United Nations Research Institute for Social Development

Working Paper 2014-19

The Drivers of Universal Health Care in South Africa

The Role of Ideas, Institutions and Actors

Rebecca Surender

prepared for the UNRISD project on
Towards Universal Social Security in Emerging Economies: Process, Institutions and Actors

December 2014

The United Nations Research Institute for Social Development (UNRISD) is an autonomous research institute within the UN system that undertakes multidisciplinary research and policy analysis on the social dimensions of contemporary development issues. Through our work we aim to ensure that social equity, inclusion and justice are central to development thinking, policy and practice.

UNRISD, Palais des Nations
1211 Geneva 10, Switzerland

Tel: +41 (0)22 9173020
Fax: +41 (0)22 9170650
info@unrisd.org
www.unrisd.org

Contents

Acronyms

BHF	Board of Health Care Funders
CMAS	Council for Medical Schemes
HASA	Hospital Association of South Africa
NHI	National Health Insurance
OHSC	Office for Health Standards Compliance
PHC	Primary Health Care
SA	South African

Summary

To address problems of inadequate public health services, escalating private healthcare costs and widening health inequalities, the South African government has launched a radical new proposal to introduce a universal health system for all South Africans; National Health Insurance (NHI). While most attention has been thus far devoted to the economics and fiscal affordability of universal coverage, relatively less attention has been paid to wider challenges—in particular the important role played by key stakeholders tasked with designing and implementing the reforms.

This paper outlines the opportunities and challenges posed by the proposed NHI reforms in South Africa. It begins by explaining the country's current system of health care provision including its human resource structure, functions and cost implications. It then summarizes the deficits and limitations of the current two-tiered health system and discusses what NHI is trying to achieve within this context and how it hopes to address the problems. Finally, the paper examines the political and institutional challenges the reforms will face with a particular focus on the actors involved.

The findings suggest that the government will face considerable challenges to its proposed reform path and that the eventual design of the new system may have to be a compromised version of the system envisaged in the original Green Paper. In particular the government will face significant challenges in garnering the support of sections of the medical profession tasked with implementing the reforms.

Rebecca Surender is Associate Professor of Social Policy at the Department and a Fellow of Green Templeton College. She is the Director of the Centre for the Analysis of South African Social Policy (CASASP) at Oxford University, the first UK academic centre to undertake research exclusively on South African social policy.

1. Introduction

Access to health care for all South Africans remains a key challenge for the country's policy makers. Debates concerning the optimal reform path have increased in urgency in recent years and led to the proposed introduction of a far-reaching and ambitious reform strategy—a system of National Health Insurance (NHI) (RSA Department of Health 2011). Despite the term "insurance" the reforms aim to achieve a universal tax-funded system: comprehensive, integrated and available to all South Africans irrespective of income tax or insurance contributions. The proposal seeks to make health care a social right of citizenship rather than a market product and is in keeping with the current international drive for universal health care in developing countries (UN 2012; WHO 2005; UNRISD 2010). While there is consensus that universal health care is effective in improving coverage, health outcomes and reducing the prevalence of catastrophic and impoverishing health expenditure for the poor,[1] debate continues about the best mix of financing and service delivery mechanisms. Debates however do not concern only technical issues but reflect conflicts of interest between different stakeholders and are underpinned by ideological and normative disagreements about the appropriate goals of reform.

This paper outlines the opportunities and challenges posed by the proposed NHI reforms in South Africa. It begins by explaining the country's current system of health care provision including its human resource structure, functions and cost implications. The paper then outlines the deficits and limitations of the current two-tiered health system and discusses what NHI is trying to achieve within this context and how it hopes to address the problems. Finally, the paper examines the political and institutional challenges the reforms will face with a particular focus on the actors involved. While most attention has been thus far devoted to the structural requirements and fiscal affordability of universal coverage, relatively less attention has been paid to wider challenges—in particular the important role played by key stakeholders tasked with designing and implementing the reforms.

2. The South African Health System: Past and Present

South Africa is a middle-income country with a GDP of US$ 420 billion (2010 estimate) and a population of 52.98 million people (Stats SA 2013). Its current health system is two-tiered in terms of financial and organizational structure and is highly inequitable in terms of access and quality. In order to understand the challenges facing the present system, it is necessary to place it in historical context.

Racial fragmentation of health care delivery during the apartheid era (1948–1994)

Apartheid, derived from the Afrikaans word for "apartness", signified the political policy under which the races in South Africa were subject to "separate development". It was a system of racial segregation enforced by the National Party governments of South Africa between 1948 and 1994, under which the rights of the majority non-white inhabitants of South Africa were curtailed and white supremacy and Afrikaner minority rule was maintained. For the purpose of implementing these policies, apartheid recognized four races: Bantu (or black African), Coloured (or mixed race), white and Asian (Shung King 2012).

[1] Chopra et al. 2009; Lagomarsino et al. 2012; Moreno-Serra and Smith 2012.

The country was subdivided into mainland South Africa, comprising four provinces, and 10 so-called "bantustans" or homelands ("self-governing" territories), to which large numbers of blacks were moved, according to their tribal origins. After "independent" status was conferred, homelands were constructed as nominally independent, mini-governments under the political domination of the central apartheid state. They were poorly governed by leaders who lacked political legitimacy for most black South Africans. They were chronically under-resourced, compounded by widespread corruption in their governments and lagged behind in all social services as compared to the "mainland" (Shung King 2012).

During apartheid, South Africa comprised an inequitable, racially fragmented system of health care delivery. Separate health departments were established in each of the homelands and became responsible for administering health care provision. Health funding and provision became further fragmented with the 1983 reforms, which restructured the system of institutionalized segregation and permitted Coloureds and Indians, alongside whites, to have their "own affairs" administrations. The administrative fragmentation of health delivery into several racialized departments reinforced inequities of funding allocations and service delivery. Access to public health care was now subject to the vagaries of new poorly organized, geographically isolated and under-resourced, racially-constituted health administrations.

Per capita health expenditure across the country and homelands differed by three- to four-fold between whites and blacks and huge inequities existed in health status and access to facilities between race groups, rural and urban dwellers, and rich and poor. Large hospitals absorbed most of the public health sector budget, despite the majority of health needs requiring primary-level and community-based care. A lucrative and poorly regulated private health sector covering less than 15 per cent of the (mainly white) population accounted for 60 per cent of total health care expenditure. A high prevalence of serious preventable health conditions directly linked to poverty, such as tuberculosis and malnutrition, afflicted the majority black population. The consequences became evident in the racially differentiated health status of the population once democratic rule was introduced in 1994, with black African, Coloured and Indian health outcomes significantly worse than those of whites (May 1998).

Table 1: Health indicators by race (1994)

Health indicator (1994)	African	Coloured	White	Indian
Infant mortality rate (per 1000)	54	36	7	10
Percentage of deaths 5 years and younger	20	19	12	13
Male life expectancy at birth (1990)	60	59	69	64
Female life expectancy at birth (1990)	67	65	76	70

Source: Poverty and Inequality Report (1996)

Health care delivery and outcomes in the democratic era

On coming to power in 1994, the health policy priority for the new democratic government was to build a single national health system, to reduce inequities in health status, service, access and provision, and to increase availability, affordability and the quality of care across the country. Part of health system transformation concerned a change from a curative, hospital-centred system to a primary-care led one and involved the redistribution of resources from tertiary to primary level care, as well as between provinces. It was an unprecedented period of major policy, legislative, structural and budgetary change. Public-sector primary-care services became free and charges in public hospitals, means tested.

Structurally, the country was reunified by incorporating all the designated "homelands" back into South Africa, which was then subdivided into nine provinces. The new South Africa consequently had a single National Department of Health, with nine provincial Departments of Health under its jurisdiction. The nine provinces were further subdivided into local government jurisdictions and health districts, of which there are now 52 (the number of districts per province dependent on their geographical size and population density).

Currently, the national Department of Health is responsible for determining policy norms, and standards and ensuring a functional national health service at all levels of government. It provides services at national level that cannot be provided cost-effectively at lower levels, such as specialized laboratory and diagnostic services, control services for major epidemics and promotion of national campaigns for a healthy lifestyle. Provincial health departments are responsible for service delivery within national policy, norms and guidelines. The major public services provided are specialized and regional hospital health services, medical emergency services, occupational health services and specific targeted programmes such as for tuberculosis. At the local level the health services provided are community hospital health care (non-specialist and non-emergency), health promotion, nutrition services, treatment of diseases and injury, maternity and family planning services, environmental health services, mental health services, elderly and hospice care, dental health services, and preventive and health promotion services for communicable and non-communicable diseases.

However, as will be shown in the next section, these reforms did not quickly overcome the historical legacies of wide disparities of services and provision across the country or improve population health outcomes. Moreover, there continues to be large variation in health outcomes across provinces. Average life expectancy for men between 2001 and 2006 ranged from a low of 44.8 in the Free State to 56.2 in the Western Cape (Stats SA 2008). If we look at service provision, table 2 shows that the distribution of different kinds of public hospitals varies considerably across the nine provinces, with a concentration of district hospitals (which generally provide only primary level care from public GPs and family physicians) in poorer provinces (Eastern Cape, 65; Kwa-Zulu Natal, 39) and a concentration of larger specialist regional and private hospitals in the richest provinces (Western Cape and Gauteng).

