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THIS EDITION

Financing of the South African National Health Insurance and involvement of the private sector

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People's health in South Africa is in the midst of a severe crisis, with a high burden of disease, and fragmented and dysfunctional health services. We are re-igniting our Critical Health Perspectives (CHP) series with a fresh face. Our first focus is on the health system transformation we would like to see with the implementation of National Health Insurance (NHI) currently under way. Our first issue gave a brief history and basic introduction to the NHI process. This, the second issue, looks at the financing of NHI and involvement of the private sector. First, we will unpack current financing of the health system and the proposed NHI financing structures, and provide a critical analysis of these. Then, we will outline a vision for an equitably-funded People's NHI. Further CHP issues will look at governance and community participation in the NHI policy process, the recent ruling on the Certificate of Need for healthcare practitioners, and the contested meaning of Universal Health Coverage.

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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

South Africa's (SA) health system is highly inequitable and inefficient. Inequality in wealth and health remain among the widest in the world. Of the 8.5% of GDP spent on health care, half is spent in the private sector catering to the wealthiest 16% of the people — the socioeconomic elite who can afford medical scheme membership and out-of-pocket (OOP) payments for private care [1]. The remaining 84% of the population, who bear the overwhelming share of the disease burden, depend on the chronically under-resourced public sector.

This is a striking example of the Inverse Care Law, which states that "the availability of good medical care tends to vary inversely with the need for it in the population served" [2]. In SA the average per capita spending on health care each year is R17,225 for the rich, and R4,480 for the poor — those who bear the overwhelming share of the disease burden [3]. There is one government-employed doctor for every 2,457 people not covered by medical schemes compared to one medical scheme-registered doctor between 429 and 571 people in private care [4].

The inverse care law operates best where medical care is mostly privatised and exposed to market forces. After almost 3 decades of neoliberal austerity under Growth, Employment and Redistribution (GEAR) macroeconomic strategy in SA, the public sector is massively underfunded and dysfunctional. It is often unreliable and lacking in specialist services. Meanwhile, the Competition Commission's Health Market Inquiry (HMI) found that the private sector is neither efficient nor competitive [5]. It is mired in its own crisis of fragmentation, incoherence, and the high and rising costs of health care and medical scheme cover.

The NHI Bill

The government under the African National Congress (ANC) describes National Health Insurance (NHI) as a *health financing system* to pool funds and purchase quality, affordable health services for all South Africans based on their needs and irrespective of socioeconomic status [6].

Financing NHI is contentious [1, 7]. The NHI Bill is vague in terms of mechanisms of payment for health care providers accredited through NHI. The current 2019 Bill proposes a single-payer system, where a future NHI Fund will collect and pool the funds for health care on behalf of the entire population. The funding will come from four proposed sources: general tax revenue, reallocation of funding from medical scheme tax credits, payroll tax, and a surcharge on personal income tax [6].

A single-payer system is pro-equity, and enables negotiation over the prices of medication, treatment, and services without escalation of costs as they are managed through one fund [8]. In contrast, the multi-payer system that SA currently has allows multiple entities such as insurance companies to collect and pay for health care. Multi-payer systems are harder to regulate with higher administrative costs, and diminished purchasing power and efficiency as multiple entities compete [9]. Overwhelming evidence shows that a single-payer system performs better in terms of risk pooling and negotiation, and achieving equity in health care [8, 10, 11].

The current policy clearly specifies the NHI fund as the sole purchaser of services. Those committed to the free market, and powerful vested interest groups reject the idea of a single-payer system [7, 12]. Instead, they argue that we already have Universal Health Coverage (UHC) [13], ignoring the need to promote and achieve equity — a fundamental principle of UHC [14]. Instead they argue for continuation of a multi-payer scheme-based system that will inevitably entrench a situation where vulnerable populations continue to receive inadequate or inferior health care [15]. These argu-

ments appear strongly in their submissions to the NHI Bill and media representations of NHI [7, 16], which often feature so-called 'independent' think tanks that promote free-market policies at the expense of public benefit.

