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How can we best achieve a universal health system:

a public conversation

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The NHI Bill can and must be improved. Greater and faster progress in addressing the serious efficiency and equity challenges facing the South African health system can only happen if the public conversation focuses on how best to achieve a Universal Health System.

The recently released National Health Insurance (NHI) Bill has once again led to heated debate about health system reform. Some media coverage of the Bill demonstrates lack of clarity on the nature of these reforms. However, much of the controversy is attributable to different levels of 'buy-in' to the goal of NHI, which is to move towards a universal health system (UHS). South Africa is not alone in pursuing this goal; it is a key element of the health-related Sustainable Development Goals. Underlying the goal of UHS are the principles of: universality (i.e. everyone benefits, not just a privileged few); and social solidarity whereby there are both income and risk cross-subsidies in the overall health system. UHS is fundamentally a redistributive policy and as such it is not surprising that it has generated intense debate.

This chapter explains what the key elements of NHI reform are and unpacks how these elements will contribute to achieving a UHS. It also considers some of the key concerns raised in debates around the Bill, particularly the pace of change; affordability and sustainability of the reforms; and governance issues.

The NHI Bill can and must be improved. It is 25 years since the first democratic elections, and there must be greater and faster progress in addressing the serious efficiency and equity challenges facing the South African health system. This can only happen if the public conversation focuses on how best to achieve a UHS, backed with clear explanations of how any proposed reforms will achieve this goal.

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Introduction

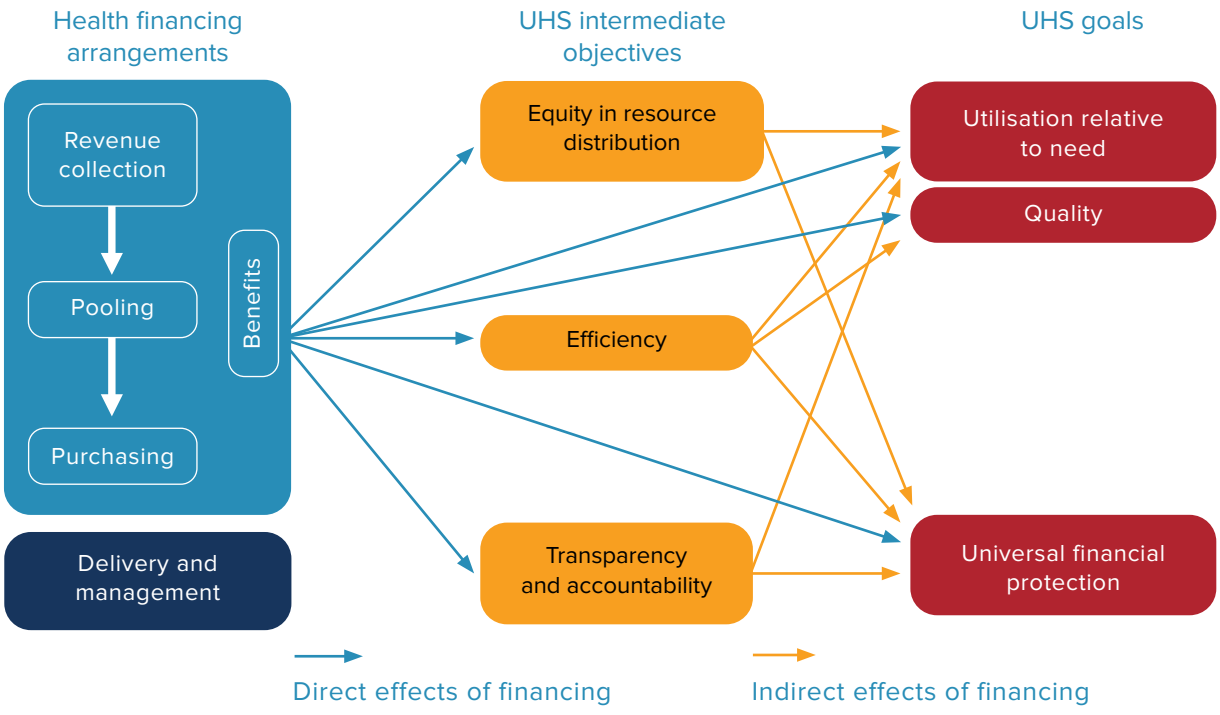
Release of the National Health Insurance (NHI) Bill[1] has generated intense debate and considerable negative media coverage. This is partly related to concerns about embarking on major structural reforms, particularly in the current weak macro-economic and fiscal environment and within the context of poor governance. In many cases, criticism is based on lack of understanding of what is being proposed. Many criticise the Bill for providing insufficient detail on the proposed reforms. However, it is not appropriate to provide intricate detail in legislation. While more detail is included in the Green[2] and White Papers[3,4] that preceded the Bill, some areas remain unclear.

