National Health Insurance in South Africa: Implications for Equity

Undergraduate Honors Thesis
Sanford School of Public Policy
Duke University
Durham, NC

Kelsey Fraser
Professor Donald Taylor
Professor Judith Kelly
December 2011
Abstract

This project examines the African National Congress’ most recent proposal for national health insurance in South Africa. By analyzing its ability to build upon the successes and avoid the pitfalls of past policies, this project evaluates the current proposal’s potential to increase equity in access to health care services. Analysis of the current proposal reveals learning from previous policies, and despite its failure to address certain pitfalls, this policy is likely to increase equity in South Africa if implemented as described in the ANC’s September 2010 discussion document. However, implementation as planned is unlikely given the brevity of the timeline, insufficient data to inform policy formulation, and the lack of a concrete policy. In order to redress inequity in its health system, the South African government should continue to pursue a national health insurance plan based on the principles of universal coverage, social solidarity, and the right to healthcare, but must slow the implementation process to allow for sufficient data collection, capacity building, and the development of fully-informed, concrete policies.
Table of Contents

List of Acronyms ...................................................................................................................... 3
1. Introduction .......................................................................................................................... 4
2. Background .......................................................................................................................... 4
3. Relevant Legislation and Past Attempts at National Health Insurance ......................... 6
4. Theoretical Framework ....................................................................................................... 8
5. Defining Equity .................................................................................................................. 9
6. Methodology ...................................................................................................................... 10
7. Post-1994 Health Policies Addressing Inequity .............................................................. 10
   7.1 Successes ...................................................................................................................... 11
   7.2 Pitfalls .......................................................................................................................... 12
8. The Current Proposal for NHI .......................................................................................... 14
   8.1 Brief Outline ................................................................................................................ 14
   8.2 Addressing Successes of Past Policies ....................................................................... 14
   8.3 Addressing Pitfalls of Past Policies ............................................................................ 16
9. Conclusions ...................................................................................................................... 21

Appendices ............................................................................................................................ 23
   Appendix A: Case Study 1—Introduction of Free Primary Health Care ......................... 23
   Appendix B: Case Study 2—Clinic Upgrading and Building Programme ....................... 26

Works Cited ............................................................................................................................ 28
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CUBP</td>
<td>Clinic Upgrading and Building Program</td>
</tr>
<tr>
<td>DoH</td>
<td>(South Africa) Department of Health</td>
</tr>
<tr>
<td>EDL</td>
<td>Essential Drugs List</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>ENA</td>
<td>Enrolled Nurse Auxiliary</td>
</tr>
<tr>
<td>FHC</td>
<td>Free (Primary) Health Care</td>
</tr>
<tr>
<td>MSA</td>
<td>Medical Schemes Act</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Act</td>
</tr>
<tr>
<td>NHI</td>
<td>National Health Insurance</td>
</tr>
<tr>
<td>OSC</td>
<td>Office of Standards and Compliance</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PMBs</td>
<td>Prescribed Minimum Benefits</td>
</tr>
<tr>
<td>SARS</td>
<td>South African Revenue Service</td>
</tr>
<tr>
<td>STGs</td>
<td>Standard Treatment Guidelines</td>
</tr>
</tbody>
</table>
1. Introduction

The South African government under the leadership of the African National Congress (ANC) has recently proposed massive healthcare reform in the shape of a National Health Insurance (NHI) scheme. The proposed NHI has the potential to greatly impact equity in South Africa by improving access to healthcare services for a large portion of the population. This project seeks to assess the NHI’s potential impact on health equity by analyzing the proposal’s ability to avoid pitfalls and build on successes of past proposals. The paper will begin with a description of the current state of the South African healthcare system and the need for reform in Section 2. Section 3 outlines relevant legislation and briefly describes past attempts at a national health insurance scheme in South Africa. Sections 4 and 5 discuss the theoretical framework and definition of equity used in this paper. Section 6 describes the methodology used to evaluate the current NHI proposal. Section 7 outlines lessons learned from case studies of four past policies, and Section 8 examines how the current proposal addresses these lessons. Finally, Section 9 draws conclusions about the NHI’s potential to increase equity in the South African healthcare system.

2. Background

South Africa is the continent’s largest economy and is home to one of the world’s biggest wealth gaps, ranking third in the CIA’s Gini coefficient comparisons (Central Intelligence Agency 2011). While its formal sector is competitive in world markets and its cities are flourishing metropolises, 74.3% of South Africa’s 49 million citizens reported no income in 2008 and shantytowns lacking basic amenities like electricity and running water fill the shadows of its skyscrapers (McLeod 2010A).

Nowhere is inequity more evident than in the health sector. Though every citizen is entitled to healthcare by Section 27 of the South African Bill of Rights, the realities of the healthcare system reflect inequities that both mirror and contribute to larger societal disparities. Many of these inequities have roots in the legacy of apartheid. Segregationist policies, particularly those that forced the relocation of Blacks to designated homelands, created disparities in determinants of health including poverty, access to sanitation and water, and education. Under apartheid rule, the health system was separated into fourteen discrete health departments divided by race, geographic location, and public or private funding. As the current health system was constructed on the skeleton of the apartheid system, this fragmentation remains, as do disparities in quality of care between racial groups and geographic areas. Present-day inequities largely follow the lines of apartheid divisions (Chapman and Rubenstein 1998). The resultant state of the health system prevents sufficient realization of the twenty-seventh right amongst the vast majority of the country’s population.

The South African population provides a less than ideal setting for an equitable provision of healthcare services. An enormous wealth gap results in a tax base that consists of only 9% of the population (McLeod 2010A). In 2008, approximately 16% of the population belonged to private medical schemes, enabling them to access the high-quality private sector facilities. The remaining 84% of the population is either entirely reliant on South Africa’s sub-par public sector or chooses to pay out-of-pocket for access to the private sector, though even those paying out-of-pocket usually revert to the public sector for care above the primary level (McLeod 2010A). To
compound these divisions, the population is plagued by a massive disease burden. South Africa has the globe’s largest number of HIV-positive citizens, along with epidemics of tuberculosis (TB) and other communicable diseases and a rising prevalence of non-communicable diseases.

A deep division between the public and private sectors afflicts the health system itself. The private sector, concentrated largely in urban areas dominated by Whites during apartheid, offers services on par with those found in the wealthiest nations. Access to this quality of care is limited to those who can afford to pay for it, namely medical scheme members or those willing to pay out-of-pocket. Increases in medical schemes costs on the magnitude of 7% annually over the past decade and contributions that exceed 10% of income for over 40% of members threaten to reduce the already small number of South Africans who can afford private sector care (McIntyre 2010B). A government tax subsidy for contributors to medical schemes offers some relief but benefits the highest-income earners over the lower-income earners it was designed to help. Private care costs have increased due to a shift in private expenditure that has directed funds more towards specialist and hospital care and away from primary care and general practitioners. A fee-for-service reimbursement scheme has drawn additional criticism for incentivizing excessive tests and procedures, while imbalances between medical schemes and a lack of competition between private hospital owners have been cited as detrimental to the effectiveness of the private sector (ANC National General Council 2010).

The misalignment of resources between the public and private sectors is the subject of perhaps the most common criticisms of South Africa’s healthcare system. A 2005/6 review estimates that doctors in the private sector each serve a population of 588 citizens while those in the public sector serve 4,193. The concentration of specialists in the private sector leaves the few in the public sector to serve a population 10,811 each in comparison to an estimated 470. Nurses, upon whom the doctor-deficient public sector is extremely reliant, face a ratio of 616 to one versus 102 to one in the private sector. The greatest misalignment of resources is seen amongst pharmacists, who each serve 1,852 people in the private sector compared to 22,879 in the public sector. While an excess of hospital beds is often found in the private sector with a population of 194 to each bed, the public sector often faces shortages with 399 people per bed (ANC General Council 2010).