Table 2: Number of health facilities (2012)

	Province									
Health Facilities 2012	Western Cape	Eastern Cape	Northern Cape	Free State	Kwa-Zulu Natal	North West	Gauteng	Mpumalanga	Limpopo	Total
District Hospitals	34	65	14	25	39	15	10	22	30	**254**
Provincial Tertiary Hospitals	-	2	-	1	1	1	1	2	2	**10**
Regional Hospitals	5	6	2	5	13	4	12	3	5	**55**
Private Hospitals *(2010)	34	15	3	16	33	14	84	9	8	**216**

*Latest Data Available for Private Sector is 2010

Source: South African Health Review 2012/2013

Most tellingly, table 3 below shows the concentration of public health professionals by province. The greatest number of health professionals are either in the richest provinces, Gauteng (22 per cent) and Cape Town (12 per cent) or in the case of Kwa-Zulu Natal (30 per cent), those that have large metropolitan centres.

Table 3: Health professionals working in the public sector by province (2012)

Public Sector Health Professionals

	Province									
2012 Public Sector	Western Cape	Eastern Cape	Northern Cape	Free State	Kwa-Zulu Natal	North West	Gauteng	Mpumalanga	Limpopo	Total
Medical Practitioners	1468	1477	392	665	3178	613	2920	729	1059	**12 508**
Enrolled Nurses	2332	3229	219	755	10800	746	5675	1634	4344	**29 735**
Medical Specialists	1405	223	19	364	739	96	1782	66	78	**4 776**
Registered Pharmacists	779	368	120	261	600	175	994	200	389	**3 902**
Dental Practitioners	123	116	26	70	113	53	224	104	152	**982**
Provincial Total	**6107**	**5413**	**776**	**2115**	**15430**	**1683**	**11595**	**2733**	**6022**	**51874**
Percentage of National Total	**12%**	**10%**	**1%**	**4%**	**30%**	**3%**	**22%**	**5%**	**12%**	**100%**

Source: *South African Health Review 2012/2013*

Government attempts through the National Health Act of 2013 to regulate both the public and private sectors to improve the quantity and distribution of services faced huge opposition from the profession, in particular from private providers. Among other things, it required anyone wishing to build or extend a medical facility to apply to the Department of Health for a "License" or "Certificate of Need"; eight years later, this is still not implemented.

The structure, financing and utilization of private health care

The private health care sector comprises all providers that exist outside the public sector and includes an array of for-profit organizations, NGOs, faith-based organizations and voluntary non-profit organizations.[2] In the period after 1994, the private sector initially grew rapidly, followed by a period of consolidation and mergers (Dambisya and Mokgoatsane 2012). In 1994 the sector absorbed nearly 60 per cent of annual health expenditure but covered only 13 per cent of the population, mainly through medical insurance (aid) schemes. Though membership is voluntary, in reality it is typically a condition of service for formal sector employees (a form of occupational health). Medical schemes offer variable "packages" of health care services, provided by private general practitioners and hospitals contracted into the medical aid schemes that provide health care services on a fee-for-service basis. The fee structure for hospital treatments used to be determined by the Board of Healthcare Funders (BHF) annually publishing a list of fees, which it recommended to all schemes as a basis for reimbursing private providers. However in 2000, the Competition Commission ruled that such fee scheduling was anti-competitive resulting in the present situation where the 100 or so medical schemes now each have to negotiate with the three large hospital groups.

In 2007, member contributions to medical schemes amounted to almost R65 billion (CMAS 2008a). However, since contributions are partly tax-deductible, the government additionally makes a substantial indirect contribution to membership costs. In 2005 this subsidy amounted to R10 billion in 2006 and rose to R14 billion by 2007 (McIntyre and Ataguba 2012).

Currently approximately 16 per cent of the population are beneficiaries of medical schemes and unsurprisingly since membership is predicated on employment status and/or wealth, membership is concentrated among wealthier households in wealthier provinces. While the poorest quintile of households make up approximately 1 per cent of medical scheme beneficiaries, the richest quintile comprise 51 per cent of all medical aid members.

As shown in Table 4, access to medical schemes is still also racially differentiated. While almost 70 per cent of white South Africans belonged to some medical scheme in

[2] Private hospitals constituted the largest segment of the for-profit sector, which was dominated by just three groups; Medi-Clinic, Life Health Care and Netcare.

2011, this compared to only 41 per cent of the Indian population, 20 per cent of the Coloured and just 9 per cent of the black African population.[3]

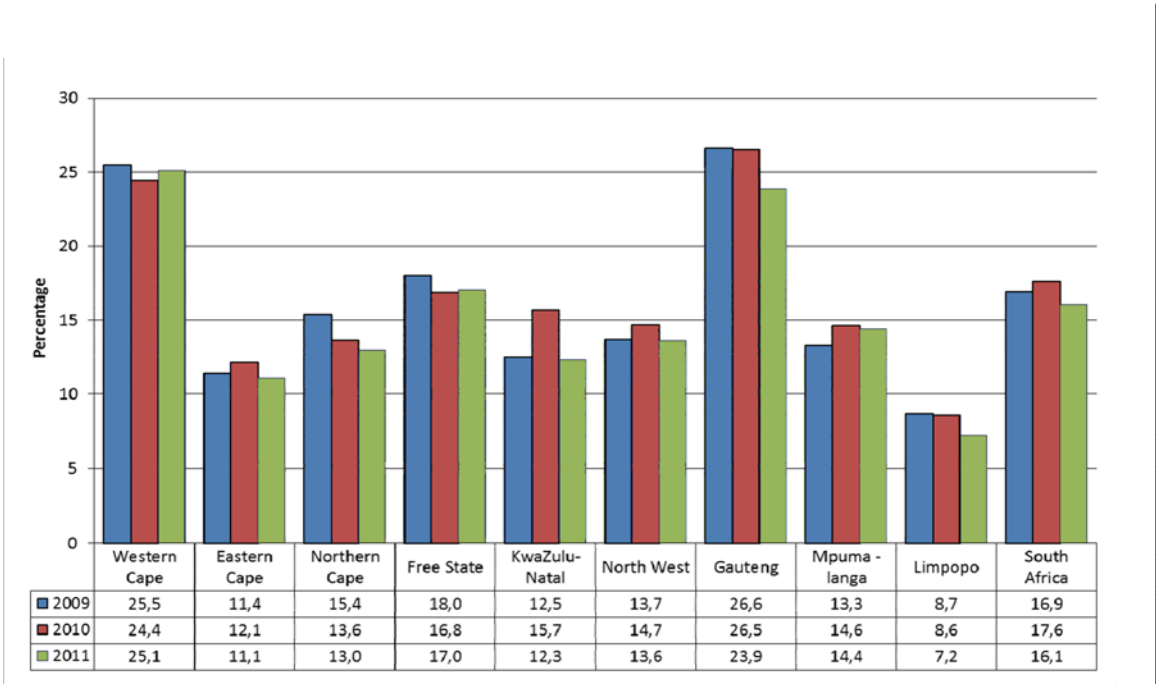
Table 4: Percentage of different racial populations that have medical scheme membership (2011)

Year	White	Indian	Coloured	Black
2011	69.7	41.1	20.3	8.9

Source: General Household Survey (Stats SA 2012)

Finally, as shown in Figure 1, the provinces with the most resources also contain the highest numbers of medical aid members, with both the Western Cape and Gauteng having about 25 per cent coverage. In contrast, the poorer provinces register much lower membership, as evidenced in Limpopo at 7 per cent and the Eastern Cape at 11 per cent. If looked at in terms of the proportion of medical scheme membership, the picture is more stark. While Gauteng has 21 per cent of the total population, it contributes 37 per cent of medical scheme members.

Figure 1: Percentage of members of medical aid schemes by province and nationally 2009–2011



	Western Cape	Eastern Cape	Northern Cape	Free State	KwaZulu-Natal	North West	Gauteng	Mpuma - langa	Limpopo	South Africa
2009	25,5	11,4	15,4	18,0	12,5	13,7	26,6	13,3	8,7	16,9
2010	24,4	12,1	13,6	16,8	15,7	14,7	26,5	14,6	8,6	17,6
2011	25,1	11,1	13,0	17,0	12,3	13,6	23,9	14,4	7,2	16,1

Source: General Household Survey (Stats SA 2012)

3. Challenges of the Current Two-Tiered System

The need to pursue universal health care in South Africa must be understood within the context of the failing and worsening state of the existing health system. The system confronts a significant quadruple "burden of disease" of poverty (perinatal and maternal diseases), non-communicable diseases, HIV/AIDS, and violence and injury (Coovadia et al. 2009) and on key morbidity and mortality indicators its performance is poor for a middle-income economy. SA has 0.7 per cent of world population but 18 per cent of

[3] However a striking feature of the post-1994 system is the rapidly increasing coverage of the black population by medical schemes due to an increase in the black middle class; in 1984 only 15 per cent of scheme beneficiaries were black. By 2010 this had increased to 46 per cent (3.8 million) (Van den Heever 2012).

global HIV infections (20 per cent among 15–49 age group) ―23 times the global average and Tuberculosis infection rates are also among the highest in the world. On several MDG targets such as prevalence of underweight children under 5 years or reduced child, infant and neonatal mortality rates, progress has actually been reversed. Infant mortality rates currently stand at 48 per 1000―much higher than comparable economies. South Africa is one of only 12 countries globally where maternal mortality rates are deteriorating; presently 625 per 100,000 live births compared to the MDG target of 38 per 100,000. Overall life expectancy has actually reduced since 1994 and currently stands at 50 years for men and 54 years for women (Stats SA 2008).