The purpose of this chapter is to provide information on the 'what' and 'how' of the proposed NHI. Due to space constraints, it is not possible to explore the 'why' of the reforms, which relate to current health system challenges in South Africa. These have been documented elsewhere in this *Review*,[5,6] including in other chapters of this edition of the *SAHR*. It is well recognised that there are challenges in both the public and private health sectors and in the maldistribution of resources between the public and private health sectors relative to the population each serves. There is growing recognition that the NHI proposals are about moving to universal health coverage (UHC), which is a key element in the health-related Sustainable Development Goals (SDGs).[7] Substantial progress towards a universal health system (UHS) cannot be achieved by 'fiddling around the edges' of a status quo system. Instead, fundamental system-wide changes are required.

The term 'NHI' may have contributed to the confusion around the proposed reforms, as the word 'insurance' leads many to assume that NHI is about creating a large medical scheme. Although the term 'UHC' is widely used internationally, it also has its drawbacks, particularly as the term 'coverage' once again creates the impression that the emphasis should be on population coverage by an insurance scheme. This is illustrated in the initial selection of insurance coverage as an indicator of UHC in the SDGs.[8] As noted by Kutzin, "UHC is a set of objectives that health systems pursue; it is not a scheme". According to him the focus should be on the "population and system as a whole".[9] It may be preferable to use the term Universal Health System (UHS) rather than NHI or UHC as it is more descriptive of the nature of the reform and less open to misinterpretation, while adopting the same internationally accepted UHC goals and objectives.

This chapter reflects the author's personal understanding of the proposals, based on involvement in some of the health financing policy processes and extensive research into efforts to progress toward a UHS in other countries, particularly middle- and high-income countries.

Figure 1: Intermediate objectives and final goals of a universal health system (UHS) influenced by health financing



Source: Adapted from Kutzin, 2013.[9]

Conceptual framework

The proposed reforms are largely, but not exclusively, related to reform of healthcare financing arrangements. Figure 1 presents an overview of the internationally accepted goals of a UHS, which are to enable everyone in a country to access and use the health services they need; these services should be of sufficiently high quality to be effective, and no one should face financial hardship through using these services. The figure also shows that health-financing arrangements are not only about how to generate funds for the health sector (the revenue collection function), but also about how these funds are pooled and how they are used to ensure that there are accessible, quality health services through active or strategic purchasing. Finally, the figure shows that the health-financing arrangements within a country can contribute directly to achieving UHS goals and contribute indirectly through influencing the UHS intermediate objectives of equity in resource distribution, efficiency, and transparency and accountability.

Before outlining the key proposed changes in health-financing arrangements in South Africa and considering how they are expected to contribute to UHS objectives and goals, it is important to recognise explicitly that UHS is fundamentally redistributive. Universality and social solidarity are core principles of a UHS. Social solidarity implies income and risk cross-subsidies within the overall health system, with individuals contributing towards health service funding based on their ability to pay but benefiting according to their need for health services. This is effectively a net transfer of financial resources for health care within a funding pool between groups with different socio-economic status and different health-risk profiles. As there is a strong relationship between low socio-economic status and a greater need for health care, and substantial income inequalities in South Africa, the net transfer required can be represented as in Figure 2.