Skews in funding for the private and public sectors are particularly dramatic. Public spending accounts for approximately half of total healthcare spending, which is currently about 8% of South Africa’s GDP. While this suggests equal funding for the public and private sectors—actual numbers are approximately R97 billion and R104 billion, respectively—the number of people served by each sector reveals a massive misalignment of resources (McIntyre 2010B). As previously mentioned, the private sector serves less than one-fifth of the South African population with the remaining people reliant on the public sector, resulting in a significantly lower per capita public expenditure than private. This inequity is recognized by Ataguba and McIntyre’s 2009 paper, as quoted in the ANC’s NHI discussion document:

There is a lack of cross-subsidies in the overall health system in South Africa. Although healthcare financing is ‘progressive,’” this is largely due to the richest groups bearing the burden of medical scheme funding; however, the richest groups are the exclusive beneficiaries of these funds. It is indisputable that benefit incidence in South Africa is inequitable; benefits from healthcare are not distributed according to the need for healthcare (ANC General Council 2010, pp. 16).
The mention of “progressive” funding is a reference to the collection of the revenue from which public healthcare spending is drawn. The South African Revenue Service (SARS) collects money via income taxes to which only the wealthiest tenth of the population contributes, implying a progressive structure in which contribution is determined by ability to pay. However, these taxpayers are the same population that purchases private medical schemes and utilizes the superior private health facilities. As a result, the wealthiest portion of South Africa’s population enjoys the vast majority of healthcare benefits despite having a lower burden of disease than its poorer counterpart (ANC General Council 2010).

Inadequate funding in the public sector is compounded by severe human resource shortages, which arise from low retention rates, high rates of emigration of educated health professionals—commonly referred to as the “brain drain”—and limited training facilities. Such problems have resulted in vacancies in funded positions and an unequal distribution of highly trained health professionals between urban and rural areas, as well as between provinces (ANC General Council 2010). Facilities of the public sector are generally insufficient (in both number and quality), lacking necessary equipment and medications, and dependent upon failing or nonexistent infrastructure. Available resources are used inefficiently due to poor management, corruption, and wasteful practices, as well as an inadequate referral system that overemphasizes specialist care when primary would suffice and contains barriers between different levels of care (ANC General Council 2010; SHEILD 2010B). Communication between the provincial and national departments of health is insufficient and, coupled with inconsistent compliance with the National Health Act, prevents fulfillment of the government’s legal obligations (SHIELD 2010B). The Congress of South African Trade Unions (COSATU) accurately expresses the heart of dissatisfaction with the government’s inability to uphold its commitments:

South African citizens have a constitution and laws which give better guarantees of social justice, human rights and equality than almost anywhere in the world. Yet in practice millions are denied these rights, especially socio-economic rights, in what has become the most unequal nation in the world (COSATU 2010).

Since the ANC’s ascendance in 1994, several policies have sought to further realization of right to healthcare and to redress apartheid’s residual inequities. While some progress has been seen, attempts as a whole have fallen far short of achieving an equitable health system.¹

3. Relevant Legislation and Past Attempts at National Health Insurance

The provision of access to healthcare is not merely a moral imperative in South Africa, but a legal one as well. Section 27 of the South African Constitution guarantees all citizens the right to access to healthcare, realized progressively within the government’s capability (Constitution of the Republic of South Africa 1996).

Even before the adoption of the Constitution, the ANC recognized the importance of providing access to health care. In its 1994 National Health Plan for South Africa, formulated with the support of the World Health Organization and the United Nations Children’s Fund, the ANC outlined a plan to transform the health system in order to “redress social and economic injustices” with the particular focus of “redressing the harmful effects of apartheid health care

¹ Background adapted from Fraser 2010.
services” (African National Congress 1994, pp. 1). The plan emphasized a focus on primary health care, community participation, efficient management practices, and accountability. In this plan, the government was to be the central coordinator for health services and investigation of a possible National Health Insurance plan was recommended. Concern for vertical equity was also present in this document, as it called for giving priority to the most vulnerable groups in the allocation of resources. The authors of this report also recognized the need to address problems with management and human resource issues, as well as the need to implement a comprehensive health information system to facilitate monitoring (African National Congress 1994). While this document offered guidelines, it was not a concrete policy and many of its recommendations were never implemented. However, it has served as the guiding document for South Africa’s health system since the establishment of democracy and many of its suggestions are central to the current proposal for National Health Insurance.

Three years after the publication of the ANC’s National Health Plan, the South African Department of Health released its influential White Paper for the Transformation of the Health System in South Africa. Like the National Health Plan, the White Paper contained recommendations for a health system based on a primary health care approach. The White Paper went beyond the National Health Plan by providing a remarkably thorough plan for the South African system, including implementation strategies and details of how many of the National Health Plan’s suggestions could be realized. Goals of the White Paper were similar: increase equity by expanding access to health care services. The White Paper differed from the National Health Plan in its call to decentralize management of healthcare services through a District Health System. Reprioritization of the budget to better allocate resources (with a vertical equity approach), ensuring the availability of essential drugs, and the development of a National Health Information System were highlighted as major initiatives. A significant addition to the National Health Plan’s recommendations was the call for integration of the public and private sectors, as well as the cooperation of government and private actors with NGOs to bring about the highest quality health system possible (SA Department of Health 1997). Like the National Health Plan, the 1997 White Paper was a guiding document and its recommendations were not implemented as a policy would have been. However, the Paper reveals insightful recognition of many problems that continue to plague the South African health system and provides concrete recommendations to address many of these issues.

Most recently, the National Health Act (No. 61 of 2003) provided a framework for a structured uniform health system that recognized “socio-economic injustices, imbalances, and inequities of health services of the past” to meet the State’s obligations under Section 27 of the Constitution (Republic of South Africa 2003, Preamble). The Act placed responsibility for protection and promotion of the population’s health on the Minister of Health (Republic of South Africa 2003, Chp. 1 Sec. 3). Specific duties and rights of health departments and South African citizens are delineated in this Act, including the right to emergency treatment and the structure of the District Health System. The act specifically calls for interaction between the public and private sectors by stipulating that the Minister “must prescribe mechanisms to enable a coordinated relationship between private and public health establishments in the delivery of health services” (Republic of South Africa 2003, Chp. 6 Sec. 45). This Act remains the primary document governing the South African healthcare system upon which the new proposal for NHI will be based.
Based on these guiding policies, there have been five significant attempts to establish national health insurance: (1) the Health Care Finance Committee plan of 1994, (2) the 1995 Committee of Inquiry, (3) the DoH Social Health Insurance Working Group in 1997, (4) the Taylor Committee of Inquiry into Comprehensive Social Security in 2002, and (5) the Ministerial Task Team for Implementing Social Health Insurance in 2002. These plans proposed public insurance, used forms of community rating and risk equalization, required contributions from people above a certain income threshold, and provided coverage for set benefit packages. All of these plans centered on multi-tier health systems and were forms of social health insurance; that is, only those who contributed to the health insurance system were offered coverage. While some suggested an eventual move towards universal coverage, it was not until the 2007 ANC Conference at Polokwane that focus shifted to plans for universal coverage from the outset, promoted through income and risk cross-subsidies (McLeod 2010B). The current proposal is the first significant attempt to establish a universal coverage system.

4. Theoretical Framework

The inequity of the South African health system is well established. While the private sector is widely considered a first-class system, the public sector on which the majority of the population depends is crippled by the world’s largest HIV/AIDS epidemic, staffing shortages, and a lack of resources (SHIELD 2010B; McLeod 2010). Disconnect between the sectors has resulted in an inefficient distribution of resources and a need for cross-subsidization (Paulus 2010; McIntyre 2006). Many scholars assert that inequities present in the current system stem from the racial divisions of the apartheid regime, specifically from the fragmented and racialized health system that existed until 1994 (Bateman 2009; McIntyre et al. 2006). These disparities exist between racial groups, income groups, and geographic locations (McIntyre and Gilson 2000).

Since the installment of the current political system in 1994, health equity has been a focus of policy discussions, in part because the health sector is often seen as a vehicle to rapid gains in equity across society as a whole (McIntyre et al. 2006; McIntyre and Gilson 2002). Government’s commitment to redress inequities stems from its desire to right many of the wrongs of apartheid and is evidenced by policy decisions like the removal of fees for primary care, the formalization of an essential drugs list, and the prioritization of population health needs over ability to pay in policies like the National Health Act of 2003 (McIntyre and Gilson 2002; McIntyre et al. 2006). Yet government policy has consistently fallen short. Policies like the National Health Act have provided little guidance for interaction between the private and public sectors, proposals for types of social health insurance have not been implemented, and the commercialization of the South Africa health system has posed difficult challenges for reform (McIntyre et al. 2006).

