transaction tax, thereby allowing those with greater financial income to support those with a lesser income.

In previous policy documents, there has been suggestion of different funding streams in a transitional arrangement, and consolidating public servants separately from the rest of the population. This risks creating a powerful interest group able to undermine the principles of solidarity and risk sharing across different groups. More detail is needed

on the funding mechanisms of NHI. Mechanisms should be decided by a transparent, participatory, and evidence-based process that is insulated from the private sector influencing decision-making.

BENEFITS

The details of what services are to be funded are not provided in the Bill or any other policy document. Much of the NHI's potential success in achieving health for all will be based on the package of services that it provides. This package will also determine the role that medical schemes will play in providing complementary cover. Since determination of the Benefits Package should emerge from an evidence-based process, much time, data and resources will be needed to accurately inform the best package of care based on cost-effectiveness, equity and maximum resource availability. However, considerable data will be required, much of which we do not have in South Africa. Additionally, what gets included in the benefits package should be the result of a transparent process and the details must be made available in a transparent manner.

PURCHASING

The Bill states that the purchasing of services is to be devolved to provincial and district level hospitals, and at a sub-district level to contracting units for primary health care. There is concern about whether these district and sub-district entities have the capacity to undertake the activities required by the Bill, given the complexity. Mechanisms should be put in place to ensure accountability and support to ensure provision of a transparent purchasing process. Furthermore, given that the mechanisms of payment of accredited service providers are vague in the Bill, there is concern that medical schemes will be enrolled to perform this function. Involvement of medical schemes for this function is a potential threat to the success of the NHI, as, without oversight, their vested interests could steer payment of providers towards options that are not most affordable, equitable and accessible for all.

COVERAGE

Coverage in the Bill is limited to citizens and permanent residents in South Africa. Many South African citizens and permanent residents do not have birth certificates or identity documents which may limit their access to health care as they cannot register without them. Documented refugees and asylum seekers will be eligible for free emergency services, care for conditions of public health importance, and services for paediatric and maternal conditions. Undocumented migrants are not covered at all. The Bill discriminates unfairly against non-South Africans. The Bill of Rights frames access to emergency medical services as a right for everyone, but the NHI scheme states that undocumented migrants would have to pay for this. This is highly discriminatory as most undocumented migrants will likely not be able to pay for services essential to preserve their life.

The Bill states a commitment to starting coverage with those who are uninsured: elderly, children, rural people and the disabled. This is welcomed, but needs to be guarded against if there are differential packages of care for these groups. In addition, in the 2017 document on NHI implementation, it was suggested that steps toward NHI will require mandating medical insurance coverage for formal sector

workers. This is inconsistent with UHC intentions, and not required as a policy step. Where schemes start out by covering certain sections of the population, such as formal health workers, as Kutzin points out: “such schemes do not naturally “evolve” to include the rest of the population. Instead, the initially covered groups, who tend to be well organized and influential, use their power to increase their benefits and subsidies, rather than to extend the same benefits to the rest of the population” [12].

GOVERNANCE

Oversight structures for NHI are extremely thin in policy documents. The NHI Fund will concentrate huge sums of money and the potential exists for this enormous fund to be looted. The Fund will be overseen by a Board of ten persons appointed or approved by the Minister. This gives extensive power to those people, as well as much indirect and unaccountable authority to the Minister to which they report. It should be clear from the Digital Vibes scandal that such control should never be vested in individuals or political parties, no matter who the Minister is. The person who appoints the NHI Board should not be the same person to whom they are accountable if they are to be independent. The NHI Fund should report to parliament, rather than the Minister, and measures to prevent and combat corruption should be strong, clear, and enforceable.

The establishment of an internal investigating unit to combat fraud is grossly insufficient. The proposed unit is under the direct control of the CEO of the NHI Fund, which compromises its abilities to effectively combat fraud at high levels as the CEO reports to the NHI Board and the Minister. Given the large sums of money the NHI Fund will manage, the size and competency of the investigating unit is lacking. In order for these oversight systems to function, they must be independent, which has been overlooked in the Bill. Furthermore, at the district and sub-district level, the NHI will rely on the capacity and integrity of local managers. However, the public sector as it stands has been crippled by weak governance, poor management, and absent leadership. Systems should be put in place to prevent opportunistic “tenderpreneurship”, and strengthen management and oversight capacity at this level.

COMMUNITY PARTICIPATION

There is no room for meaningful public participation in the NHI and its committees as it currently stands. In previous NHI policy documents, civil society is recognised as playing an important oversight role. However, the composition of the Benefits Advisory Committee and Benefits Pricing Committees have no civil society or labour representation. The Bill limits civil society to representation in a single body referred to as the Stakeholder Advisory Committee (SAC). Advisory committees often lack teeth and exist to provide advice with little traction. Placing civil society and community voice into one big pot of stakeholders will seriously dilute any community voice in key decisions. There is no clarity about the power and the functions of the SAC, and the Minister effectively has complete power to select, appoint, and fire members of the SAC. The Minister is free to appoint members of organisations of his or her choice rather than true representatives of citizen groups.