NHI cannot cover all health care services for all people. Instead, the NHI Bill proposes a "service benefits" package – a list of conditions and health care services to be covered by NHI. This list has not yet been determined. What it eventually includes will influence both financial and operational planning. It will also influence how equitable the system is. To achieve equitable health care for all requires more than coverage of certain health care services or a change in financing of the health system. It requires an approach to provision of health care that is rights-based and in the interest of the people, being both responsive and accountable to their needs.

The private sector in South Africa

Currently, expenditure in the private sector in SA amounts to over half of all expenditure in the health system [17]. This expenditure covers only 16% of the population who are the wealthy minority that can afford the expensive cost of treatment in the private sector and contributions to medical schemes [1].

The private sector in SA comprises a range of for-profit and not-for-profit actors [18]. Different groups of actors will be impacted differently by NHI. For example, private health care providers and private health facilities, who operate on a for-profit basis, will still be able to provide services if they are accredited under NHI. On the other hand, medical schemes, who are registered as non-profit organisations, are only able to provide complementary cover according to the current Bill, i.e., cover for services not included in the benefits package of NHI which is yet to be determined. We refer mainly in this section to the for-profit medical scheme-based providers.

The SA Competition Commission conducted an in-depth review of the SA private sector, the HMI, and published its findings in 2019 [5]. It found that the private sector was characterised by high and rising costs of health care and medical scheme cover; overutilisation by users without demonstrated associated improvements in health outcomes; and restricted competition in the market due to highly concentrated funders and facilities, disempowered consumers, poorly regulated practitioners and a lack of accountability at many levels [5]. The issues in the private sector were illustrated clearly during the COVID-19 pandemic, as SA private health facilities' profits soared [19, 20], when large numbers of people were unable to access basic, life-saving care in SA.

The recommendations made by the HMI were extensive and detailed [5]. The private sector utilises a fee-for-service system that has been determined globally to be the single most influential driver of costs in health service delivery [21]. The HMI recommended a single comprehensive benefits package combined with a mechanism of equalising the risk between medical schemes. It was advised that this benefits package should be determined through a negotiating forum for all practitioners to set a maximum price for prescribed minimum benefits [21, 22]. Further recommendations included addressing the pricing of services, licensing in provinces, and health services monitoring in the form of a supply-side regulator and economic value assessments.

Most stakeholders, including actors in the private sector, appear to be in support of the HMI recommendations. However, there has been little, if any, move towards implementation since 2019 when the Competition Commission released its report. We must ask why the government and its regulatory agencies, particularly the Council for Medical Schemes, seems not to have made any progress towards implementing the regulatory reforms specified in the recommendations of the HMI. The state, whose objective should be to provide equitable health care to all in an accountable manner, appears unable or unwilling to implement reform that will limit the power and profitability of the private sector. It's tempting to think that vested interests may be involved.

Despite their apparent agreement in press releases [23, 24], or what they may say to support the principles of UHC, private sector resistance is powerful in SA and they are attempting to block health sector reform that does not benefit them. The private sector's overall objective is not to provide health care to those in need. Private hospitals in SA are profit-driven, and although medical schemes are registered as non-profit organisations, many big schemes are listed on the Johannesburg Stock Exchange. Their accountability is not to patients, but to shareholders.

During the pandemic, the government appears to have taken "lessons for implementation" of NHI from its partnership with the private sector. One publication looked at the insights of contracting the private sector for critical care during the pandemic, and highlighted how gaining trust of the private sector is important in achieving public health goals and argues for the development of national-level capacity for public-private engagement [25]. Involvement of the private sector in the pandemic response is closely linked to the development of NHI. The "constructive" cooperation between the public and private sector should be heeded when considering how implementation of NHI might unfold in SA. Implementation of the HMI recommendations should be advocated for, but NHI must completely change the institutional arrangements for both the public and private sectors. The key question is whether mere systems reform can eliminate inequity to provide all with good health care according to need rather than means.

Universal health coverage vs. universal health care

To further understand the private sector's role in NHI, let us unpack how UHC is framed and understood at both the global and national level, and how this framing can be utilised as a vessel for private sector gain. There has been a shift in global policy discourse from universal health *care* to universal health *coverage*.