There are many factors that contribute to the absolute and relative poor health status of South Africans and as now widely acknowledged, social determinants (particularly poverty, income inequality, high unemployment and poor living conditions) are an important part of the explanation.[4] However, equally recognized in the government's own policy documents, South Africa's failing health system is also an important explanatory variable―in particular that the system remains highly inequitable (National Planning Commission 2011). Though SA exceeds the WHO recommendation that middle-income countries devote at least 5 per cent of GDP to health (current health expenditure is 8.5 per cent of GDP) the expenditure is inequitably distributed. While still only 16 per cent of the population belong to private insurance (medical) schemes, they consume over 50 per cent of total health care expenditure; the remaining 84 per cent relying on the under-resourced public sector. Put another way, approximately R11,150 per capita is presently spent on private patients compared to R2,776 spent on public patients. Also, in terms of the distribution of human resources, the structure is dominated by private practitioners: 59 per cent of doctors, 93 per cent of dentists, and 89 per cent of pharmacists are in private practice, as well as the majority of traditional healers.[5] While there is approximately one GP for every 540 beneficiaries in the private sector, the ratio is one GP to 4,000 patients in the public system.

Overburdened public health sector

All this means that the quality of care received by the majority of the population dependent on the public sector is vastly inferior to current levels of care in the private sector and the levels of care necessary to achieve good health outcomes overall. Although in theory, primary health care services in the public sector are free and charges in public hospitals are means tested, many barriers to access exist, including availability of facilities (especially in rural areas), distance to facilities and cost of public and emergency transport (Department of Health 2012). Furthermore, in order to apply for exemption from payment at tertiary level, many eligible patients face administrative difficulties proving their income status and exemption policies are unevenly implemented throughout the country (National Planning Commission 2011; RSA 2011). Most importantly, the lack of risk pooling, income cross-subsidization, and government subsidies to medical scheme members means that the public sector is deprived of necessary public funds. Many communities in rural areas still cannot easily obtain care and many in urban areas rely on overcrowded public facilities with too few health professionals and poor equipment. Differences in the quality of service provision in each sector regarding medicines, equipment, waiting times, cleanliness and infection control and numbers and attitudes of health personnel are conspicuous. Of these, lack of routine availability of medicines and lack of qualified clinical and technical staff (Mkokeli et al. 2012; Kahn 2013a) are among the most significant problems.

[4] Harrison 2010; Health Systems Trust 2011; Ruiters and Van Niekerk 2012.
[5] McIntyre 2010; Ruiters and Van Niekerk 2012

Findings from a high level audit from the Eastern Cape Health Director General's Office dramatically illustrate the above points (Health Systems Trust, 2013). It found that:

- most public health facilities in the Eastern Cape would have to be closed down once the proposed accreditation requirements of the NHI reforms became law;
- six health institutions were already condemned but continued operating out of necessity;
- most buildings were not structurally sound enough to provide services, but operated anyway;
- 168 clinics and 17 hospitals lacked piped water;
- 43 health facilities had no proper electricity and operated via generators;
- 16 per cent of facilities had no telephones;
- 68 per cent of hospitals lacked essential medical equipment;
- Tuberculosis wards were poorly ventilated;
- Eastern Cape Department of Health was embroiled in several court cases involving alleged contamination of water sources due to poor sanitation and dysfunctional sewerage systems;
- overall staff vacancy rates stood at 46 per cent, the majority of which were clinical posts.

Private sector health funding crisis

However, it is not only the bad predicament of the public sector and issues of equity that are problematic. The private sector also faces a looming crisis of affordability and sustainability (Dambisya and Mokgoatsane 2012; Doherty and McIntyre 2013). Possibly the greatest challenge facing the private health sector is the rapid rise in expenditure, particularly by medical schemes. Though membership of medical schemes is heavily concentrated among wealthier households, these households are nevertheless facing escalating and debilitating costs. Since the beginning of the 1980s medical scheme contributions have grown far more rapidly than inflation and since the early1990s after controlling for inflation, have doubled in real terms. Average contributions increased from less than R4,500 per person in 1992 to over R9,600 per person in 2008 (in 2008 Rand terms) and stand at approximately R12,000 today (2014). There is no data available on the average income of medical scheme members over time, however, according to Stats SA (Income and Expenditure Survey) in 2006, contributions by members of medical schemes averaged 9 per cent of total household income but varied from less than 6 per cent in respect of high income members to 14 per cent for lower income members (McIntyre and Ataguba 2012). Moreover, although medical schemes cover most of the costs of health care, members are still required to make substantial out-of-pocket payments. In 2007, out-of-pocket payments amounted to more than R20 billion (Ataguba and McIntyre 2009) and more than 60 per cent of these payments were made by members of medical schemes as co-payments where all family dependents or the full cost of a service is not covered or where the scheme benefits have run out.

Drivers of escalating costs in the private sector

The reasons for the increased costs, to a large extent, reveal the intrinsic inefficiencies of all private health care systems. Public and health economics clarify the underlying causes of inflationary pressures contained within all market based health systems[6] and we outline just three key determinants here:

- Firstly, in "NHS" systems such as the UK, the state functions typically as both a monopsony (single purchaser) and single payer and thus has significant power in

[6] Barr 2004; Donaldson et al. 2004; OECD 2003; Kutzin 2001.

negotiating prices with all other stakeholders including health professions (who are usually state employees) and pharmaceutical companies. In contrast, in a fragmented and competitively driven market system, the state has relatively less regulatory or bargaining power to control wages and prices.

- Secondly, the mechanism for reimbursement of private providers in private systems also comprises inherently inflationary pressures and perverse incentives for over treatment, including more diagnostic tests, frequent visits to hospitals and longer hospitalization. The combination of the "third party payer" problem (where consumers do not face the full costs of services, which are borne instead by third party insurance companies) and fee-for-service remuneration (where clinicians earnings are directly related to the type and volume of services they provide) further result in perverse incentives and inevitably higher costs. Both providers and users of health services are thus incentivized to engage in more rather than fewer services.
- Finally, the transaction costs (overhead and administrative costs) of more fragmented (often market based) systems are invariably more expensive than in more centralized national health systems. Increased expenditure relating to billing, auditing and accounting (not including marketing and advertising) and the duplication of these services across the plethora of providers and insurance companies, all add to overall costs.

All these issues are particularly exacerbated in the South African case, where ownership of the private sector is highly concentrated and largely dominated by three large hospital groups and a few pharmaceutical manufacturers (Financial Mail, July 5, 2012). While there are over a hundred different medical schemes, twelve of the largest control the market for health insurance funds and one single company owns several medical scheme administrators. The industry has proved to be a powerful lobbying force which has consistently resisted government regulation of prices and working practices. Some have accused these groups of not engaging in price competition but acting in an oligopolistic fashion and using their market power to charge excessively high prices (Van den Heever 2012; BHF 2010). Evidence of perverse incentives having a distorting effect on clinical practice is also apparent. In 2008, the Council for Medical Schemes (CMAS) highlighted the increase in expensive services in private hospitals such as Caesarean sections, MRI and CT scans and angiograms (CMAS 2008a). A massive increase in expenditure on medicines resulted from the deregulation and expansion of medical practitioners dispensing and selling drugs directly to patients. The resulting effects were that doctors dispensed a greater amount of prescription drugs, and the cost of the medicines dispensed, especially by private GPs, increased from R85 per medical scheme member in 1985 to R233 in 1990 (McIntyre et al. 1995). Finally, administration costs have also increased rapidly in real terms at rates far exceeding inflation (McIntyre and Ataguba, 2012). Whereas administration costs for the UK NHS are estimated to account for approximately 3–5 per cent of total medical spending, in South Africa they are presently 10 per cent in the private sector—excluding the further 9 per cent attributed to managed care activities and broker fees (CMAS 2008b).

The institutional challenges to health care delivery: The problems of weak governance and fiscal controls on provincial health care expenditure

The problem of fiscal differentiation between private and public health care provision is accentuated by the governance arrangements for delivery of health care. The period following 1994 established new governance and fiscal institutions, which via processes of "path dependency" continues to impact negatively on health policy and has arguably been a significant cause of the failure of the current health system. The 1996 Constitution provided that health, social security and welfare were designated as Schedule Four Functions, which meant they were to be concurrent responsibilities of the national and nine new provincial governments. As indicated in section 2, spheres of responsibility were divided between the national government, which established the

policy framework, and nationally uniform norms and standards, and the provincial and local government levels who were responsible for delivery of health programmes.

The separation of policy making from implementation between national and provincial government failed, however, to consider the extent to which poorer provinces with "Bantustan" legacies of weak bureaucratic and fiscal capabilities (such as the provinces of the Eastern Cape and Northern Cape) would be institutionally disadvantaged in their ability to implement the new health policies. The new provinces that inherited the former Bantustans recorded the highest levels of poverty and inequality in the country and unsurprisingly experienced the most severe problems in the post-apartheid era in delivering health services.