Government polices attempting to address inequities have been plagued by a variety of ills. Concerns about the private sector and distrust of its motives have led government to focus almost exclusively on improvement of the public sector instead of interaction between the two (McIntyre et al. 2006). Resistance to regulation from the private sector and disagreements amongst policymakers about financing and the role of the private sector have resulted in general weakness toward the private sector (McIntyre et al. 2006). Little has been done to reduce government subsidies to the private sector and past proposals have not done enough to encourage
cross-subsidization between the private and public sectors (McIntyre and Gilson 2000, 2002; McIntyre et al. 2006).

The introduction of a proposal for national health insurance presents an opportunity for South African policymakers to improve upon mistakes of the past and fulfill their commitment to redressing the inequities left over by apartheid. Scholarship on the NHI’s potential to improve equity within the South African health system is limited due to the proposal’s recent introduction, but preliminary works suggest the policy’s potential to reduce mortality and DALYs, thus improving general societal equity (Frogner 2010).

Scholarship on potential improvements in equity in South African health policy as a whole is extensive, however. Analyses of past policies have made several recommendations that can be applied to the NHI. McIntyre and Gilson argue for the promotion of vertical equity, taking into consideration the different starting points of groups and not simply treating all citizens the same (McIntyre and Gilson 2000). The conflict between the private and public sectors must be resolved through regulation of the private sector and encouragement of interaction between the two, particularly in the form of subsidization of the public sector by the private sector (McIntyre et al. 2006; McIntyre and Gilson 2000). In addition to subsidization between the two sectors, income cross-subsidization is crucial, as is risk equalization (McIntyre et al. 2006; McIntyre and Gilson 2000; McLeod 2010A). Improved management of the health sector is paramount, with preference given to disadvantaged areas (McIntyre and Gilson 2000; Bodibe 2010). An open process in which many stakeholders are consulted should be adopted in order to develop appropriate measures to redress inequities. In particular, the process should involve the disadvantaged and should have a goal of defining legitimate and illegitimate inequalities (McIntyre and Gilson 2000; McIntyre 2010; Paulus 2010; Ncayiyana 2009). A focus on primary health care is important, as is the galvanization of civil society and the redistribution of government resources with preference given to historically disadvantaged provinces and populations (McIntyre and Gilson 2000; Paulus 2000; Frogner 2010). The current proposal for NHI takes into account many of these recommendations, but could be further amended to reflect scholarly suggestions.

5. Defining Equity

This paper considers equity specifically in the context of access to health care, bearing in mind that access to health care has ramifications most directly for health status and by extension for many facets of life, including economic productivity and quality of existence. An equitable health system is defined in this paper as one in which those who require health care have the ability to access necessary services. Care should be accessible not only in name but in practice, without restrictions due to financial, geographic, social, or other barriers. The definition of necessary services should begin at a basic level (i.e. those which are necessary for survival) but should be expanded as resources and capacity increase.

A distinction is drawn here between “inequity” and “inequality.” Both are measurable differences between two parties, but while inequities are unjust and unnecessary, inequalities are not necessarily so (Braveman and Gruskin 2003). Inequalities may take the form of inherent differences between groups, such as differing health status amongst the elderly and the young, and may be neither avoidable nor unfair. However, inequalities can transform into inequities when access to things to which citizens have a legal or moral right becomes conditional on other
characteristics like ethnicity, political standing, or gender (Walzer 1983). The eradication of such inequities should be a societal goal.

6. Methodology

This paper aims to evaluate the potential of the current proposal for a national health insurance scheme to address and reduce inequity within South African society. The study relies almost exclusively on qualitative data. Data sources include government documents; analysis of the current and past health policies conducted by academics, health professionals, think tanks, government-sponsored assessors, and others; media outlets including Health-E News, the South African Mail and Guardian, and other sources obtained through the internet and through the libraries of Duke University and the University of KwaZulu-Natal. Additional data was drawn from interviews conducted with experts on health policy and South Africa in America, as well as with South African academics and health professionals with whom the author had contact while studying in South Africa.

Evaluations of the current proposal are based upon comparison to South African health policies implemented in the period following the end of the apartheid regime. Four policies with goals to increase equity were identified as having significantly impacted the South African healthcare system. These policies are:

1. The introduction of free primary health care for pregnant women and children under six in 1994 and the extension of free PHC to all South Africans citizens in 1996
2. The Clinic Upgrading and Building Programme of 1994

Each of these policies was evaluated as an individual case study. Common trends in successes and failure of these policies were identified and are outlined in Section 7 (see Appendices for example case studies of FHC and CUBP).

Findings from these case studies were then applied to the current proposal for National Health Insurance. The NHI’s ability to address each failure and build upon each success was assessed individually. Conclusions about the ways in which the current proposal succeeds in doing so were used to evaluate the potential of the NHI to improve equity in the South African healthcare system. These conclusions were supplemented by input from South African academics and healthcare professionals—via interviews and published works—and placed in the context of the current South African healthcare climate to draw final conclusions about the NHI’s likely impact on equity.

7. Post-1994 Health Policies Addressing Inequity

After the ANC accession to power in 1994, the South African government took several steps to address inequities in health care. This paper examined four policies that had a significant effect on equity in South Africa. These policies were (1) the introduction of free primary health
care for pregnant women and children under six in 1994 and the extension of free PHC to all South Africans citizens in 1996; (2) the Clinic Upgrading and Building Programme of 1994, which sought to improve existing clinics and construct new facilities where necessary; (3) South African national drug policy, specifically the Essential Drugs List and Standard Treatment Guidelines, first introduced for PHC in 1996 and for hospital care in 1998, which set a minimum standard for medications and care of common ailments; and (4) the Medical Schemes Act of 1998, which shifted the basis of risk-rating from the individual to the community, prohibited discrimination based on age, medical history or health status, and introduced the Prescribed Minimum Benefits.

Case studies of these policies revealed commonalities in their successes and failures.

7.1 Successes

1. Focus on primary health care

By emphasizing primary health care in its plan to improve South Africans’ health status, the ANC was able to extend access to health care services at relatively low costs while preferentially allocating resources to those with the greatest need (McCoy 1996; SA Department of Health 2000; Smith et al. 1999; McIntyre and Gilson 2002). The removal of user fees for primary health care, accompanied by the improvement and construction of primary care clinics, led to an increase in visits to PHC facilities, particularly—and predictably—amongst those seeking antenatal care and pediatric outpatient services (McCoy 1996; SA Department of Health 2000). The simultaneous development of an Essential Drugs List and Standard Treatment Guidelines for PHC improved the quality of care available by mandating the supply of certain medications and providing instruction for the treatment of common conditions (Gray and Suleman 1999; World Health Organization 1999; Barron 1998).

2. Removal of barriers to health care

Through the removal of user fees for primary health care and the construction of new clinics, particularly in the poorest districts and those with the least access to healthcare facilities, the introduction of FHC and the CUBP made significant process in reducing financial and geographical barriers to health care access (SA Department of Health 2000; McIntyre and Gilson 2002; Smith et al. 1999; Government of SA 1999). The regulation of drug prices and the promotion of generic medications by national drug policy further improved access to essential medical care through the removal of economic barriers to medications (SA Department of Health 1996; Gray and Suleman 1999).

Despite this progress, significant barriers to healthcare access remain. Geographical barriers (i.e. distance to travel) linger in many communities, particularly in rural areas, and limited operating hours prevent many South Africans from accessing care (Smith et al. 1999; Zuma 1996; Harris et al. 2011).

3. Establishment of minimum standard

The Medical Schemes Act’s definition of Prescribed Minimum Benefits set the baseline standard for the provision of services in South Africa and provided the clearest and most comprehensive outline of treatments deemed essential (Pieterse 2010; Khosa 2000). Similarly, the Essential Drugs List and Standard Treatment Guidelines provided a minimum standard for
essential medications and common treatments (SA Department of Health 1996; World Health Organization 1999; Gray and Suleman 1999). Together these policies defined a base level of care guaranteed to all South Africans.