Universal health *care* approaches have historically been associated with defending the need for strong public health systems as an essential mechanism for (1) decommodifying health services, and (2) em-phasising a preventative health care approach. *Care*, therefore, implies a caring relationship between provider and recipient based on shared human val-ues such as equity and quality of care. *Coverage*, however, is a market-oriented statistical concept concerned with the number of beneficiar-ies covered by medical schemes [26]. This shift from *care* to *coverage* is a shift away from the thinking of health as a universal human right towards health as a marketable commodity [27]. The inverse *care* law operates strongly where health *care* is most exposed to market forces [28].

Universal health *coverage* is only one aspect of uni-versal health *care*. UHC systems such as NHI are de-signed to universalise *coverage* through a common financing pool and regulation of an array of private and public providers rather than providing universal access to *care* [27]. When UHC insurance-based models are implemented, ambiguities in this discourse can be exploited to promote a market-driven model. A combination of pooling of funds and private provision becomes a way for private capital to extract profits in the system [27]. This market-driven discourse of *coverage* contrasts sharply with the vision of *Primary Health Care* in the Alma Ata declaration that envisioned integrated, comprehensive health systems organised to promote equity and driven by community needs [29].

The SA NHI Bill specifically mentions striving for universal health *coverage*, not *care*. The private sector in SA is structurally aligned to maximise profits which supports the inverse *care* law, and does not align with the equity-based vision of health for all. For equity, universal health *coverage* requires cross-subsidisation from the rich to the poor, and

from low-risk to high-risk groups [30]. This can only be achieved through public financing, where the state has a role to raise revenues according to people's ability to pay and allocate pooled resources according to health needs [31]. Currently, the NHI Bill is not clear as to whether taxation financing NHI will be progressive or regressive, so we are unable to determine whether NHI will be equitably based on a system where those with the ability to pay more, do so. Regressive taxation such as VAT, or a flat rate increase in income tax can exacerbate inequality with a deleterious effect on the health of low-income individuals and households.

In addition, continuing corruption and poor management in the public health sector impedes SA's ability to implement a successful and accountable NHI system that moves towards universal health *care*. The argument that the current SA government and health department are unable to successfully implement and manage such a large state-owned fund is valid. Clear accountability mechanisms including active involvement of civil society organisations could mitigate these risks. However, eliminating corruption will not cure the health system entirely. The underlying reason for the poor state of the public sector is severe underfunding after three decades of austerity budgets under the government's neoliberal macroeconomic policy. Nonetheless, we maintain that involvement of the private sector, or a multi-payer system is not the solution. Below we outline how achievement of universal health *care* could be achieved through a People's NHI.

A People's NHI

To overcome the realities of a corrupt public sector, and a private sector motivated by profit, we need to build consensus from below and advocate for universal access to health care from the ground up.

PHM-SA advocates for a People's NHI: one which is equitably financed through a single-payer, pro-public system where meaningful community participation in decision-making is central and health is provided for all on the principles of social solidarity and universality. We believe that health care should be approached not as a commodity, but as a human right.

Financing of NHI needs to be clearly outlined in the Bill or future NHI policy documents prior to its implementation. We support progressive taxation such as an incremental increase in income tax rates, an increase in company tax, or salary exempted financial transaction tax based on the principle of social solidarity, allowing those with greater financial income to support those with a lesser income. The mechanisms of financing of NHI should be decided by a transparent, participatory, and evidence-based process that is insulated from the influence of the private sector. Engagement should take place with all stakeholders (communities, civil society, private sector, research institutions, and others) throughout the policy making process. Participation of vulnerable communities should be actively sought (and will be further discussed in future CHPs). Private sector involvement should be transparent and managed in a way that their powerful and vested interests do not hijack or restrict the process.

Many lessons can be learnt from other countries. For example, a study of 11 countries, both high and low income, that implemented reforms to move towards UHC revealed several commonalities which should be considered when implementing NHI in SA [28]. First, cross-subsidisation is needed which must be done through a publicly-funded system. Secondly, economic growth was not a necessary prediction for starting to move towards UHC. This is important in SA, as given the instability of our current political and economic environment, some critics believe there is not capacity to successfully implement NHI at this time. Instead, current conditions could be viewed as a window of opportunity to implement real change in the system. Finally, the study found that social movements play a catalytic role in putting UHC on the political agenda and the ability to implement meaningful change. This last point is most important to note when advocating for a People's NHI in SA.