The problem of separating policy determination (at national level) from policy implementation (provincial level) was compounded by the introduction of the Intergovernmental Fiscal Relations Act of 1998 which introduced fiscal federalist funding arrangements. The objective of the Act was to establish mechanisms for making provinces more accountable for their expenditure by providing them with greater autonomy over the prioritization and allocation of health and welfare functions at provincial level. However, a major weakness in the restructuring of these new fiscal arrangements was that they did not ring-fence health funds at provincial level. The nine new provinces were in effect allocated a cumulative block grant from the national Department of Finance (now National Treasury) for health, education and welfare services, determined using a formula aimed at achieving inter-provincial equity. Once in receipt of the grant, provinces were entitled to allocate it according to their own provincially determined priorities (albeit, alongside nationally agreed norms and standards). The fact that funds for health spending were not designated or protected made them vulnerable to re-direction to infrastructural or other spending based on the political priorities of the provincial politicians. These problems associated with fiscal federalism, which have their roots in the early years of democracy, continue into the current era and contributed to a health service delivery crisis in weaker provinces.[7]

The problems associated with fiscal federalism and the non-ring-fencing of social expenditure are severely compounded by corruption. The Public Standards and Accountability Monitor—an Eastern Cape-based research agency focused on accountability of public expenditure—estimated that as much as R110 billion remained unaccounted for over a six-year period and only 12 per cent of the Eastern Cape's provincial budget was adequately accounted for between 1997 and 2003. Perceptions of corruption in government are widespread and form a permanent feature of media reports (City Press 2012; Fin24 2013a) and government's own diagnostic reports reveal that state agencies tasked with fighting corruption are of the view that corruption is at a very high level and that "weak accountability mechanisms make corruption at lower levels of government almost pervasive" (National Planning Commission 2011). There is evidence that corruption in infrastructure procurement in particular has led to rising prices and poor quality across health and social services (building a school cost R5million in the late 1990s yet cost R40 million by 2011). Various factors are typically cited as reasons, including weak legislative and municipal oversight, the fragmentation

[7] In a bid to contain "over-spending", the Eastern Cape Provincial Treasury, one of the poorest provinces and with a large population, ordered its Health Department to cut its 2011/12 budget by R205 million and halt the appointment of 400 new doctors (City Press 2012). The termination of appointments of new doctors exacerbates an already dire human resource situation, where the Eastern Cape recorded the second lowest number of doctors (17 per 100,000 people) working in the public sector in 2010 (Health-e *News* 2010).

of institutional arrangements to fight corruption as well as the disintegration of social ethics and values caused by low social mobility and high inequality.

4. The National Health Insurance (NHI) Proposal and Its Plan to Address the Problems of the South African Health System

It is these combined problems of inadequate public health services, inefficient and escalating costs of private care, and extreme and widening health inequalities, that the current NHI proposals seek to address. Initially announced as a key priority by the ANC in its 2009 Election Manifesto, and subsequently confirmed by President Jacob Zuma in his 2010 State of the Nation Address, the NHI proposals were eventually released in the form of a Green Paper for Public Consultation in August 2011 (RSA 2010). The launch of the final White Paper, initially scheduled for late 2012, has been delayed and is at the time of writing, still outstanding.

The broad objective of the NHI is to put into place the necessary funding and service delivery mechanisms to enable the creation of an efficient, equitable and sustainable health care system in South Africa. In order to address the imbalances in access, utilization of services and health care outcomes among the different socioeconomic groups, the NHI proposals intend a fundamental transformation of the system. The new NHI system will be underpinned by an NHI Fund which will provide finance for health care and will enter into contracts with public and private hospital specialists and public and private GP practices to deliver health services free of charge to every South African citizen and legal resident.

The NHI will be based on the following *principles and objectives*:

- universality;
- social solidarity;
- equity;
- efficiency;
- quality and effectiveness;
- integrated single system;
- care free at the point of use;
- comprehensive range of health care services.

Of these, universality and social solidarity are possibly the most pivotal, since they assert that all citizens regardless of their socioeconomic (or any other) status will be able to access the same essential health care services on the basis of need regardless of their financial means. It redefines health care as a public good rather than a market commodity and entitlement as a social right. South Africa would thus join the majority of OECD NHS and Social Insurance health systems which encompass five key income cross-subsidies between population groups: from rich to poor; healthy to sick; young to old; individuals to families and men to women.

Funding the NHI

The new system will be funded through (mainly) general tax sources, a new mandatory employment insurance contribution for higher earners, and the removal of tax subsidies for private insurance. Both employers and employees will contribute to the new NHI Fund. The proposed funding structure is highly progressive and must be understood in the context that it is estimated that approximately only 5.2 million South Africans are

employed in the formal sector and currently pay income tax (that is 19.14 per cent of the working population) and estimated unemployment rates are between 25 and 40 per cent.

According to the 2011 Green Paper it is anticipated that the NHI will require R145 billion additional funding over the next 14 years. The proposed NHI funding model predicts that fiscal resource requirements will increase from R125 billion in 2012 to R214 billion in 2020 and R255 billion in 2025 over a 14-year period (in real value terms as estimated in 2010). These figures must be compared to current spending on health (2010/11 figures) which was R101 billion, increasing to R110 billion in 2012/13 (2010 prices). Spending in the private sector through medical scheme contributions totaled R90 billion in 2009 (2010 prices). A total of over R227 billion was thus spent on health services in South Africa in 2010, equivalent to approximately 8.5 per cent of GDP (RSA 2011). According to a KPMG report (KPMG 2012) which reviewed the NHI financing model, per capita expenditure on healthcare will increase by 14 per cent in real terms under the NHI arrangements.

It is envisaged that the extra funds will be generated through a range of measures including additional windfall taxes and the removal of tax subsidies for those with private insurance. However, as importantly, it is anticipated that the reformed system will benefit from several efficiency savings including lower overall administration costs, greater emphasis on less costly preventive and primary-care services and the benefits of the state's new monopsony powers. As a single payer and purchaser of services, the government will be able to take advantage of economies of scale and a new bargaining position *vis-à-vis* clinical providers. It is envisaged that rates of remuneration to both public and private clinicians will be the same for both groups and are thus predicted to be higher than those currently paid to most public-sector providers but lower than those paid by medical schemes tariffs to private-sector providers.

Organizational structures

A complete reconfiguration of the institutions and organizations involved in the funding, pooling, purchasing and provision of health care is planned. Key features involve the creation of an NHI Fund to collect, pool and distribute funds, a purchaser-provider split and devolved funding and management to district authorities as the new purchasers. It is anticipated that these internal checks and balances will provide the necessary framework to ensure both efficiency and effectiveness. In place of "historic budgets" where public-sector health institutions are allocated fixed budgets based primarily on past expenditure patterns, a process of "active purchasing" is anticipated, where new district purchasing authorities assess population need and construct agreements and contracts with providers in a manner that links payment to performance and ensures appropriate, efficient and quality care for its local population. The NHI Fund will only provide finance to health facilities and providers that meet required quality standards set by the new Office for Health Standards Compliance (OHSC) which reports directly to the Minister of Health.

The gate-keeping role of primary-care clinicians and the referral system will be reinforced and patients will be required to follow referral protocols. In addition to the strengthening of the gate-keeping role of primary-care GPs, there will be a focus on Primary Health Care (PHC) re-engineering more broadly. In order to address the poor health outcomes and high maternal and neonatal death rates outlined above, district clinical specialist support teams will be deployed to work at district level and will include obstetricians, gynecologists, midwives, paediatricians, paediatric nurses,

anaesthetists, as well as family physicians and primary health care nurses. To improve equity in access, teams will be initially targeted in the most underserved areas.

School-based PHC services (also funded as part of NHI) are a further component of the comprehensive range of reorganized PHC services. They will, in most instances, be delivered by a school health team of nurses, dental therapists and health promoters and will be led by a professional nurse. In addition to general preventive services and curative referrals, there will be a focus on child immunization, child sex and substance abuse, nutritional services, family planning services and HIV/AIDs related programmes.

Hospital care

The NHI plan proposes detailed mechanisms for improving the efficiency of the tertiary sector by increasing the managerial autonomy of hospitals. This will entail providing hospital managers with more decision-making powers in budgeting and resource allocation, revenue generation and retention, human resources management, procurement of goods and services and estate management. It will be achieved through a gradual process of enhancing management training and competencies, establishing better remuneration and career paths, and strengthening the role of Hospital Boards.

Management at the district level

The management of primary health care provision (including GPs pharmacists, dentists, optometrists, physiotherapists, psychologists) will be undertaken at the district level in order to avoid the NHI Fund having to purchase individual elements of PHC services from thousands of different providers. Current District Health Management teams will establish the necessary institutional structures that will have independent management authority to purchase and manage PHC services. They will contract with public and private providers within their district in order to ensure a full range of services are available to its residents and will receive support from the Provincial Departments of Health. It is planned that the capacity of District Health Councils throughout the country will be strengthened by improving political governance, oversight and accountability structures as well as managerial capacity.

The concept of District Health Systems was well established by the time the NHI Green paper was launched; first developed as part of the 1997 White Paper reforms and implemented fully with the National Health Act of 2003. The principles underpinning the model of District Health Systems are access to services, local accountability, community participation, and decentralization among others. The model is very much aligned with other international best practice and WHO recommendations that a "District health System is the best vehicle for implementation of PHC… and is the building block of a national health system" (WHO 2005).

Role of private sector

Private health insurance will be allowed to continue, though tax subsidies for premiums will be removed and it is envisaged it will eventually play only a complementary role. The goal is that ultimately the majority of the population, including the middle classes, will come to actively choose to use the new improved tax-funded public system without additional complementary private insurance.

Though we still lack details about the role of private providers within the new NHI structure, the current reality of significant staff shortages and capacity means that there will be a need to include private GPs in the reformed system. Following initial public acrimonious debates between the government and private-sector providers (Mail and

Guardian 2011), the government subsequently "toned down" its statements and acknowledged that private-sector doctors (initially at least) are an essential factor in implementing a successful NHI. The exact organizational or provider payment arrangements are still being determined, but range from the "contracting-in" of private GPs through sessional periods in public facilities, to the "contracting-out" to private health professionals to deliver services in their own facilities. It is also not yet decided whether reimbursement will be based on fee-for-service, or capitation.