4. Regulation of private sector

The Medical Schemes Act (MSA) of 1999 stands out as the first successful attempt at regulation of the private sector. Through the introduction of a compulsory minimum benefits package; the prohibition of discrimination based on age, medical history or health status; the requirement that contributions be determined only on the basis of income and number of dependents; and the replacement of individual risk rating practices with community risk rating, the MSA increased equity of access to medical scheme membership and provided mechanisms for cross-subsidization between the elderly and young and low- and high-income earners (Khosa 2000; Council on Medical Schemes 2000; Soderlund and Hensl 2003; Pieterse 2010). The regulation of the distribution of medications through South African national drug policy provided additional protection against the potential for inequitable distribution of essential medications (SA Department of Health 1996).

7.2 Pitfalls

In addition to these successes, the following were identified as areas in which past policies have failed or fallen short. While many of these are aspects or direct results of the four policies, several are realities of the South African healthcare system that these policies revealed as major issues.

1. Human resource problems

The South African healthcare system lacks an adequate supply of trained and able health professionals, including administrators and personnel with sufficient management capabilities. The implementation of these four policies brought the human resource crisis to light as all depended at least in part on the adequacy of healthcare workers. An insufficient number of healthcare staff prevented the opening of several new clinics constructed through the CUBP (McIntyre and Gilson 2002). In clinics that maintained enough staff members to operate, crowded facilities, long wait times, and decreased consultation times were common as deficient numbers of staff were not equipped to handle the increases in visits caused by FHC (McIntyre and Gilson 2002; Wilkinson et al. 2002; Smith et al. 1999). Staffing shortages also extended to the pharmaceutical industry where a lack of pharmacists and the inequitable distribution of existing pharmaceutical personnel hindered the successful implementation of national drug policies (Gray and Suleman 1999; World Health Organization 1999). Even in areas with adequate numbers of personnel, the equity-increasing impacts of the PMBs, EDL, and STGs were restrained by doctors and nurses lacking the training required to utilize these lists and guidelines (Khosa 2000; Barron 1998; Zuma 1996).

2. Quality of care and facilities

Human resource problems are accompanied by outdated and insufficient facilities and poor quality of care. When present, health care workers are often described as overworked and having low morale, leading to poor treatment of patients (Leatt et al. 2006; McIntyre and Gilson 2002; Wilkinson et al. 2001; Smith et al. 1999). Dissatisfaction with the quality of care in public
facilities has led many to spend money out-of-pocket for private sector services (Leatt et al. 2006).

Public sector facilities are also ill equipped to deal with many health problems and to support the successful implementation of these policies. The limited availability of certain public sector services has caused concerns about the efficient implementation of PMBs (Khosa 2000). A lack of infrastructure has prevented the storage, safeguarding, and distribution of medications on the EDL and has resulted in frequent drug shortages that prevent realization of the list’s equity-improving effects (Gray and Suleman 2000).

3. Problems with implementation, consultation, and monitoring

Problems with several of these policies have been attributed to a lack of planning and rushed implementation. Insufficient planning has been blamed for congestion in primary care facilities following the implementation of FHC (McIntyre and Gilson 2002; Wilkinson et al. 2001; McCoy 1996). The simultaneous implementation of the first wave of free primary care, the CUBP, the Essential Drugs List, and the Standard Treatment Guidelines made the successful implementation of all four nearly impossible and overwhelmed the health sector by imposing several policies without allowing the system sufficient time to prepare for the accompanying changes (Gray and Suleman 1999). The rushed implementation of these policies also prevented the extensive consultation with stakeholders needed to produce policies that would best suit the needs of South Africans. Scholars have called for more widespread consultation in order to increase buy-in, as well as greater transparency in policy development (Gray and Suleman 1999).

In some areas, policies simply have not been implemented. Significant numbers of patients still pay user fees for primary care services, which undermines FHC’s equity objectives and reveals the discretionary power of the providers and bureaucrats who ultimately determine the realization of policies (Harris et al. 2011). Trouble reaching consensus about the placement of clinics, a lengthy tender process, and cash flow problems that caused delays in the distribution of funds slowed the implementation of the CUBP. These problems prevented the policy from meeting several of its early targets and seriously undermined equity objectives as areas with the smallest resource endowments were hit hardest by these delays (Harrison 2009; McIntyre and Gilson 2002; Government of SA 1999). A unclear plan for implementation of the EDL that left major decisions up to the provinces resulted in its slow and patchy execution, particularly in hospitals (Gray and Suleman 1999; World Health Organization 1999). A rocky and opaque legislative process also hindered the implementation of the EDL and STGs (Gray and Suleman 1999).

The need for monitoring of implemented policies has also been identified by scholars evaluating these four (World Health Organization 1999). This is particularly important for the Essential Drugs List, Standard Treatment Guidelines, and Prescribed Minimum Benefits, which must be regularly reviewed in order to remain relevant and appropriate. The Medical Schemes Act has been fairly successful in creating mechanisms for monitoring the PMBs, of which biannual review is mandated, and for receiving feedback, but the other policies require better monitoring mechanisms in order to reach their efficiency potential (Khosa 2000; Pieterse 2010).

4. Insufficient focus on regulation of private sector and on public-private sector interactions
Though the Medical Schemes Act succeeded in placing initial regulations on the private sector, further regulations are necessary, particularly to prevent the rise of healthcare costs and medical scheme contributions, which have been escalating rapidly in recent years (Khosa 2000; McIntyre 2010B). Closer interaction between the public and private sectors is also necessary in order to increase the efficiency of health policies. The focus on separate regulation of the private sector to reduce inequities should be replaced by a focus on encouraging and regulating private-public sector interaction (Khosa 2000).

8. The Current Proposal for NHI

8.1 Brief Outline

Though the ANC has not released an official policy, a discussion document from September 2010 provides an outline of the most recent plan for national health insurance. The policy outlined in this document (referred to as the “current proposal” in this paper) is based on the principles of the right to health, social solidarity, and universal coverage. The policy’s primary aim is to extend basic health insurance coverage to all South African citizens through a publicly administered national health insurance scheme. Though specific financing mechanisms have not yet been determined, funding for universal coverage will come from a mandatory contribution by all citizens above an established income threshold. Revenue will be collected by the South African Revenue Service and managed by a newly created National Health Insurance Fund, to be led by a Chief Executive Officer reporting directly to the Minister of Health. The South African government (through the National Health Insurance Fund) will serve as the single payer for healthcare services, which will be accessible from a variety of public and private facilities accredited by the government. Simultaneously with the rollout of NHI, which is set to begin in rural and under-resourced areas in 2012, the government will implement a massive plan to strengthen the public health system. The new plan will focus on the promotion of PHC through a new model of primary health care teams, the strengthening and expansion of infrastructure, improved staffing of the health system and addressing of human resource problems, and the installation of advanced information systems to allow for more efficient recordkeeping and system monitoring (ANC General Council 2010).

8.2 Addressing Successes of Past Policies

1. Focus on primary health care

The NHI builds on the success of policies that have emphasized PHC by centering its proposed health system overhaul on primary health care, as laid out in the ANC’s discussion document: “At the core of revitalizing and strengthening of the South African health system is a primary health care approach that seeks to improve access to quality health services as the first point of entry to the health system” (ANC General Council 2010, pp. 33). The discussion document envisions a renewed health system in which primary health care facilities provide 80% of care, with higher levels accessible only by referral. As such, the health insurance plan centers on a comprehensive package of benefits based on PHC as the principal form of care and calls for a revision of the referral process and the revitalization of the district health system so as to make increased focus on PHC possible (ANC General Council 2010).

The version of PHC envisioned in the discussion document includes services encompassed in the current edition of primary health care but will be expanded to include
extensive community- and home-based services. Such expansion of services is to be made possible through the creation of primary health care teams, a major tenet of the proposal. Each team is to be composed of three to four community health workers (CHWs), one nurse, and one doctor or clinical associate and will be responsible for a population of approximately 10,000 people. These teams will be the primary proponents of the PHC approach as envisaged at Alma Ata, providing community- and home-based services with the support of health professionals in fixed facilities. The ANC estimates about 5,000 teams will be required to cover the South African population, suggesting that 5,000 doctors and nurses will be needed for this program alone, along with 15,000-20,000 CHWs (ANC General Council 2010). A shortage of doctors and nurses is likely to prevent the creation of the 5,000 teams deemed necessary to cover the population, though the ANC proposes doctors and nurses could be phased in as new ones are trained and some are recruited from the private sector. However, current numbers of community health workers are thought to be around 60,000 (ANC General Council 2010). If estimates are correct, the number of CHWs per team could be more than doubled, perhaps reducing the role of doctors and nurses in each team and presenting a partial, temporary solution to the problem posed by the lack of healthcare personnel. Community health workers’ lack of formal medical training renders them incapable of taking over the full set of doctors’ and nurses’ duties, but increasing their role could allow the teams to function for a period while the human resource problem is addressed.