What are the NHI reforms about?

Figure 3 provides a visual overview of the main health-financing changes envisaged in the NHI Bill, organised in relation to the three key functions of healthcare financing, namely revenue collection, pooling, and purchasing. The figure also indicates key changes required in service delivery and management.

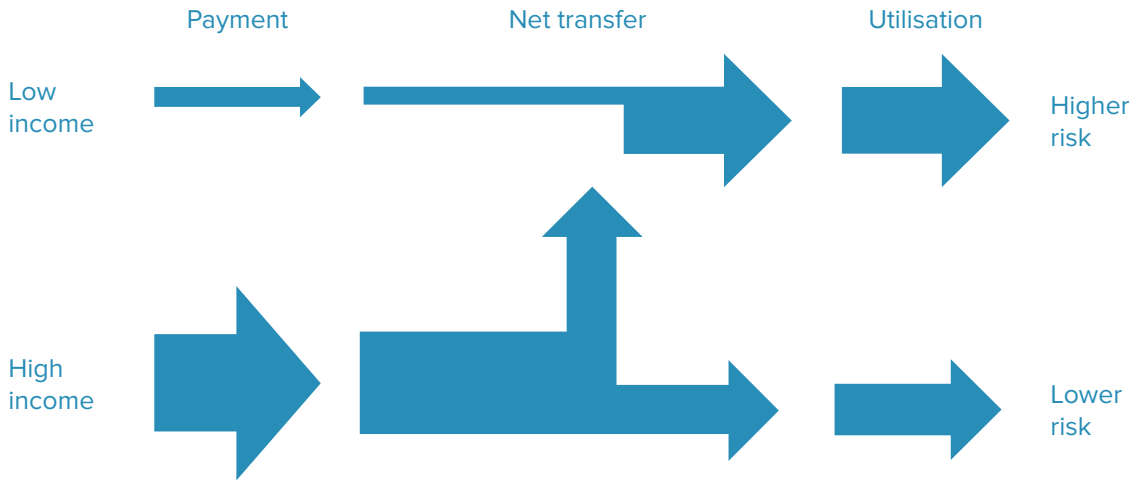
Revenue collection

Revenue collection changes relate mainly to gradually increasing the allocation of tax funding to the health sector, including ultimately increasing tax rates or introducing new 'NHI-related' taxes. This would be in line with international evidence that mandatory pre-payment financing is critical for a UHS. It would not simply represent an absolute increase in tax funding, but more importantly, a change in the relative share of tax funding in overall health financing, as contributions to medical schemes are likely to decline over time. There would also be a decline in out-of-pocket (OOP) payments for health services, both through removing user fees at public sector hospitals and through a relative shift away from voluntary private health insurance (medical schemes) and the associated co-payments and restrictions on benefit packages.

Pooling

The NHI Bill proposes a change in pooling arrangements through the introduction of a single pool of tax funds, allocated to the NHI Fund (NHIF), for health services to benefit the entire population. It is proposed that once the reforms are fully implemented, medical schemes will only provide 'complementary cover', i.e. will cover services not funded under the UHS (e.g. elective caesarean section deliveries). The overall intention is to reduce fragmentation in funding pools to maximise income and risk cross-subsidies.

Figure 2: Illustration of income and risk cross-subsidies in a universal health system



Source: Adapted from WHO, 2000.[10]

Purchasing

Probably the most important aspect of the proposed changes relates to purchasing, particularly the creation of an autonomous institution (the NHIF) to strategically purchase health services for the whole population. Key characteristics of strategic purchasing (as opposed to passive purchasing) include:

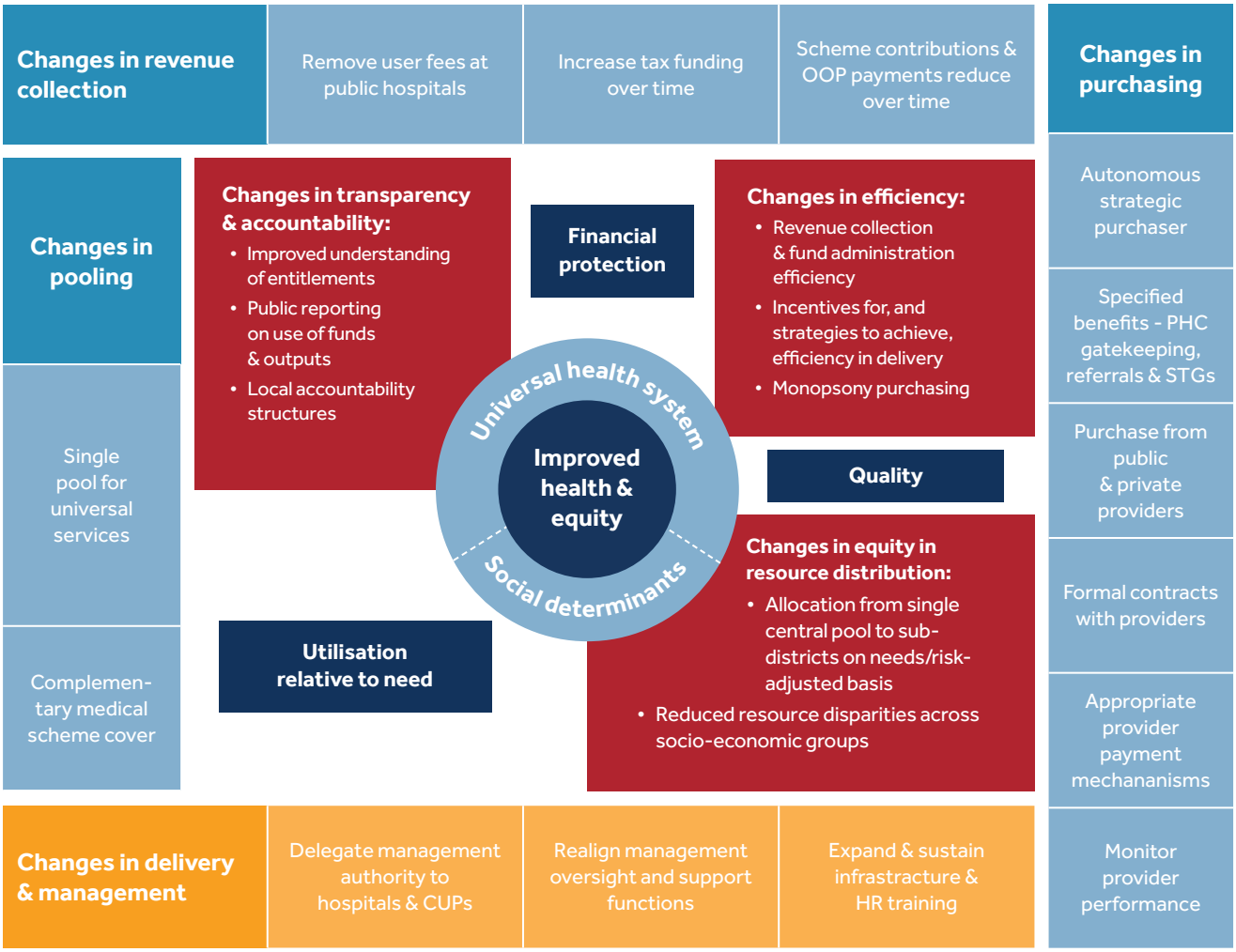
- Specifying service benefits – this does not require an exhaustive itemised list of services covered, but it is likely to include detailed specification of the type and range of services to be provided at different facilities, the use of standard treatment guidelines (STGs), and primary care gatekeeping with a requirement to follow referral pathways.
- Having formal service-level agreements or contracts that indicate explicitly to providers the range, quantity and quality of services they are expected to deliver.
- Allocating funds and paying providers using mechanisms that provide appropriate signals and incentives for quality, efficiency and equity in service provision.
- Actively monitoring quality and other aspects of service provision.