Communities need to be empowered through involvement in decision-making processes at all levels of health systems. The existing provisions in the National Health Act are inadequately accountable

to communities. Currently, health committees only exist in the public sector, and not in private. Participation structures such as health committees and hospital boards need to be built and strengthened, and extended to all facilities in both the public and private sectors. These structures need clear governance and accountability roles, consistent with their location in the PHC system. Consideration should be given specifically to the governance role when purchasers and providers are split, and legislation is required to ensure community participation in the private sector as well.

ACCREDITATION

Both public and private facilities will require accreditation prior to being able to provide services under NHI. Given current infrastructure and functioning of the public sector (about 90% of public sector facilities did not reach the Office of Health Standards Compliance benchmark in the last audit [13]), there is a greater likelihood of private/urban providers being accredited. Inequities in the health system will be exacerbated if public, particularly rural facilities, cannot be accredited. These facilities need support to address the factors preventing their accreditation.

What is missing?

Of note are several things which are missing in the Bill:

- There is not one structure in the NHI Bill that specifically addresses the strengthening of the public sector. PHC is declared to be the heart-beat of NHI, and public health care services are the backbone of health system serving 80% of the population, but there are no systems, funding streams or committees to strengthen PHC in the public sector. Strengthening the public sector must be a priority and not come after the creation of the NHI.
- Prevention is hardly mentioned in the Bill, instead there is a preoccupation with hospital care, tertiary services and packages of benefits dominated by curative care. The Bill describes prevention in terms of services delivered by providers at a “Primary Health Care level”. This is a misnomer, as PHC is not a level of care but a descriptor of a health system in line with the vision of Alma Ata. This also limits the conception of prevention under the NHI to a narrow idea of personal services, not recognising that many of the most effective preventive strategies are population-based rather than individual. Inter-sectoral engagement needs to occur in order to effectively coordinate upstream preventive action, but there is lack of recognition or structure for this in the current Bill.
- The Bill also lacks attention to obstacles to care for rural populations, for example physical barriers to access such as patient transport. The Bill should cover transport to primary sites of care where needed.
- Overall, the Bill lacks clarity and critical insight into the meaning of UHC, rendering it vulnerable to vested interests and jeopardizing its potential to achieve equity in health care.

Conclusion

As a nation, we cannot let the health crisis continue. The NHI, with all its faults and lack of clarity, is a rare opportunity to establish an equitable health system that will deliver health care to all of us according to need rather than means. These opportunities are rare, occurring about once a generation, and have been previously squandered due to the power of vested interests in the past. Today's opportunity to build an equitable health system for all through NHI is our collective duty. We, the People's Health Movement of South Africa, envision a People's NHI that ensures community participation and prioritises equity, with the development of a health system that is pro-public, supported by a single payer, providing universal benefits equally to all and based on social solidarity through public mobilisation. Let us all rally behind this call towards true Health for All in South Africa.

REFERENCES

1. Sengupta A. Universal health coverage: beyond rhetoric, vol. 20. Canada: Municipal Services Project; 2013.
2. World Health Organisation. Universal Health Coverage. 2022. Available from: https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
3. Republic of South Africa. National Health Insurance Bill [B11-2019]. 2019. Available from: https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf
4. Yach D, Tollman SM. Public health initiatives in South Africa in the 1940s and 1950s: lessons for a post-apartheid era. *Am J Public Health*. 1993;83(7):1043-1050.
5. Declaration of Alma-Ata. *WHO Chron*. 1978;32(11):428-430.
6. Cueto M. The origins of primary health care and selective primary health care. *Am J Public Health*. 2004;94(11):1864-1874.
7. Republic of South Africa. White paper on reconstruction and development. 1994. Available from: <https://www.gov.za/sites/default/files/governmentgazetteid16085.pdf>
8. African National Congress. A national health plan for South Africa. 1994. Available from: <https://www.anc1912.org.za/policy-documents-1994-a-national-health-plan-for-south-africa/>
9. Republic of South Africa. Growth, employment and redistribution: a macroeconomic strategy. 1996. Available from: <http://www.treasury.gov.za/publications/other/gear/chapters.pdf>
10. SA Competition Commission. Health Market Inquiry final findings and recommendations report. 2019. Available from: <https://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf>
11. Cleary K. What SA's COVID-19 experience tells us about NHI. 2021. Available from: <https://www.spotlightnsp.co.za/2021/03/03/what-sas-covid-19-experience-tells-us-about-nhi/>
12. Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. *Bull World Health Organ*. 2013;91(8):602-611.
13. Office of Health Standards Compliance. OHSC Annual Report 2018/19. 2019. Available from: <https://ohsc.org.za/publications/ohsc-annual-report-final-30-aug-2019/>



ABOUT THE PEOPLE'S HEALTH MOVEMENT

The People's Health Movement South Africa (PHM-SA) is the South African Chapter of the People's Health Movement, a global network of grassroots activists, civil society and academics, predominantly from low and middle income countries. PHM-SA was started in 2003 by a small group of health activists, and launched in 2007 with its Right to Health Campaign. The mission of PHM-SA is to improve the capacity of individuals and communities to realise their right to health and health care, and to advocate for a Primary Health Care (PHC) approach, as defined in the Declaration of Alma Ata. PHM uses the term PHC in its broad, developmental sense, affirming health as a social, economic and political issue and, above all, as a fundamental human right. Fulfilment of this right requires not only universal access to excellent, equitable health services, but also concerted intersectoral state action to address the social determinants of health.