2. Removal of barriers to health care

The proposal imitates past policies in their removal of financial barriers to health care. Though primary health care is already free for all South Africans in the public sector, the NHI will eliminate all fees at the point of service, except for non-citizens and services not covered under NHI. Removal of financial barriers for care above the primary level (provided patients obtain a referral) is a significant improvement on past policies. The extension of coverage to those who currently lack insurance is seen as the removal of an additional barrier to health care and is predicted to result in an increase in utilization of health facilities by the presently uninsured on the magnitude of 70% for outpatient care and 80% for inpatient care. These rates are comparable to the utilization increases observed after the removal of fees for PHC, according to the ANC (ANC General Council 2010).

The discussion document does not provide any means of directly addressing other barriers to healthcare access, however. Geographical barriers, unpleasant health workers, limited operating hours, and other obstacles deter or prevent citizens from seeking health services. The proposal’s failure to offer solutions to these problems is a significant weakness.

3. Establishment of minimum standard

The NHI builds directly on the success of the bottom line for care established by the Essential Drugs List and Prescribed Minimum Benefits. Services provided to the public under NHI cannot be any less than what the public currently receives, according to the discussion document (ANC General Council 2010). The comprehensive package of services covered by NHI will be developed using the PMBs outlined (and since updated) in the Medical Schemes Act. A list of fundamental pharmaceutical and medical supplies and devices, as well as medications, will be devised from the EDL (ANC General Council 2010).
4. Regulation of private sector

Despite the steps made by the Medical Schemes Act and the ANC’s recognition of the need to address disparities between the public and private sectors, the NHI does little build upon the MSA’s success imposing regulations on the private sector.

8.3 Addressing Pitfalls of Past Policies

1. Human resource problems

A shortage of sufficiently trained healthcare personnel in the public sector was a major hindrance to the implementation of all four policies examined above. In its discussion document for the new proposal, the ANC recognizes the severity of this problem and notes that their proposed reforms will require more adequate healthcare personnel than the system currently possesses. Primary health care facilities in particular will need an influx of trained doctors and nurses to support the PHC focus of the NHI. While data shows growth in the number of professional registrations across most health professions and increases in public sector appointments, South Africa remains severely undersupplied with key health professionals and faces huge challenges in the medium to long term. As such, the ANC has outlined a comprehensive set of strategies to increase the supply, quality, distribution, and retention of health workers (ANC General Council 2010).

The first step outlined by the ANC is a thorough audit of the health professional workforce to determine the numbers and categories of personnel needed to execute the new health plan. Institutions will be required to develop human resource performance improvement plans based on competency gaps identified by this audit. These plans will focus on workplace skills and prioritize training of individuals. In support of the NHI’s primary health care focus, learnership programs for the training of community health workers, HIV/AIDS counselors, and home-based carers will be developed (ANC General Council 2010).

As the most highly trained health workers, doctors with sufficient capabilities are crucial to the success of any health system. Recognizing the significance of doctors and their skewed distribution between the private and public sectors, the ANC proposes means of increasing the number of doctors in the public sector. The discussion document acknowledges the need for the rapid identification, assessment, advertising, and filling of vacant posts nationwide and the creation of new medical practitioners posts where necessary. As many of these vacancies are found in rural areas, the ANC proposes attracting doctors to more remote locations through incentives like opportunities for research and personal development, as well as the “personal satisfaction of working for the benefit of the poor” (ANC General Council 2010, pp. 37). Additionally, the discussion document offers the improvement of salaries, hospital infrastructure, and accommodation in rural locations, accompanied by study and career opportunities, as a means of persuading doctors to work in underserved areas. Investigation of the heavy workloads resulting from the shortage of public sector doctors is also recommended. As a possible solution to the burdens that deter doctors from public sector service, the ANC suggests considering the future introduction of medical assistants to alleviate some of the burden and the transfer of some tasks from highly trained professionals to workers with lower qualifications or to lay workers like CHWs. In the present, the document recommends recruiting doctors from the private sector to public service on a sessional basis (ANC General Council 2010). The exodus of many South African doctors to other countries with better working conditions is also correctly
identified as a crucial area of focus. The ANC calls for a study of the motivations that cause South African doctors to leave the country and for the provision of incentives to combat these driving factors. Additionally, the document calls for examination of the opportunity for homecoming recruitment. In the meantime, better use of foreign doctors living and/or working in South Africa is cited as a potential temporary solution to shortages (ANC General Council 2010).

Doctor shortages have produced a health system heavily reliant on nurses. Yet a scarcity of nurses also plagued the healthcare system, particularly in the context of the HIV/AIDS and TB epidemics. The discussion document recognizes the need to examine the emotional and physical effects of HIV/AIDS and TB on the health system as a whole and on nurses specifically. The scale of the burden renders greater numbers of nurses necessary than might otherwise be the case. Risks of contracting HIV/AIDS and/or TB as a nurse deter some from pursuing the profession, as do stigmas attached to being an HIV-positive health worker. The ANC calls for the development of programs to encourage health professionals to get tested and to break down these stigmas (ANC General Council 2010). In addition to encouraging private sector nurses to return to the public sector, the ANC’s discussion document suggests a reassessment of the public nurse education system in order to increase the number of nurses in the public sector. Past restructuring resulted in the merging and closure of several nursing colleges, which the ANC suggests be reopened. The General Council also calls for reconsideration of the emphasis on a secondary school degree as a qualification for four-year nursing colleges. Because of weaknesses and inequities in the South African education system, many potential nurses cannot obtain the degree required for admission to nursing college. The ANC believes such focus on the degree excludes students with the potential to succeed as nurses after four years of training, even if they have failed to complete secondary schooling (ANC General Council 2010). In its efforts to increase numbers of nurses, the ANC recommends a focus on producing enrolled nurses (ENs) and enrolled nurse auxiliaries (ENAs) by reprioritizing their training in provincial and hospital budgets. In order to meet levels required for effective service provision under the NHI, the ANC estimates production of enrolled nurses and enrolled nurse auxiliaries must be at least doubled. When attrition rates are taken into account, the estimate calls for the training of six times as many ENs and ENAs as the country currently turns out each year (ANC General Council 2010).

In addition to health care workers with high levels of formal training, the South African system also lacks people with sufficient management skills to effectively implement policies. The ANC recognizes the need for particular forms of knowledge and skills and calls for methods of developing these in health management training programs. To this end, the General Council offers the possibility of supplementing university initiatives with new health institutes that contain dedicated health management programs and the arrangement of apprenticeship or job-shadowing programs to build capacity in the public sector. In the short-term, the use of managers from the private and non-health sectors to improve efficiency and manage change is suggested. Upon the procurement of adequate management skills, greater authority will be devolved to managers to allow them to make decisions, encourage accountability, and cushion them from bureaucratic inefficiencies (ANC General Council 2010).

Building up numbers of doctors and nurses to the levels required by the new health system under NHI will be a time-consuming task, and supplementation of native health workers with imported healthcare professionals is probable and recommended, particularly in the short term.
The discussion document proposes allowing foreign doctors and nurses already in South Africa to work in their fields of expertise for specified periods of time, determined by the length of their residency in South Africa, the status of their residence, and need for workers in their field of expertise. These people will be used especially in areas with large numbers of refugees, particularly those with refugees from the foreigners’ own countries, and in areas of public and rural service where shortages prevail. Additionally, the ANC calls for increased financial and moral support to non-governmental organizations (NGOs) and professional associations recruiting personnel from developed countries to work in South Africa. Restrictions for foreign doctors who meet requirements will be loosened to allow them to work in NGOs serving the poor and uninsured and not only in the public sector (ANC General Council 2010).