Given the sectoral distribution of health professionals in South Africa, the NHIF will purchase from both public and private service providers, with the emphasis initially on the primary health care (PHC) level, given that most health service needs can be addressed at this level.

Service delivery and management

In addition to these financing changes, several changes are required in service delivery and management. Most importantly, operational management of service delivery must be delegated to individual hospitals and geographically defined groupings of PHC providers, called Contracting Units for PHC (CUPs) in the NHI Bill. Such delegation is necessary to enable facility managers to be responsive to strategic purchasing incentives

Figure 3: Overview of proposed health-financing changes in South Africa and their relationship with UHS goals and intermediate objectives



CUP = contracting unit for primary health care; HR = human resources; OOP = out-of-pocket; PHC = primary health care; STG = Standard Treatment Guidelines.

and population needs, and to be held accountable for performance.[11] This will in turn require a realignment of service delivery management functions in provincial health departments towards an increased emphasis on oversight and support functions. There will be an ongoing need for National Department of Health (NDoH) involvement in ensuring an adequate supply of health service infrastructure and human resources.

How will the NHI reforms promote UHS?

This section elaborates on the proposed changes outlined in the previous section through exploring how they can contribute to achieving the intermediary objectives and goals of a UHS. Explored in the next section are some of the key concerns raised in the media and public debates, particularly the pace of change; affordability and sustainability; and governance issues.

Promoting efficiency

The proposed changes will promote administrative and service delivery efficiency in the following ways:

- Using the existing tax system will minimise revenue collection costs.
- International experience demonstrates very low administration costs where a single institution purchases services for the population (e.g. 3.6% of total health expenditure in the South Korean NHI and 1.2% in Thailand's Universal Coverage scheme).[12,13]
- Moving away from fee-for-service payment of private providers and line-item budgets in the public sector, to provider payment mechanisms such as capitation at the PHC level and diagnosis-related groups (DRGs) or other case-based payments at hospitals, will promote efficiency in service delivery.[14]
- Requiring contracted providers to comply with STGs and with formularies or lists of drugs, medical devices and other medical supplies will also contribute to efficient service delivery and improved cost-effectiveness. STGs will cover all interventions, including surgical procedures, in contrast to the current focus in the public health sector on interventions requiring medicine prescription.
- A single, large (monopsony) purchaser will hold considerable power in managing increases in provider payment rates.[11]
- PHC gatekeeping and clear referral pathways will promote service provision at the lowest cost possible.[14]

A potential source of inefficiency could be multiple layers of management and duplication of management responsibilities. This must be avoided by realigning the functions of existing health department structures (national, provincial and district) in line with delegation of service delivery management to hospitals and CUPs and centralisation of purchasing responsibilities within the NHIF.

Promoting equity in resource distribution

Equity in resource distribution will be promoted by:

- Having a single pool of funding for the whole population, with medical schemes only providing complementary cover; this will greatly reduce disparities in funding available to meet health needs across socio-economic groups.[15]
- Allocation of funds for PHC services by the strategic purchaser (NHIF) on a risk-adjusted (i.e. needs-based) capitation basis will promote equity in PHC services across geographical areas.
- Equitable distribution of service providers will be promoted through taking account of providers' location relative to population health needs in that area when contracting providers, and the equitable allocation of financial resources. Expressed differently, if there is an oversupply of providers in a specific area then some providers may not be contracted (called selective contracting), while areas with an undersupply can attract new providers as they will have funds to contract with more providers than are currently located in that area. This must be supported by NDoH actions to ensure an equitable distribution of health facilities and health workers, including regulation of the supply of new private facilities in line with the recommendations of the recent Health Market Inquiry.[5]

Equitable distribution of resources for specialist and inpatient hospital care could be undermined by a case-based payment system, which allocates funds according to use of services rather than need for care. Research has indicated much greater use of hospital services, particularly at the highest referral level, among higher socio-economic groups.[16] While removal of user fees at hospitals will improve access to referral services, the cost of transport to referral facilities will remain an access barrier for poorer groups.[17] Therefore, to promote equity it will be necessary for the UHS to include patient transport to referral facilities as a service benefit, particularly for those living in rural areas.