Countries such as Brazil, Thailand, and India have all implemented UHC systems which have increased coverage to some extent in their countries [32, 33]. However, all three utilised an insurance-based model of fund pooling coupled with increased private provision of health care which resulted in decreased efficiency and equity in these countries [27]. There is much evidence that private sector involvement in health sectors can be damaging [34-36]. The World Health Organisation highlighted how a "hands-off or laissez-faire approach" to governance has resulted in the growth of unregulated commercialisation of health with resulting inequitable access, impoverishing costs, and erosion of trust in health care that constitutes a threat to social stability [37].

A multi-payer system where multiple private insurance companies exist has been shown to be damaging and costly to a country's health system. The US is the only high-income country (HIC) that does not have a universal health insurance model [10]. A systematic review of economic analyses of introducing a single-payer health financing system in the US found that a single-payer system would reduce health expenditures in the US while providing high-quality insurance to all US citizens [10]. Implementation of a single-payer system in the US would have additional benefits including a reduction in unemployment with workers receiving higher wages, and lower insurance premiums and OOP expenditures [38].

Although SA is vastly different from a HIC such as the US, the underlying principles of universal access remain the same. These can only be achieved through a single-payer, pro-public system. Voluntary insurance schemes designed for the benefit of members tend to benefit an elite group of people at the expense of the rest of the population [39]. We call for a People's NHI – one that is driven by the people and for the people – ultimately providing access to health for all in SA.

Conclusion

To provide universal access to health, focus should not be placed on how best to include the private sector. Instead, we should be asking how best to reform existing public systems to provide health for all. The current public system in SA is characterized by corruption and lack of accountability, and requires massive transformation. These systems need to be reclaimed by citizens and reformed in the interest of the people [27]. There is much to lose if actors with vested interests prevail in implementing an NHI which continues to exacerbate the inequalities we experience today. But at the same time, there is much to gain if we advocate for a system that is socially just and equitable. We must continue to fight for universal access to health for all through a public system that is accountable and inclusive.

REFERENCES

1. Michel J, Tediosi F, Egger M, Barnighausen T, McIntyre D, Tanner M, et al. Universal health coverage financing in South Africa: wishes vs reality. J Glob Health. 2020;4:e2020061.
2. Hart JT. The inverse care law. Lancet. 1971;1(7696):405-412.
3. Section27. Fact sheet: funding the right to health. Johannesberg: Section27; 2019.
4. Africa Check. [Fact Check] Does 1 doctor in SA treat 4,000 patients in public care? 2018. Available from: https://ewn.co.za/2018/08/15/fact-check-does-1-doctor-in-sa-treat-4-000-patients-in-public-care-but-fewer-than-300-privately
5. 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
6. South African Government. National Health Insurance. Available from: https://www.gov.za/about-government/government-programmes/national-health-insurance-0
7. Solanki G, Myburgh N, Wild S, Cornell J, Brijlal V. Summary of views on the proposed health funding model presented to Parliament. 2022. Available from: https://www.dailymaverick.co.za/article/2022-03-23-a-summary-of-views-on-the-proposed-health-funding-model-presented-to-parliament/
8. Petrou P, Samoutis G, Lionis C. Single-payer or a multipayer health system: a systematic literature review. Public Health. 2018;163:141-152.
9. Hussey P, Anderson GF. A comparison of single- and multi-payer health insurance systems and options for reform. Health Policy. 2003;66(3):215-228.
10. Cai C, Runte J, Ostrer I, Berry K, Ponce N, Rodriguez M, et al. Projected costs of single-payer healthcare financing in the United States: A systematic review of economic analyses. PLoS Med. 2020;17(1):e1003013.
11. Liaropoulos L, Goranitis I. Health care financing and the sustainability of health systems. Int J Equity Health. 2015;14:80.