2. **Quality of care and facilities**

In an apparent demonstration of learning from the pitfalls of past polices, the ANC recognized the need for massive improvements in the quality of health services and facilities: “The successful implementation of the NHI system will rest on the accelerated, visible, and sustained improvements in the provision of quality services to all” (ANC General Council 2010, pp. 24). To combat the system’s current ills, the ANC has proposed an improvement in resources over a five-year period, indicating the urgency of this intervention. This service improvement plan has the specific goals of (1) quality improvement within facilities, (2) increasing access to HIV treatment to meet 2011 NSP goals, (3) increased patient safety though a system for collection, classification, and analysis of past incidents that will lead to reduction and prevention of future mishaps, and (4) disease management (ANC General Council 2010).

The health system improvement plan, to be rolled out in conjunction with the restructuring of the health insurance system, will begin with a detailed inventory of public and private facilities to establish the system’s current capacity and identify gaps for expansion and facilities needing upgrading and repair. This inventory will be used to develop a concrete plan to refurbish and expand facilities in line with the existing health care facilities revitalization program. While needs of the private sector will be considered, the program will focus on the improvement, expansion, and revitalization of public infrastructure and services. Enhancements in the District Health System through the strengthening of District Health Councils and the improvement of political governance, managerial oversight, and accountability structures are an important facet of the plan. These will be accomplished through a focus on improving service integration, quality of services offered, efficiency, effectiveness, and community participation (ANC General Council 2010).

The upgrading of facilities and services will be based on a quality improvement approach that uses continuous assessment, collaborative, participatory, and systems approaches to integrate quality improvement and monitoring mechanisms into routine management functions. This approach regards quality improvement as a “progressive and gradual process that relies on the guiding principles of teamwork, systems and processes, patient-centeredness and measurement” (ANC General Council 2010, pp. 40). Efforts to train healthcare workers in quality improvement methodology, monitoring, and evaluation using appropriate information systems will be crucial to the building of capacity at all levels of the health system to entrench and ensure the sustainability of quality improvement and assurance. Peer review and benchmarking will be used to share best practices and minimize differences in quality of care between locations. Focus will be placed also on systems required to provide coordinated hospital
and PHC care, with a mandate for the development of institutional human resources performance improvement plans to minimize competency gaps in individuals.

At the heart of plans to improve the quality of healthcare will be the new Office of Standards and Compliance (OSC). The institution will be responsible for establishing multidisciplinary standards for healthcare facilities based on principles set by the International Society for Quality in Healthcare in a process that will incorporate expert input. These standards will provide specific indicators of performance to be used as points of reference in the evaluation of system functioning. Compliance with these standards will be assessed using data gathered by a customized computer system and will be used to determine facilities’ accreditation status. The OSC will act also as an accreditation agency, and facilities will not be eligible for payment from the NHI without accreditation from the OSC. The OSC will recognize progress by facilities towards meeting accreditation requirements and will support quality improvement efforts. Four training centers, each consisting of a hospital and three PHC facilities, will be identified in each province to act as centers of learning where health workers receive training in quality assurance. High-level workers who attend these centers of learning will then be responsible for the training of other workers in their facilities (ANC General Council 2010).

3. Problems with implementation, consultation, and monitoring

As quality improvements plans indicate, health system monitoring is central to the ANC’s proposal. The upgrading of the health system will be subject to formal monitoring, with particular focus on efforts to meet the standards delineated by the OSC. Improvement plans will be accompanied by identified time frames and people will be held accountable for their responsibilities. The establishment of a database and regular referral to its contents will facilitate this monitoring. After receiving upgrades, several aspects of the health system will be subject to monitoring of their own. An electronic information system will support monitoring and will collect information to allow analysis of health system status and utilization. Staff will be trained to evaluate the quality of care against the OSC’s standards and to enter data into the newly installed information system. Workers will also be trained to use this IT system to extract and use information to better manage their facilities. National and regional staff will also use this data to monitor performance of facilities and to encourage improvement on a continual basis. As in the quality improvement plans, patient safety is a focus area of monitoring plans, in accordance with recommendations from the World Health Assembly (WHA 55.18 2002). Researchers in Free State are currently examining the possible establishment of an adverse event management system with the hope that results from this project might be used to develop a national reporting and learning program. A Benefit Advisory Committee established within the National Health Insurance Fund department of the DoH will regularly review and update the lists of exclusions from coverage and of essential supplies (ANC General Council 2010).

Weaknesses of past policies attributed to limited consultation of knowledgeable stakeholders appear to have been recognized by policymakers, who insist that the development of the NHI will incorporate increased consultation of communities, experts, and other stakeholders. Highlighting the importance of involving communities, the discussion document states, “It is critical that appropriate strategies be designed on how communities will be involved in planning of health services at district level including their role in providing inputs into district health plans” (ANC General Council 2010, pp. 34). The discussion document also includes plans to involve health workers’ unions and professional associations in the development of the scope of
practice and in all policy discussions concerning mid-level and community health workers (ANC General Council 2010). Whether these claims will be fulfilled in practice remains to be seen; despite claims to involve stakeholders in the past, the South African government’s policies have been criticized for limited consultation (McIntyre and Gilson 2002).

Problems with the implementation of past policies hindered their effectiveness and similar issues may very well plague this policy. Legislative hold-ups and failures to implement polices as outlined can hardly be addressed at this stage in the development of the NHI. At the most, policymakers can strive to design a thoroughly explicated policy with an implementation plan that contains few opportunities for exploitation. The implementation strategy outlined in the discussion is set to begin with wide consultation of public and private stakeholders, the review of relevant legislation, and the drafting of new legislation where necessary. The determination of appropriate revenue mechanisms and implementation of interim mechanisms to facilitate the shift from the current system to the single-payer structure of NHI will be accompanied by the quality improvement plan for facilities and service. Facilities are to be upgraded over a period of five years, with all reaching accreditation standards by the end of this period. A full transition to the single-payer system with upgraded health facilities will be complete within fourteen years, according to the discussion document (ANC General Council 2010).

While plans for assessment and consultation in the development of policies are positive steps towards avoiding past problems with implementation, the strategy presented for rollout of the NHI does not reflect significant learning from past mistakes. Despite the fact that the ANC plans to begin roll out in 2012, no concrete policy document exists with specifics of the new health system or mechanisms for raising revenue. Plans to transition to universal coverage in fourteen years are overly ambitious, as other countries have taken far longer to implement similar systems. The transition took 127 years in Germany and 118 in Belgium. Only two countries have completed this transition in under forty years: Japan in 36 and Korea in 26 (McLeod 2008A). The plan to simultaneously convert to the universal coverage, single-payer system and improve health system infrastructure also reflects a failure to learn from past policies and a source of likely failure for NHI. Past attempts to implement several policies at once complicated the roll out of these initiatives, none of which approached the transition to universal coverage or the rebuilding of health facilities in scale (Government of SA 1999). Attempting to introduce such massive initiatives concurrently seems likely only to ensure that neither task will be executed to its full potential.

Perhaps an even more significant problem with the proposal to simultaneously rebuild health facilities and transition to the new system of health insurance lies in the NHI’s inherent dependence on public health infrastructure. The ANC’s proposal suggests that the government both expects and desires greater usage of public health sector facilities. Utilization increases will come from formerly uninsured people who had refrained from seeking health services prior to NHI and from former users of the private sector. Assuming the NHI is funded at least in part by a mandatory tax increase for those above a specified income level (as is highly probable), there will inevitably be a class of people whose ability to afford private medical insurance schemes will disappear. At least some of those on the lower end of earners above the income tax threshold who currently participate in private medical insurance schemes are likely to be forced to contribute the money now spent on private insurance to the NHI via increased income taxes. This will create an influx of patients to the public sector in addition to the surge in users from the extension of universal coverage. Public sector facilities, which will at best be in the early stages of an upgrade when this surge begins, will be overwhelmed.
4. **Insufficient focus on regulation of private sector and on public-private sector interactions**

Though the ANC’s discussion document recognizes the vast disparities in public and private sector resources and quality, it provides little concrete guidance for increasing interaction between the sectors. A major component of the proposal that will reduce the gap between the public and private sectors is the removal of the tax subsidy for private medical scheme members (ANC General Council 2010). Because the subsidy takes the form of a tax break, it rewards only those above the income threshold, benefitting the highest earners while offering no support to private medical scheme members below the income tax threshold who would benefit most from a reimbursement for their medical scheme contributions. In 2005, the cost of this subsidy to the government was an estimated R10.1 billion, which constituted 20% of total government spending on public health services that year (McLeod 2008A). Removal of this subsidy will not only return significant amounts of money to the South African government, it will also dispose of a policy that benefits the highest income earners over other groups and contributes to distortions in funding between the public and private sectors.