There has been extensive media debate surrounding the notion that private sector doctors are rational actors who legitimately seek to maximize their economic wellbeing. Certainly, early research suggests that private GPs have strong views on the reimbursement proposals (Surender et al. Forthcoming) and concerns that the likely tariffs and prices will not reflect "true" costs and compensate fully for medical training, overheads, transport, and insurance. Findings suggest that many take the view that one flat price regardless of the quality of the service flew in the face of market principles and competition; i.e. that the facilities, skill and reputation of a doctor should determine the price they charged and the custom they attracted, not a bureaucratic mechanism. From media coverage, it appears that doctors have quite a sophisticated understanding of the different (at times, perverse) incentives flowing from varied payment mechanisms, many predicting that "gaming" would occur through adverse selection or diluted care. For example, if NHI pays not per patient but by the hour then doctors will be incentivized to work as slowly as possible i.e. see fewer patients per hour since there is no advantage in working faster. Equally, if as seems likely, there will be a flat single rate regardless of the patient's presenting problem, many predict doctors will not be incentivized to take on high cost or high risk patients. (Fin24 2013b; Moosa et al. 2012).

Accreditation of providers

All facilities providing services, whether private or public, will be accredited for NHI using agreed national norms and standards. A National Office of Standards Compliance was established in 2013 under the 2004 National Heath Act in order to undertake the licensing and quality approval. It has three sections: an inspection unit to monitor compliance of hospitals and clinics with national norms and standards; an ombudsman function to deal with user complaints; and a certification unit that will certify every health establishment before it is licensed to practice. An audit of all (3,880) public-sector facilities was completed in 2013 and the next stage of inspection of facilities has begun (Health Systems Trust 2013). Currently there are no formal statements about what will happen if facilities fail to meet standards—instead, significant resources are being put into an extensive communications process and use of recognized quality improvement methods to close identified gaps and shortcomings (Health Systems Trust 2013).

Pilots

Implementation of the NHI will be over a 14 year period starting with pilots in 11 selected districts from April 2012. The pilots will test interventions that are necessary for implementing NHI while also strengthening the functioning of the district health system in order to ensure a smooth roll out of the service when it becomes national (RSA 2011). The pilots will assess the feasibility, acceptability affordability and effectiveness of the proposals including ways of engaging private-sector resources for public purposes. They will assess the costs of introducing the new system and the implications of scaling up the innovation on a national level. They will also monitor and

examine utilization patterns, population health outcomes and the extent to which communities are protected from financial risks.

Selection of the pilots in the most disadvantaged districts involved a combination of factors such as demographics, socioeconomic factors including income levels and social determinants of health, health profiles, health delivery performance and health service management performance (RSA 2012).

Table 5: NHI pilot districts

District (population, 2012)	Province
OR Tambo (1,754,499)	Eastern Cape
Thabo Mofutsanyane (771,610)	Free State
City of Tshwane (2,520,435)	Gauteng
Amajuba (517,279)	KwaZulu-Natal
uMgungundlovu (1,071,606)	KwaZulu-Natal
Umzinyathi (517,806)	KwaZulu-Natal
Vhembe (1,312.197)	Limpopo
Gert Sibande (946,719)	Mpumalanga
Pixley ka Seme (192,572)	Northern Cape
Dr Kenneth Kaunda (905,675)	North West
Eden (567,993)	Western Cape

5. Challenges to Achieving the NHI Plan

Despite the Department of Health's public determination to enact the NHI proposals, it is yet unknown whether the arrangements will be implemented as envisaged. The proposals represent a radical and fundamental overhaul of the current system and it is clear that they face many obstacles and critics—the delayed publication of the White Paper is one conspicuous illustration of the ongoing tensions and uncertainties. While most attention has been devoted to the fiscal requirements and affordability of universal coverage, relatively less attention has been paid to wider aspects—in particular the important issue of ideological and normative disagreements about the goals and nature of the NHI, the significant institutional challenges and perhaps most importantly, the role played by key actors and stakeholders tasked with implementing the reforms.

The battle of ideas

Although receiving strong support from organizations such as the WHO, the idea of a publicly funded and delivered universal health care system is still a contentious one in South Africa—provoking resistance and opposition across political, academic and private sector groups. At the heart of the debate is the question of whether health care is a "public good" rather than a market one and the connected issue of the extent to which the state should assume responsibility for its provision. Related to this are political economy debates about the relative merits of public versus private mechanisms for meeting health and other welfare needs.[8]

Opposition to the reforms from political parties, academic and other analysts as well as the "usual suspects" (private-sector health businesses that arguably have the most to lose) has been intense. Arguments range from traditional public sector critiques (the state will always be less efficient, innovative and consumer oriented than the market) to

[8] Marmor and Wendt 2011; OXFAM 2008, 2009; Watson 2005.

attacks on the specific mismanagement and capacity of the SA system. Opponents have been successful in galvanizing media sources and the national debate and have raised concerns, especially among middle-class tax payers and medical scheme members, about the future viability and sustainability of the health care system.[9]

Though there has been no formal research to date into the views of patients and/or citizens about the proposals (and it is too early to establish service recipients' satisfaction) a national household survey undertaken in 2008 suggests that South Africans want changes in their health system. Respondents were dissatisfied with both the quality of public-sector services and the affordability of medical aid schemes (McIntyre 2010). Letters and commentary by the public in the media more recently, however, tends to emphasize concern rather than support for the proposals—with most anxiety about the quality of services under NHI, access to technology and drugs, lack of choice, unaffordability of NHI and that the funding will excessively burden tax payers.[10]

More formal stakeholder consultations indicate similar concerns (Ruiters and Van Nekerk 2012). Most constituencies of the private health industry (which include individual medical schemes, the Board of Health Care Funders (BHF) a representative Association of medical schemes and the Hospital Association of South Africa (HASA) which represents the private for-profit hospital sector) have been notably cautious in their response—agreeing with the broad objectives of improving and expanding heath care for all—but indicating criticism and opposition to the specific NHI proposals. Moreover, the sector has lobbied openly and privately for medical schemes to play a major role in NHI, potentially acting as the financial intermediaries for NHI (HASA 2010).

Of the main opposition political parties, the Democratic Alliance has articulated outright opposition to the proposals, arguing that they lack credibility and are driven by ideology and party politics. The Independent Democrats (before they were absorbed into the Democratic Alliance in 2010) voiced similar concerns, stating that "Government must avoid sacrificing attention to detail in its rush to overhaul heath care" (SA News 2012). Both parties warned that the middle classes would be the losers of the reforms.

Unsurprisingly, employer groups such as Business Unity South Africa have responded in a similar vein to the private health sector, namely in support of the principal of equitable access to health care, while raising concerns about the specific details of NHI and defending the role of the private health sector. In contrast, employees groups and trade unions such as COSATU have given unequivocal support for NHI, endorsing both its goals and design, as have civil society health related organizations such as the Treatment Action Campaign and social movements such as the People's Health Movement.

More subtle tensions exist about the design and nature of the proposed NHI within Government itself. In particular, the Treasury has a cautious view of the fiscal implications of the NHI and is concerned not to alienate private sector health care providers. It has voiced public criticism of the Green Paper's lack of detailed strategy for reforming public health services and argued that more attention needs to be directed towards drawing in private providers to district level health service provision (The Star,

[9] Archer 2014a and 2014b; Kahn 2014; Malan 2014.
[10] City Press 2012; Business Day 2013a; The Star 2012.

February 24, 2012). These disagreements about the extent to which NHI should utilize private providers in delivering a public service are normative as much as technical in nature. Ongoing discussions between the Treasury and the Department of Health about the potential for the NHI model to include an element of "performance-related pay" both at the PHC and hospital level, and some element of "co-payments" (in order to incentivize "consumers" to reduce unnecessary demand) reflect the ideological debates that are occurring within government on the NHI.

Institutional challenges: Human resources, management and organizational fragmentation

The challenge of producing sufficient health professionals for the NHI is a major one. The nurse to population ratio has decreased from 149 public sector professional nurses per 100,000 population in 1998 to 110 per 100,000 population in 2007. Doctors working in the private sector increased from 40 per cent of total doctors in the 1980s to 79 per cent in 2007, while the vacancy rate for unfilled health posts in the public sector registered at 42.5 per cent in 2012. Despite the aim of the government's Human Resource Strategy (2012) to produce 2,353 medical doctors by 2025, the capacity of the education system to produce new medical doctors is limited. Currently, medical schools produce 1,300 medical doctors annually. Producing an additional 1,053 extra clinical graduates annually will require increasing the enrolment of medical students from 8,589 to 15,549 nationally per year.

Management capacity has also been identified as a key priority for human resource development. A strong system of health management and leadership will be needed to run the district health authorities and meet the new demands of a restructured primary health care system and a system of referrals to secondary and tertiary services. However, the Department of Health recently revealed a number of failures in management including repeated reports of catastrophic management of hospitals; over-expenditure at all institutional levels in the health sector; understaffing; lack of implementation of the planned restructured PHC model; demotivated professionals and support workers and lack of retention of staff and an inability to fill vacant posts (RSA Department of Health 2012).