Promoting transparency and accountability

This is an area where many commentators believe that there are inadequacies in the NHI Bill (see discussion on governance). Nevertheless, certain important UHS design elements will promote transparency and accountability, including:

- Clarity that UHS service users will not be required to make any payment at point of service; this will be a major improvement in transparency about entitlements (i.e. it will prevent informal or 'under-the-counter' payment demands, or balance-billing, by providers).
- Annual reporting by the NHIF to parliament will promote transparency and accountability in the use of resources.
- Delegation of management authority to CUP and hospital level will be accompanied by improved local accountability structures. As delegation is likely to require a change in organisational form for hospitals and CUPs

(e.g. to specialised service delivery units), more effective local accountability structures can be established through associated regulation than exist at present.[18]

Achieving UHS goals

The main way in which financial protection will be enhanced is through the removal of user fees at public hospitals and through having no out-of-pocket payments at point of service use. A potential challenge to financial protection relates to services not funded through the UHS. This will depend on how medical schemes structure their complementary cover packages, such as the extent to which co-payments are required, and the affordability of such cover.

Many of the ways in which service utilisation based on need and quality service provision will be promoted are covered above, particularly in terms of equity in resource distribution. Tax funding of the UHS, rather than via health insurance contributions, means that entitlement to use health services is not directly tied to contributions/payments. Having a single pool of funds will maximise income and risk cross-subsidies, which as indicated in Figure 2, is fundamental to service use in line with need. Strategic purchasing is critical to promote quality health services, particularly through making quality expectations clear in contracts with providers, using provider payment mechanisms that incentivise provision of quality health services, and that monitor service quality and act on poor performance.

Is UHS feasible?

The proposed reforms are in line with recommendations from international organisations for moving towards a UHS, based on detailed review of experience worldwide. For example, the World Health Organization (WHO) notes that: "Three broad principles guide health financing reforms to accelerate progress towards universal health coverage. The first is to move towards a predominant reliance on compulsory (i.e. public) funding sources. The second is to reduce fragmentation in pooling to enhance the redistributional capacity of these prepaid funds. The third is to move towards strategic purchasing, which seeks to align funding and incentives with promised health services."[11] Nevertheless, many media reports question the feasibility of the reforms. In this section, three areas of concern most frequently raised in media reports are briefly considered: the pace of change; affordability and sustainability of the reforms; and governance issues.

Pace of change and phased implementation

There is concern that the NHI Bill implies full implementation by 2026. Reforms of the magnitude envisaged must be phased in gradually and sequenced appropriately, particularly within the current context of serious macro-economic and fiscal challenges. While explicit timelines can be helpful in maintaining momentum and engendering a sense of urgency, they should be linked to detailed implementation plans; however, it is inappropriate to include these plans in legislation such as the NHI Bill. In the absence of an implementation plan in the public domain, suggestions and questions are presented in this section around the phasing and pace of implementation.

A critical first step, which could be implemented alongside piloting key reform elements, is to develop an integrated information system to ensure all data necessary for strategic purchasing are available before wide-scale UHS reforms are implemented.[11]

While there were some achievements on the NHI Green and White Paper 'first phase' and associated 'NHI pilot district' initiative, these did not focus on piloting the core components of financing and service management arrangements that are critical for progressing towards a UHS. Therefore, it would be advisable to pilot some of the proposed reforms to 'learn by doing' through careful monitoring and evaluation of pilots, particularly in terms of delegation of management authority to hospitals and CUPs along with appropriate governance and accountability mechanisms, and initiating strategic purchasing.

Delegation of management authority to public hospitals must be phased in gradually to develop adequate management capacity within each hospital. Delegating all management responsibilities to individual PHC

Box 1: What are CUPs?