Despite this progress, there is need for encouragement of greater interaction between the public and private sectors and more equitable allocation of resources between the two. The ANC should examine ways to leverage the resources of the private sector to increase the quality of public sector services, as well as ways to keep healthcare costs under control and allocate a greater share of healthcare spending to the public sector.

9. **Conclusions**

As 2012 (the supposed commencement date of NHI roll out) rapidly approaches, consideration of this policy’s likely impacts on equity is crucial. Based on comparisons of the current proposal to past policies and the assumption of a concrete policy document, the ANC’s latest proposal for National Health Insurance seems likely to increase equity in South Africa. Its foundations in the principles of universal coverage, social solidarity, and the right to health are not only in line with the State’s constitutional obligations, but also reflect the ideals that should preside over South Africa’s health system. The proposal outlined in the ANC’s September 2010 discussion document shows evidence that policymakers have learned from past lessons and have worked to build upon successes and avoid pitfalls. In many cases it does well, particularly by continuing the focus on primary health care and suggesting solutions to problems with the quality of care and facilities, human resources, and health system monitoring. Given the assumption that at least some people are deterred from accessing health services because of a lack of insurance or inability to pay—an assumption for which there is substantial evidence and that has served as the basis for past policies—the extension of coverage to all South Africans will have an equity-increasing impact as these barriers will be removed. Likewise, given that poor quality of facilities and services prevents some citizens from accessing appropriate care, the upgrading of the health system will also increase equity. Other steps forward, such as the removal of tax subsidies for medical scheme members, will serve to reduce disparities between South Africans and to build upon the equity increases from the universal coverage and health system strengthening tenets.

Despite significant positive aspects, this proposal for NHI falls short in several regards. It fails to address some pitfalls of past policies, most notably the need to facilitate private-public
sector interaction and to avoid rushed implementation. The biggest obstacle to the NHI’s positive impact on equity will be the feasibility of its implementation as proposed. It is one thing to describe in broad terms a policy to revolutionize a national health care system and quite another to effectively implement the changes necessary to accomplish desired goals. Potentially great roadblocks stand in the way of the NHI’s effective implementation, not the least of which is the lack of a concrete policy document despite the plan to begin implementation next year. Likewise, the absence of a plan for funding sources raises serious questions about the NHI’s affordability. Bureaucratic problems, stemming in part from the creation of a new and perhaps unnecessary government agency, pose likely hindrances, especially given the South African government’s less than pristine record on corruption. The policy also rests on a degree of public buy-in. While contributions will be mandatory, they are likely to be accompanied by protests from the less than one tenth of the South African population that will very probably be paying for a system that benefits all citizens, and often the free-riders more than the contributors. The policy assumes a shift of some private sector users to the public sector in order to reduce skews in funding, yet it is unlikely many will make a voluntary transition to a lesser system. A glaring gap in the proposal is its lack of recommendations for dealing with the HIV/AIDS crisis, which would impose significant strain on even the strongest health systems and is already threatening to cripple South Africa’s system even without the influx of patients the NHI is expected to spur.

This proposal represents a step towards increased equity in South Africa’s health system, yet significant room for progress remains. To achieve a more equitable health system, the ANC will need to continue work on its plan for National Health Insurance. The discussion document released in September 2010 describes the beginnings of a policy based on the principles that should underlie any plans for reformation of the South African health sector. While the policy has in some ways been informed by the successes and pitfalls of past policies, it fails to address some major issues. Even if the policy were complete in its attempts to tackle the crucial ailments of the South African health sector, its implementation as outlined, particularly within the proposed time frame, seems unlikely. South Africa needs to slow down plans for roll out, allowing time for extensive research and quality improvement so as to avoid a less than fully informed policy reliant on an inadequate health system. The ANC should look to the 1997 White Paper for guidance and should focus on upgrading health infrastructure before transitioning to universal coverage. A policy that fully addresses the needs of South Africa’s health system and creates a successful National Health Insurance system based on the principles of universal coverage, social solidarity, and the right to healthcare is indeed possible and should be pursued, but must derive from fully informed polices implemented over a sufficient length of time.
Appendices

Appendix A: Case Study 1—Introduction of Free Primary Health Care

In his May 1994 inaugural address, Nelson Mandela announced the beginning of a new era for South Africa—an era that would seek to rectify the injustices of his country’s recent history and propel the Rainbow Nation into a time of unity, democracy, and freedom. Included in his outline of the Presidential priorities was the need to address South Africa’s health struggles. At the heart of his plan to improve the health of his country was a model of improved health care provision centered on a primary health care approach.

Mandela’s first act towards the achievement of this plan was the announcement of free primary health care (FHC) for pregnant women and children under six years of age. While primary health services at public sector facilities had previously required the payment of a user fee, all preventive and curative PHC services would now be available to this particularly vulnerable subset of the population free of charge. User fees had been implemented in several developing countries, driven in part by the recommendation of international agencies like the World Bank. Though these fees could be used to raise revenue for facilities, increase the perceived value of services, and deter unnecessary or excessive use, critics had been quick to accuse user fees of compromising equity in access to health services (Wilkinson et al. 2001).

The policy went into effect on June 1, 1994 and was quick to impact South Africa’s health system. Most public health sector facilities saw an increase in patient attendance. Figure 1 demonstrates the spike in visits to three public clinics immediately following the implementation of FHC. The increase is particularly evident in visits for antenatal care and pediatric outpatient services. The rising number of patients seeking antenatal care was accompanied by a related reduction in the proportion of “unbooked pregnancies” (the delivery of babies to women who had not received antenatal care prior to delivery). McCoy claims this “almost certainly” translates to a reduction in the number of avoidable infant deaths (McCoy 1996). The financial costs associated with these positive health trends were minimal, accounting for less than 1% of the public health sector budget (McCoy 1996).

A separate study by McCoy and Barron cited in the Department of Health’s review of primary health care examined the attendance to outpatient departments in several healthcare...
facilities twelve months before and twelve months after implementation of free PHC for pregnant women and children. The authors found that total attendance to outpatient clinics increased by 14.5% in the two-year period centered at implementation, and pediatric OPD attendance increased by 102.2% (SA Department of Health 2000).

Two years after the implementation of free health care for these select groups, the removal of user fees for primary health care services was extended to all South Africans in April 1996. Accompanying the removal of user fees was the implementation of a by-pass fee, to be imposed on those who opted for hospital care without first visiting a primary care facility and obtaining a referral.

Evaluation of these two policies is limited by the scarcity of available data. A review by the Department of Health collected data on utilization of primary health care services in the late-1990s, but noted that difficulties obtaining data, particularly data collected through a standard method throughout the provinces, should not be overlooked. The DoH review found that utilization rates increased dramatically in the period between 1994 and 1999, the time during which both free health care policies were implemented. Notable increases occurred in Gauteng Province, where visits to a PHC facility increased from 1,651,681 in 1994 to 12,215,025 in 1999, and in KwaZulu-Natal, where visits increased from 10,474,385 in 1994 to 19,476,079 (SA Department of Health 2000).

Changes in utilization rates differed across types of primary care. Women were observed to be seeking pre-natal care earlier and more frequently than they had been prior to the implementation of FHC (Department of Health 2000). A DoH report entitled “Saving Mothers” outlined the positive effects FHC was anticipated to have on maternal and child health in South Africa. Plagued by a maternal death rate 22 times higher than that in many developed countries, South Africa had identified the need to devote special attention to the care of its women. The “Saving Mothers” report conducted a study of 676 maternal deaths, concluding that in almost half of these there was a missed opportunity for preventing death. The women studied were found not to be seeking antenatal services and their cases revealed several problems in the provision of services, many of which occurred at the primary care level. A South African Demographic and Health Survey cited in the report also found that 16% of South African women had given birth without medical assistance, very probably increasing the nation’s incidence of maternal death. By removing fees preventing mothers from seeking care both prior to and during birth, the FHC policy would directly contribute to reduction of the number of maternal deaths (Department of Health 2000).