The relationship between national and provincial government in the implementation of the NHI also poses challenges for the implementation of NHI. As indicated in section 3, the separation of national level policy making from provincial level implementation, accompanied by federalist budgeting arrangements means that the central government has little leverage to ensure national policy priorities are uniformly implemented at provincial level.

The key institutional challenge, however, given the inequalities between provinces is the creation of a nationally uniform high quality service, so that patients can expect the same quality of care irrespective of their geographical location. It would seem that many provinces do not possess the capability to spend even their current health budgets, a pre-requisite for the implementation of a universal system of provision. The scale of under-spending in 2012 was: the Eastern Cape underspent on its public health budget by 52 per cent (R191 million), the Free State by 35 per cent (R134 million), Limpopo by 27 per cent (R89 million) and the Northern Cape by 37 per cent (R158 million) (McIntyre 2012). Though, in this context, the drive to take over control of failing provincial health services becomes understandable, it is unclear how the national government will manage the additional responsibilities of provincial health care services.

The role of actors

Given that the NHI reforms are quite different to past incremental reorganizations and will have far-reaching implications for the private health sector, it is unsurprising that early indications are that many SA private health agencies—including hospitals, insurance companies and clinicians—are opposed to the measures which many view as a threat to their commercial and professional interests.[11] Instead, the private sector has advocated that the government should most effectively deal with the problems of health care by focusing on improvements to the public sector while allowing the private sector to address escalating costs and other fiscal pressures itself (SAPPF 2011). It asserts that the SA health care system is already a universal system through the combination of a tax-funded system and the subsidized private health care insurance system (medical aid schemes) (Van den Heever 2011) and is not in need of radical reorganization. Historically, this sector has been a powerful stakeholder in shaping health care policy and is likely to be a strong lobbying force in terms of shaping the outcome of the NHI proposals. For its part, though the Ministry of Health is exploring a greater role for private medical doctors in implementing the proposed new health care arrangements, it has remained determined to reduce the costs of the private medical care industry. It has come out in vociferous support for a government Competition Commission inquiry which is examining the reasons for the spiralling costs of private medical care (SA News 2012). There are signs of a standoff, as major private-sector health care companies prepare to take the government to court on the proposed new health care arrangements.

Historical and comparative analysis reveals that whenever health systems undergo radical reform, the role of providers, especially the medical profession, is without exception, crucial in determining its eventual success and character.[12] Findings from early research (Surender and Walker 2013) suggest that the SA government will face significant challenges in garnering the support in particular of private GPs (who form the largest clinical constituency within private sector primary care) and it is unclear whether they will comply with the proposals. Main concerns revolve around remuneration, resistance to local state control, increased workload, clinical autonomy, and concern about "blame" for diminished quality of care. However, despite strong concerns from the majority of private practitioners, the study highlighted that opinions were not unanimous and there were differences in emphasis. Most public-sector GPs, particularly those working in hospital settings, were largely welcoming of the reforms, believing they would lessen their workload by increasing capacity in the private sector. Additionally, some private practitioners, particularly smaller practices in less affluent areas also welcomed the potential increased work prospects and better security of remuneration that the new arrangements afforded. It was apparent that not all practitioners faced the same sets of conditions and consequently there was variation of opinion and experiences among them.

Nevertheless, most media coverage suggests that the main response from the private sector is one of scepticism, opposition and anticipation that NHI will entail less remuneration but increased workload for private GPs (Loggerenberg 2013; Fokazi 2013). Despite public statements about strengthening primary-care services and the referral system, most of those surveyed believe it will mean less empowerment for primary-care providers and morale is reportedly low. The most fervent response

[11] HASA 2010; BHF 2010; Discovery Health 2010; Kahn 2013b.
[12] Rodwin 2011; Le Grand 2003; Light 2000; Ugalde 1979.

concerns resistance to local state control and there appears to be little confidence in its ability to implement or manage the new system (Kahn 2013a and 2013b).

However, in terms of who "is winning the battle", it is interesting to note that there are as yet few signs of real mobilization or agency by private clinicians in the policy process. It is interesting to observe that in terms of influencing the policy process, the SA profession appears mostly to be "reactive" rather than proactive, to the extent it is mostly trying to block reform rather than initiate it. There are mixed views about the main professional body, the South African Medical Association (SAMA) in part reflecting the specific Apartheid history and transitions after 1994. Though some clinicians remain critical, it seemed that a number who had left the organization after 1994 are in the process of re-joining, encouraged by SAMAs recent oppositional stance on NHI.

One explanation for the relatively muted response is that is it just too early in the process (and scepticism about the feasibility of the initiative). Equally, it may be that due to historical legacies, the exceptionally fragmented nature of the profession undermines its power as an actor in the policy arena. However, in either scenario, government would be foolish to ignore the professions' discontent. There are certainly recent examples of the SA medical profession using its power to block reform and assert its own interests, including stalling government attempts to issue a "Licence or Certificate of Need" (2004) and the recent victory for the profession in the courts in the 2001 "dispensing row" (Pretorius et al. 2012). Given the necessary reliance on the private sector to contribute to healthcare services in the immediate term, policy makers will need to identify strategies to incentivize them to achieve desired outcomes.

6 Conclusion: The Limits, Challenges and Possibilities of Universalizing South African Health Care

The NHI proposals set out a far-reaching path of reform for SA health care based on principles of social solidarity and universality. It is a hugely ambitious project that seeks to address the inadequacies and inequities of the country's historic and present health care system and improve its quality. However, almost three years on from the initial launch of the Green Paper in August 2011, there has been relatively slow progress towards the realization of the goals and a conspicuous delay in the launch of the White Paper.

As section 5 suggests, there has been significant contestation occurring behind the scenes about the planned reforms between the Department of Health and the private health care sector and between different sections of government. While it is too early to predict "success" or "failure" of the plan, there are indications that the government will face considerable challenges to its proposed reform path and that the eventual design of the new system may be a compromised version of the system envisaged in the Green Paper. This paper has sought to highlight some of these challenges, in particular the role of ideological and normative conflicts surrounding the goals of the reforms; the institutional context, and the role of actors tasked with implementing and delivering the new system.

Goals and objectives: The ideological underpinnings of the reform

Since there is little consensus among key stakeholders about the nature or definition of the problem, it is unsurprising that there is lack of agreement about the appropriate goals or mechanisms for reforming the system. While the government has pointed to the unrestrained commercialism and disproportionate power of the private sector as a major

contributor to the current system's problems, others point to government failure to run social programmes as the fundamental problem (i.e. corruption, bloated bureaucracies and lack of managerial and technical capacity). For these critics, rather than "build a new system on poor foundations" (Amado et al. 2012), what is needed is for the existing public system to be overhauled and better administered. Equally, while the architects of the proposals have emphasized a discourse of social rights and distributive justice and sought to justify NHI in terms of ethical considerations, other sectors of government, in particular the Treasury, have taken a more "instrumental" approach, emphasizing the efficiency and developmental benefits of a healthier workforce. This divergence in problem definition and aspiration has to some extent become translated into disagreements in the strategies and mechanisms that should be used—in particular the extent the private sector should be both accommodated and relied upon in the new NHI system.

Though the Department of Health appears to be seeking greater accommodation with the private sector, a political stalemate nevertheless seems to be looming on the reform of private health care. It is revealing that there has not yet been a major statement by the central government in support of the Department of Health and Minister Motsoaledi in their pursuit of reducing private health care costs. Instead, the central government has focused on the pragmatic task of improving the public health care system in the 11 NHI pilot sites and the capacity to deliver the new public health care system under the NHI. It may well be that the limits have been reached on the central government's willingness to aggressively challenge the private sector, which is mainly utilized by the middle-class, and likely to be a pivotal site of electoral contest in the imminent 2014 elections.[13]

The SA case demonstrates that the determination of individual policy champions and pioneers (in this case the Minister of Health) to achieve universal health care reforms is not sufficient. Rather, achieving consensus with key stakeholders and crucially, the support of the wider central government are essential if the momentum for far-reaching health reforms is to be maintained.

Recent SA experience also highlights the need for policy reform to be evidence based and "problem solving" rather than politically driven. In this vein, there is much to be gained from comparative analysis and learning from the experiences of other countries. While a lot of attention has been paid in South Africa to archetypical NHS systems such as in the UK, it may be more constructive for South Africa to examine the approaches of other more similar middle-income countries who have recently implemented universal health care systems, such as Ghana, Tanzania and Thailand.

Institutional challenges

The institutional challenges for reforming the SA health care system are formidable and the existing evidence suggests that the country has limited capacity to establish a genuinely comprehensive universal system of health care. The public health care system is on the brink of collapse in provinces with ex-Bantustan legacies such as the Eastern Cape. These provinces will require a massive investment of infrastructural resources to upgrade and expand health facilities and information and communication technology systems. Perhaps more challengingly, they will need to undertake a systematic overhaul

[13] This article was written before the 2014 elections in which the ANC party was re-elected with a significant majority. In the end, the NHI reform did not feature prominently in the election debates. However, the fact that Aaron Motsoaledi was reappointed as Health Minister can be interpreted as continued government support for the existing direction of policy reform.

of their health management systems and recruitment of additional health personnel. While the historic weaknesses of the "ex-Bantustan" areas are an important explanation for their current difficulties, it is equally true that the problems outlined are not unique to these provinces only. Government reports show that the challenges identified here, of inadequate human resources, infrastructure, stewardship and management are also felt across the wider health system. Mass exodus of doctors overseas and to the private sector has contributed to a vacancy rate of between 42 per cent and 56 per cent among public-sector positions and has placed the system under considerable strain (Bateman, 2012).