12. Settas M. Covid-19 and the case against a state-run National Health Insurance. 2020. Available from: https://www.dailymaverick.co.za/opinionista/2020-09-13-covid-19-and-the-case-against-a-state-run-national-health-insurance/
13. Settas M. NHI is a politically motivated policy sure to break this camel's back. 2022. Available from: https://irr.org.za/media/nhi-is-a-politically-motivated-policy-sure-to-break-this-camel2019s-back-biznews
14. Loewenson R. Which UHC? Features for Equity and Universalism Comment on "Universal Health Coverage for Non-Communicable Diseases and Health Equity: Lessons From Australian Primary Healthcare". Int J Health Policy Manag. 2022;11(5):704-707.
15. Rodney AM, Hill PS. Achieving equity within universal health coverage: a narrative review of progress and resources for measuring success. Int J Equity Health. 2014;13:72.
16. Bust L. A mixed method media analysis of the representation of the South African National Health Insurance policy in the mainstream media from 2011 to 2019. Cape Town: University of Cape Town; 2021.
17. Health Policy Project. Health financing profile: South Africa. Washington DC: Health Policy Project; 2016.
18. Hassim A, Heywood M, Berger J. The private health care sector. In: editors. Health and democracy. Johannesburg, South Africa: Section27; 2007.
19. Mahlangu A. Netcare issues dividend on jump in full-year profit. 2021. Available from: https://www.businesslive.co.za/bd/companies/healthcare/2021-11-22-netcare-issues-dividend-on-jump-in-full-year-profit/
20. Mukherjee P. Mediclinic's first-half profit more than triples. 2021. Available from: https://www.moneyweb.co.za/news/companies-and-deals/mediclinics-first-half-profit-more-than-triples/
21. Parliamentary Monitoring Group. Healthcare Market Inquiry Report: briefing by Competition Commissioner. 2020. Available from: https://pmg.org.za/committee-meeting/30019/
22. Nkonki L, Bhengu N, Ramokgopa M, Fonn S. The Health Market Inquiry and its potential contribution to improving health systems functioning in South Africa. In: Moeti T, Padarath A, editors. South African Health Review 2019. Durban, South Africa: Health Systems Trust; 2019.
23. Life Healthcare. The Health Market Inquiry. 2018. Available from: https://www.lifehealthcare.co.za/news-and-info-hub/latest-news/the-health-market-inquiry/
24. Discovery. Discovery Health preliminary views on the provisional report of the Health Market Inquiry (HMI). 2018. Available from: https://www.discovery.co.za/corporate/health-hmi-findings-and-recommendations
25. Solanki G, Blecher M, Cornell J, Crisp N, Engelbrecht B, Manning M, et al. COVID-19: Insights from contracting the private sector for critical care. In: Govender K, George G, Padarath A, Moeti T, editors. South African Health Review 2021. Durban: Health Systems Trust; 2021.
26. Reynolds L. Reframing the right to healthcare in terms of insurance cover is a bad idea. 2022. Available from: https://www.dailymaverick.co.za/article/2022-04-05-reframing-the-right-to-healthcare-in-terms-of-insurance-cover-is-a-bad-idea/
27. Sengupta A. Universal health coverage: beyond rhetoric, vol. 20. Canada: Municipal Services Project; 2013.
28. Watt G. The inverse care law revisited: a continuing blot on the record of the National Health Service. Br J Gen Pract. 2018;68(677):562-563.
29. Declaration of Alma-Ata. WHO Chron. 1978;32(11):428-430.
30. Reich MR, Harris J, Ikegami N, Maeda A, Cashin C, Araujo EC, et al. Moving towards universal health coverage: lessons from 11 country studies. Lancet. 2016;387(10020):811-816.
32. Massuda A, Hone T, Leles FAG, de Castro MC, Atun R. The Brazilian health system at crossroads: progress, crisis and resilience. BMJ Glob Health. 2018;3(4):e000829.
33. Sundararaman T. Lessons from Thailand: For universal health coverage, invest in public systems and human resources. 2018. Available from: https://scroll.in/pulse/869170/lessons-from-thailand-for-universal-health-coverage-invest-in-public-systems-and-human-resources
34. Hallo De Wolf A, Toebes B. Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health. Health Hum Rights. 2016;18(2):79-92.
35. Viva Salud. Why public health care is better. Belgium: Viva Salud; 2020.
36. Goodair B, Reeves A. Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013-20: an observational study of NHS privatisation. Lancet Public Health. 2022;7(7):e638-e646.
37. World Health Organisation. World Health Report: Primary Health Care: Now more than ever. Geneva: World Health Organisation; 2008.
38. Nelson J. Economic effects of five illustrative single-payer health care systems. Washington DC: Congressional Budget Office; 2022.
39. 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.

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.