A 2001 World Health Organization paper found a significant difference in the change in utilization rates for preventive and curative PHC services following the implementation of FHC. The study examined utilization of primary health care services in the Hlabisa medical district in rural KZN. Preventive services of immunization and growth monitoring were free prior to implementation of FHC, which removed existing user fees for antenatal care and curative services. The study found a sustained increase in new registrations and attendance for curative services, with the upturn beginning shortly after the first FHC policy change. After implementation of the first policy change the authors observed a brief increase in new registrations for immunization and growth monitoring, but this declined thereafter. Registrations and attendance in antenatal care decreased insignificantly over this period. The authors attributed these decreases to an increase in congestion and reduced consultation times that were not offset
by fee removal, as many of these services had been free prior to FHC. There was no evidence that the second policy change had any significant influence on underlying trends. The study concluded that the implementation of these policies initiated a shift in demand for primary care from preventive to curative, with the total number of consultations for curative care doubling in one mobile clinic while the number of consultations for preventive care fell (Wilkinson et al. 2001).

Despite successes in increasing access to health care services by removing the barrier of user fees, the FHC policies were not without their flaws. Critics have cited lack of planning and hurried implementation as major flaws that may have led to congestion in PHC facilities and a reduction in consultation time (McIntyre and Gilson 2002; Wilkinson et al. 2001; McCoy 1996). Patients, healthcare workers, and evaluators also cite the impact of the policy on the morale of primary healthcare workers as a negative effect of the policies (McIntyre and Gilson 2002; Wilkinson et al. 2001).

In some areas, the policies have not been implemented. A 2011 study by Harris et al. found that a significant portion of groups exempted from user fees still pay for services. For example, 7.7% of uninsured patients are still paying out of pocket to attend a PHC facility (Harris et al. 2011). The failure of some clinics to eliminate user fees undermines the equity objectives of the FHC policies and risks undoing the financial protection offered to poor households and vulnerable groups. This powerfully illustrates the discretionary power of the providers and bureaucrats who ultimately determine who receives care free of charge (Harris et al. 2011).

Several evaluators recognize the strides these policies made toward reducing health inequity in South Africa, but insist that more action is imperative. While removal of user fees eliminated one barrier to PHC access, several barriers remain, some perhaps even more obstructing that user fees. Physical access to PHC facilities remains a major problem as many South Africans, particularly in rural areas, live too far from a clinic to be able to take advantage of the free care offered to them (Leatt et al. 2006; McIntyre and Gilson 2002). Those who make it to the clinics often find that medicines are out of stock or that the staff, if the clinic is even fully staffed, is under pressure and impatient (Leatt et al. 2006). In order to continue on the path towards improved healthcare access, South Africa must address these issues and others. The quality of care provided in PHC facilities must be improved, staffing and medication shortages must be resolved, and developments like the technology of telemedicine should be employed to leverage existing resources in new and more efficient ways (Department of Health 2000).
Appendix B: Case Study 2—Clinic Upgrading and Building Programme

In conjunction with the implementation of free health care, newly elected President Mandela prescribed an upgrade and expansion of the country’s primary health care facilities. Introduced alongside FHC for pregnant women and children under six as a Presidential Lead Project, the Clinic Upgrading and Building Programme (CUBP) commenced in 1994. Driven perhaps in part by the anticipation of increases in health care utilization resulting from the new FHC policies, the CUBP was designed to remove another obstacle to health care access: geographic barriers. Using WHO recommendations for one clinic per 10,000 people to determine which provinces had the greatest need for new clinics, the CUBP demonstrated some concern for principles of vertical equity by preferentially allocating clinics to areas with worst existing level of PHC infrastructure (McIntyre and Gilson 2002).

The first phase of CUBP began in the 1994/95 fiscal year, followed by phase two in 1995/96, and phase three in 1996/97. It was slow to gain momentum, not really taking off until August 1996, and failed to meet its clinic-building target for the end of phase three in 1997, with only 92 of the allotted 295 clinics completed by the target deadline (Harrison 2009; McIntyre and Gilson 2002; Government of SA 1999). However, CUBP continued after the end of 1997 and succeeded in the building and upgrading of many more clinics.

By 1999, when the Department of Health conducted a primary health care progress report, 506 new clinics had been completed, with 62% of clinics being allocated to the poorest 40% of districts (Department of Health 2000; McIntyre and Gilson 2002). An additional 252 existing clinics had received a major upgrade, often including the construction of new maternity sections. Over two thousand additional clinics had received new equipment and/or minor upgrades of up to R10,000 per clinic (Department of Health 2000).

A report funded by the Kaiser Family Foundation in the same year surveyed South Africans to assess the real impact of CUBP on citizens’ lives. The authors found that the CUBP had succeeded in increasing the number of South African citizens within fifteen minutes of health facility from 47% in 1994 to 61% of respondents in 1998 (Figure 2). There was no observable difference in the change in proportions of South Africans traveling an hour or more to receive care, however. Twenty-seven percent of respondents reported that a new clinic had been built in their area in the two years preceding the study. Black Africans were the most likely to report construction of a clinic in their district, while Indians were the least likely, a statistic that might
reveal concerns for vertical equity as Black Africans generally have the worst access to health care. Thirty-four percent of respondents reported the perception that their access to the health system had improved over the past four years, though 47% percent felt that their access had not changed. Despite this, 15% of respondents identified CUBP as the South African government’s best health policy, favoring CUBP over other policies including FHC (Smith et al. 1999).

Several obstacles delayed realization of the policy’s prescriptions and hindered implementation of CUBP. Problems reaching consensus of the location of new clinics, a lengthy tender process, and cash flow problems that delayed funds being sent to provinces significantly impeded the policy’s implementation (McIntyre and Gilson 2002; Government of SA 1999). Areas with the smallest resource endowments were hit hardest by these delays (McIntyre and Gilson 2002).

Once constructed, new clinics were not immune to the challenges faced by the South African health sector. Many clinics were successfully completed but unable to be put into operation due to staffing shortages (McIntyre and Gilson 2002). Concerns about the quality of care were not assuaged by CUBP, nor were concerns about waiting and consultation times. Clinics’ hours of operation also presented an issue for many citizens who were unable to seek care during limited hours. Only 30% of respondents in the Kaiser survey reported that their public PHC facility was open every day. Racial disparities in access to PHC facilities open seven days were apparent as well: 27% of urban Africans and 21% of rural Africans reported a facility open every day while 49% of Indians and 43% of Whites did (Smith et al. 1999).

The CUBP’s attempts to redress vertical equity concerns were not without merit. The majority of clinics constructed under its directive were placed in the poorest magisterial districts, with the Northern (now Limpopo) Province and KwaZulu Natal (the two provinces with the poorest clinic to population ratios) emerging as the major beneficiaries (Government of SA 1999). However, these improvements in geographic access and clinical infrastructure were not fully successful because they lacked accompanying improvements in service quality and other policies to address concerns of South African citizens that may have deterred utilization of new clinics. The CUBP failed to address major health sector problems like the staffing shortage and poor quality of care, which was not unnoticed by citizens. Respondents in Smith et al.’s study identified better service and better treatment by staff as the two most important recommendations for changes in health service, followed by increased availability of medicines, improvement of staff skills, and improvements in affordability, convenience of operating hours, and geographic accessibility (Smith et al. 1999).
Works Cited


African National Congress (2009). Statement of the National Executive Committee of the African National Congress on the occasion of the 97th Anniversary of the ANC.


McIntyre, D., & Gilson, L. (2002). Putting equity in health back onto the social policy agenda: experience from South Africa. Social Science & Medicine, 54(11), 1637-1656.


Pieterse, M. (2010). Legislative and executive translation of the right to have access to health care services. Law, Democracy & Development 14.


SHIELD (2010B). What resources do we need for a universal health system in South Africa and what are the design implications? SHIELD Reports. Cape Town: Strategies for Health Insurance for Equity in Less Developed Countries.