Recent government concern about failure of provinces to implement policy has resulted in attempts to assert greater control from the centre. A resolution was passed at the ANC Mangaung Elective Conference in 2011 that 10 major hospitals, mainly teaching hospitals, should come under the control of the national Ministry of Health due to service failure deliveries. Controversially, this included not only institutions in traditionally weak provinces such as the Eastern Cape but also those in better resourced and managed provinces such at Gauteng and the Western Cape. This has led to accusations that attempts to impose national government control is politically driven rather than evidence based (Mkokeli et al. 2012; Business Day 2012) and has further complicated the institutional challenges of health care delivery. Recent tensions have also surfaced over the government's decision to make the procurement of medicines a national function following weak regulatory compliance and corruption in the award of tenders at provincial level and recommendations of a USAID funded report issued in 2010 on medicines procurement reform (RSA Department of Health 2010).

Deficits in institutional capacity also extend to insufficient clinical human resources, especially the number of doctors and nurses. Again the evidence suggests that South Africa's education system is unable to produce the number of health personnel required. The government's attempts to redress the shortage of health personnel by increasing the intake of training institutions and utilizing training facilities in Cuba to quickly "grow" the capacity are essential and must also be accompanied by efforts to stem the drain of the existing pool of professionals to the private sector or overseas (Health Systems Trust 2013).

Implementing NHI amidst the limitations of the present system will indeed be challenging and the government is correct to focus the first phase of implementation on strengthening the institutional capacity of the public sector. Efforts to strengthen management capacity by providing leadership and management training and courses for hospital chief executives and their managers are to be welcomed. In particular, the Ministry of Health launched an Academy for Leadership and Management in Health Care in 2012 to address the deficit of public-sector management skills and expertise. The aim is to develop a national management and leadership competence framework for the sector based on a needs analysis and ensure competency requirements are implemented for appointments to leadership and management positions (RSA 2012). A recent study of health workers' employment decisions (George 2013) suggests that the re-skilling of human resources is not the only aspect that will need to be addressed. The study revealed that the public sector reported the poorest working conditions in the health care service, as indicated by study participants' self-reports on stress, workloads, levels of remuneration, standard of work premises, level of human resources and frequency of in-service training. The study recommended that non-financial incentive packages to recruit, retain and maintain health professionals should be embedded in workforce planning to prevent the attrition of health professions in the public sector.

The challenge to educate, recruit and retain a health professional workforce that can implement the new arrangements under the NHI is a major one and evidence suggests that this will take a considerable period to establish. However, though the government has been strategic in investing in key pilot districts to develop the human resource and infrastructural capacity, the record of implementation of the pilots has not been promising, with a third of the 13 districts failing to spend their allocated grants by July 2013, a year after the grants were awarded. Only 2 per cent of health facilities in OR Tambo District in the Eastern Cape had the necessary equipment, medicines and space to allow private GPs to work in them (Business Day 2013b). Most tellingly, only 96 private sector doctors signed contracts to work in NHI pilot clinics between March 2013 and March 2014, well short of the target of 600 set for the year (Kahn 2014). Moreover, the majority of those participating were in Gauteng Province (one of the richest and best capacitated provinces) with the lowest participation rate in the Eastern Cape site where this study was conducted (Cook 2013). On this record, the NHI will take a much longer period to establish in many areas than the time line envisaged by government.

Finally, the problem of policy determination (at national level) being separated from policy implementation (provincial level) combined with fiscal federalist budgeting arrangements will continue to pose significant institutional challenges to rolling out the proposed reforms. It highlights the problem of how to implement a universal health care reform agenda when the central state is constitutionally unable to enforce compliance with its policy mandate at the regional level. The ability to achieve universal provision across the country, with patients receiving similar levels of care irrespective of their geographical location, is complex in this context.

The importance of actors in the delivery of health reform

While current government efforts to boost management capacity and administrative leadership for local authorities and clinical institutions are important, it will be essential for the government to also address the concerns of front line clinicians if it is to ensure successful implementation—not least because the performance of the new system will depend on their support and motivation. Evidence from other developing country attempts to introduce universal health care shows that despite radical reform efforts, many systems largely remain two-tier, and demonstrates that without a motivated medical workforce, efforts to change the system will be ineffective or even counterproductive (World Bank 2013).

Given the likely reliance on the private sector to meet healthcare needs at least in the immediate term, SA policy makers will need to identify strategies to meaningfully engage and incentivize them to achieve the desired outcomes. Given the entrenched and deep-rooted market culture which presently exists, a key challenge will be to achieve a shift in culture and norms, in particular to instil a more cooperative model of care with patient-centred values. Public and ongoing media "spats" indicate that the government has not yet been able to convince private medical doctors (in particular GPs) that the NHI scheme is viable, or indeed in some cases, desirable.[14] Since doctors working in private practice constitute nearly 70 per cent of the total number of GPs working in South Africa, these GPs will need to be convinced of the new proposals if the NHI scheme is to be implemented.

[14] Archer 2014a and 2014b; Kahn 2014; Malan 2014.

References

Amado, L., Christofides, N., Pieters, R. and Rusch, J. (2012) 'National health Insurance: A lofty ideal in need of cautious implementation' *SAJBL*, June 2012, 5(1).

Archer, C. (2014a) *NHI: Let's talk about this revolution*. http://mg.co.za/article/2014-02-06-lets-talk-about-this-revolution. Accessed 7 February 2014.

Archer, C. (2014b). *Right of reply: Motsoaledi makes fools of us*. http://mg.co.za/article/2014-02-13-right-of-reply-motsoaledi-makes-fools-of-us. Accessed on 14 February 2014.

Ataguba, J. and McIntyre, D. (2009) 'Financing and Benefit Incidence in the South African Health System', HEU Working paper 09/1, University of Cape Town.

Barr, N. (2004) *The Economics of the Welfare State*, Fourth Edition. Oxford: OUP.

Bateman, C. (2012) 'Will our public health care sector fail the NHI?' *SAMJ*, 102(11).

BHF (Board of Health Care Funders) (2010) in S. Padarath (ed) *South African Health Review* (2010) Durban: Health Systems Trust.

Business Day (2013a) 'NHI affordability depends on rate of future growth'. 28 February 2013.

Business Day (2013b) 'Health Insurance Plan, price regulation soon, says minister'. 16 May 2013.

Business Day (2012) 'ANC plan to grab control of top state hospitals'. 28 December 2012.

Chopra, M., Lawn J., Sanders D., Barron P., Abdool Karim S., Bradshaw D., Jewkes R., Abdool Karim Q., Flisher A., Mayosi B., Tollman S., Churchyard G., Coovadia H. (2009) 'Achieving the Health Millennium Development Goals for South Africa: Challenges and priorities', *The Lancet*, 374(9694):1023–1031.

City Press (2012) 'SA healthcare quality declining—Motsoaledi'. 7 September 2012 http://www.citypress.co.za/news/sa-healthcare-quality-declining-motsoaledi-20120907/ Accessed 3 December 2012.

CMAS (Council for Medical Schemes) (2008a) *Annual Report 2007–8*. Pretoria: CMAS.

CMAS (2008b) *Evaluation of Medical Schemes' Cost Increases: Findings and Recommendations.* Pretoria: CMAS.

Cook, R. (2013) 'GPs contracting with the NDoH: the practice and the promise'. Presentation to the Child Health Priorities Conference, 1 November 2013.

Coovadia, H,. Jewkes, R., Barron, P., Sanders, D. and McIntyre, D. (2009) 'The health and health system of South Africa: Historical roots of 80 current public health challenges'. *The Lancet*, 374: 817–34.

Dambisya, Y. and Mokgoatsane, S. (2012) 'The growth of the private health sector in South Africa up to 2007' in Ruiters, G., and Van Niekerk, R., (eds) *Universal Health Care in Southern Africa*. Scottsville: University of Kwa-Zulu Natal Press.

Discovery Health (2010) in S. Padarath (ed.) *South African Health Review* (2010) Durban: Heath Systems Trust.

Doherty, J. and McIntyre, D. (2013) 'Addressing the failings of public health systems: should the private sector be an instrument of choice? ' in Surender, R. and Walker, R. (eds) *Social Policy in a Developing World*. Cheltenham: Elgar.

Donaldson, C. et al. (2004) *Economics of Health Care Financing*. Basingstoke: Palgrave.

Financial Mail (2012) 'Seeking A Remedy', *Financial Mail*, July 5–10, 2013.

Fin 24 (2013a) 'Wrong timing for NHI, warns Sama'. www.fin24.com/Economy/Wrong-timing-for-NHI-warns-Sama-20130208. Accessed 10 November 2014.

Fin24 (2013b) 'Medical profession still wary over NIH'. www.fin24.com/Budget/Medical-profession-still-wary-over-NHI-20130226. Accessed 10 November 2014.

Fokazi, S. (2013) 'Doctors have doubts on NHI', *IOL News*. http://www.iol.co.za/news/politics-1.1415976. Accessed 9 November 2013.

George, G. (2013) 'Understanding the factors influencing health-worker employment decisions in South Africa', *Human Resources for Health*, 2013, 11:15.

Harrison, D. (2010) *An overview of health and health care in South Africa 1994–2010: Priorities, progress and prospects for new gains.*

HASA (Hospital Association of South Africa) (2010) in S. Padarath (ed) *South African Health Review* (2010). Durban: Heath Systems Trust.

Health-e News (2010) 'Eastern Cape: Health system reform debated', 24 May 2010. http://www.health-e.org.za/news/article.php?uid=20032799. Accessed 13 June 2012.

Health Systems Trust (2011) *South African Health Review*. Durban: Health Systems Trust.

Health Systems Trust (2013) *National Health Facility Audit: Baseline Audit*. Durban: Health Systems Trust.

Kahn, T. (2013a) 'Province health vacancies for doctors, nurses, shocking'. www.bdlive.co.za/national /health/2013/01/17. Accessed 25 January 2013.

Kahn, T. (2013b) 'Doubts in Soweto over NHI'. www.bdlive.co.za/national/health/2013/03/06/. Accessed 14 June 2013.

Kahn, T. (2014) 'Doctors too greedy for NHI says Motsoaledi' http://www.bdlive.co.za/national/health/2014/03/06/. Accessed 18 October 2013.

KPMG (2012) '"Funding NHI: A Spoonful of Sugar" An economic analysis of NHI', kpmg.co.za.

Kutzin, J. (2001) 'A Descriptive Framework for Country-Level Analysis of Health Care Financing Arrangements', *Health Policy*, 56:171–204.

Lagomarsino G, Garabrant A, Adyas A, Muga R, Otoo N. 2012. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. The Lancet 380: 100933–43.

Le Grand, J. (2003) *Motivation, Agency and Public Policy: Of Knights and Knaves, Pawns and Queens*. Oxford: OUP.

Light, D. (2000) 'The medical profession and organisational change: from professional dominance to countervailing power' in Bird, C. (ed) *Handbook of Medical Sociology*, New Jersey: Prentice Hall.

Loggerenberg, D. (2013) 'NHI: economic suicide for doctors?', *News 24*. http://www.health24.com. Accessed 5 July 2013.

Marmor, T. and Wendt, C. (2011) *Reforming Health Systems*. Cheltenham: E. Elgar.

Mail and Guardian (2011) 'Motsoaledi Speaks Of Brutal Private Health System'. 09 November 2011.

Malan, M. (2014) *Motsoaledi frenzy over NHI*. http://mg.co.za/article/2014-02-21-00-motsoaledi-frenzy-over-nhi. Accessed 21 February 2014.

May, J. (ed) (1998) *Poverty and Inequality in South Africa*. Report prepared for the Office of the Executive Deputy President and the Inter-Ministerial Committee for Poverty and Inequality. Durban: Praxis Publishing.

McIntyre, D., Bloom, J., Doherty, J. and Brijhal, P. (1995) *Health Expenditure and finance in South Africa*. Durban: Health Systems Trust.

McIntyre, D. (2012) 'What health care changes are needed to reach universal coverage in South Africa?', *South African Medical Journal* 102(11): 817–818.

McIntyre, D. (2010) 'National Health Insurance: Providing a vocabulary for public engagement' in Fonn S. Padarath, A. (eds) *South African Health Review*, 145–156, Durban: Health Systems Trust.

McIntyre, D. and Ataguba, J.E. (2012) 'Modelling the affordability and distributional implications of future health care financing options in South Africa'. *Health Policy and Planning*, 27(1):101–12.

Minister of Health. 2012. 'National Health Insurance: Presentation on NHI Pilot Districts Selection'. www.doh.gov.za/docs/presentations/2012/nhipilot.pdf. Accessed 5 January 2014.

Mkokeli, S. (2012) 'ANC plan to grab control of top state hospitals', www.bdlive.co.za/national /health/2012/12/28. Accessed 25 January 2013.

Moosa, S. Luiz, J. and Carmichaela, T. (2012) 'Introducing a national health insurance system in South Africa: A general practitioners' bottom up approach to costing'. *SAMJ*, 102(10)794–794.

Moreno-Serra, R. and Smith, P.C. (2012) 'Does progress towards universal health coverage improve population health?' *Lancet*, 380 (9845):917–23.

National Planning Commission (2011) *Diagnostic Report, June 2011*. Pretoria: Department of the Presidency.

OECD (2003) *A Disease-based Comparison of Health Systems: What is best and at what cost*? Paris: OECD.

OXFAM (2009) *Blind Optimism: challenging the myths about private health care in poor countries*. www.oxfam.org.uk/resources/policy/health/bp125. Accessed June 2012.

Pretorius, J.C., South, M.S. and Care, N.R. (2012) 'BHF 'upset but undeterred' by Appeal Court ruling', *South African Medical Journal*, 102(11), 819–820.

RSA (Republic of South Africa) (2010) *State of the Nation Address*, by His Excellency JG Zuma, President of the Republic of South Africa, at the Joint Sitting of Parliament, Cape Town, 2010. http://www.info.gov.za/speeches/2010/10021119051001.htm. Accessed 13 August 2012.

RSA (2012) *Health Minister launches health academy*, 1 Nov 2012. http://www.info.gov.za/speech/DynamicAction?pageid=461&sid=31946&tid=89265. Accessed 19 April 2013.

RSA Department of Health (2012) *Human Resources for Health South Africa, HRH Strategy for the Health Sector: 2012/13—2016/17*. Pretoria: Department of Health.

Republic of South Africa (RSA), Department of Health (DoH) (2011) *National Health Insurance: Healthcare for all South Africans* (Green Paper). www.doh.gov.za. Accessed 13 March 2013.

RSA Department of Health (2010) *Medicines Procurement Reform in the Public Sector: Challenges and Opportunities for Improvement of Medicines Procurement in South Africa's Public Sector—March 2010.* Pretoria: Department of Health http://www.imsa.org.za/download/policy&reportsgeneralhealth/deptofhealth/Medicines. Accessed 9 November 2012.

Rodwin, M. A. (2011) *Conflicts of Interests and the Future of Medicine*. Oxford: OUP.

Ruiters, G. and Van Niekerk, R. (2012) *Universal Health Care in Southern Africa*. Scottsville: University of Kwa-Zulu Natal Press.

SAPPF (South African Private Practitioners Forum) (2011) *National Health Insurance in South Africa: Submissions on the Green Paper on National Health Insurance*

2011. http://www.mm3admin.co.za/documents/docmanager/1E9AEA2C-B58D-4AED-B5A2-96187D705AEE/00021475.pdf. Accessed 18 February 2012.

SA News (2012) *Motsoaledi Spells Out Non-Negotiables for NHI. South Africa News.* http://www.sanews.gov.za/south-africa/motsoaledi-spells-out-non-negotiables-nhi. Accessed 6 May 2013.

Shung King, M. (2012) *Why child health policies in post-apartheid South Africa have not performed as intended: The case of the School Health Policy*, Doctoral Thesis, University of Oxford.

South African Medical Association (2011) *National Health Insurance in South Africa: Submissions on the Green Paper on National Health Insurance 2011*. http://www.mm3admin.co.za/documents/docmanager/1E9AEA2C-B58D-4AED-B5A2-96187D705AEE/00021475.pdf. Accessed 18 Feb. 2012.

The Star (2012) 'SA health 'low value for money'', 24 February 2012. http://www.iol.co.za/the-star/sa-health-low-value-for-money 1.1241748?ot=inmsa.ArticlePrintPageLayout.ot. Accessed 9 January 2014.

Stats SA (Statistics South Africa) (2008) *Income and Expenditure Survey 2005/6*. Pretoria: Stats SA.

Stats SA (2012) *General Household Survey*. Pretoria: Stats SA. http://www.statssa.gov.za/publications/P0318/P0318April2012.pdf. Accessed 5 January 2014.

Stats SA (2013) *Mid-Year Population Estimates*. Pretoria: Stats SA. http://www.statssa.gov.za/publications/P0302/P03022013.pdf. Accessed 7 January 2014.

Surender, R. and Walker, R. (eds) (2013) *Social Policy in a Developing World*. Cheltenham: Elgar.

Surender, R., Van Niekerk, R., Hannah, B., Allan, L. and Shung King, M. (Forthcoming) 'The Drive for Universal Healthcare in South Africa: Views from private General Practitioners', *Health Policy and Planning*.

Ugalde, A. (1979). 'The role of the medical profession in public health policy making: the case of Colombia', *Social Science and Medicine. Part C: Medical Economics*, 13(2), 109–119.

UN (United Nations) (2012) 'The Future We Want'. http://un.org/doc/N1243688.pdf. Accessed 13 March 2014.

UNRISD (United Nations Research Institute for Social Development) (2010) *Combating Poverty and Inequality: Structural Change, Social Policy and Politics*. Geneva: UNRISD.

Van den Heever, A. (2011*) Evaluation of the Green Paper on National Health Insurance.* Johannesburg: Helen Suzman Foundation. http://hsf.org.za/siteworkspace/gp-review-alexvdh-dec2011-vf-1.pdf. Accessed 4 September 2012.

Van den Heever, A. (2012) 'The role of insurance in the achievement of universal coverage within a developing country context: South Africa as a case study'. *BMC Public Health* 2012, 12(Suppl. 1): S5. http://www.biomedcentral.com/1471-2458/12/S1/S5. Accessed 4 September 2012.

Watson, J. and Ovseiko, P. (2005) *Health Care Systems*. London: Routledge.

World Bank (2013) *UNICO Studies Series 25, The Impact of Universal Coverage*

Schemes in the Developing World: A Review of the Existing Evidence. The World Bank,

Washington DC, January 2013.

WHO (World Health Organization) (2005) *Sustainable Health Financing, Universal Coverage and Social Health Insurance*. World Health Assembly Resolution 58.33, Geneva.