A CUP is envisaged as a grouping of PHC providers within a defined geographical area, including all public clinics and/or community health centres and the ward-based outreach teams (WBOTs) in that area. As first-level referral hospitals are an integral part of comprehensive, integrated PHC services, each CUP should ideally include a district hospital. CUPs can also include private PHC providers where this will promote access to comprehensive, quality PHC services for all in the area. The concept of a CUP is likely to function best at what is currently the sub-district level; districts are too large to allow truly decentralised and cooperative management. Thailand has successfully used CUPs in its universal system.[13]

facilities such as clinics would result in unsustainably high management costs. It is within this context that the NHI White Paper and Bill have proposed CUPs (Box 1).

The Minister of Health has appointed an expert in public sector change management to design and develop the organisational structure for the NHIF. While it will take time to establish the NHIF as an autonomous entity, it is anticipated that the core capacity for strategic purchasing will begin to be assembled in the near future, possibly as a 'NHIF Office' within the NDoH.

A key question is how to phase in the NHIF's strategic purchasing function. It is evident that Treasury's preference is to contract out services to private providers to plug perceived holes in current service delivery, and to designate almost all 'NHI grant' funding for this purpose. Treasury officials have indicated that priorities in this respect are:

- Contracting private GPs to see patients in their own practices;
- Expanding the Central Chronic Medicines Dispensing and Distribution (CCMDD) programme through private pharmacies;
- Contracting (presumably with private hospitals and specialists) to address backlogs in cataract surgery, cancer care and other high-priority areas; and
- Creating a mixed public and private platform for maternity and obstetric services.

Emphasis on private-sector contracting in use of NHI funding was also pointed to in the recently released Medium Term Budget Policy Statement (MTBPS), which stated that "given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable" and that instead "National Treasury assisted the Department of Health to develop an actuarial model with updated fiscal costs and *limited policy reforms* to strengthen the current healthcare system" (author's emphasis).[19] This implies a change in implementation emphasis from that outlined in the Green and White Papers. The MTBPS also indicates that the NDoH has been required to "reprioritise funds *within its 2019/20 budget* to establish an NHI Office" (author's emphasis).[19] The only reference to *additional* funds for the health sector is that "Provinces will receive a direct grant to *contract* health professionals" (author's emphasis) and that "from 2021/22 new components will be added to the [conditional] grant for mental health and oncology".[19]

This approach raises several questions and concerns about how implementation of the reforms will be phased in. While there is no question about the severity of the macro-economic and fiscal constraints faced at present, a key question is whether the way forward is the "limited policy reforms" referred to in the MTBPS, contracting out some services to private providers, or whether it is better to proceed with the trajectory envisaged in the White Paper, but at a far more gradual pace and over a longer timeframe. One of the concerns about Treasury's preferred approach is that it is somewhat 'piecemeal' and could detract from integrated, comprehensive service provision, creating vertical programmes and entrenching separation of public and private sector provision. A related concern is that the efficiency gains of strategic purchasing are very unlikely to be achieved by contracting out a few services to private providers via direct grants to provinces rather than through building the strategic purchasing capacity of the NHIF.

An important element of the proposed reforms is to be able to draw on the human resources in the private health sector to assist in meeting the needs of the entire population. Given the importance of improving access to quality PHC services (see later section on affordability), the emphasis should be on drawing on private primary care providers such as GPs for services requiring a doctor, pharmacists for dispensing of medicines, and on providing access to dental, optometry, physiotherapy, mental health and other services. While this is to some extent in line with Treasury's priorities, to promote integrated provision of comprehensive PHC services it would be ideal for these providers to be part of the local CUP. In this way, the NHIF would purchase services from the CUP, which would include all relevant public and private providers, with co-operative governance and shared responsibility for ensuring access to quality PHC to the population in that area. This would also enable peer clinical and operational support across providers. It is unclear how contracting out services to GPs and pharmacists as proposed by Treasury would promote an integrated public and private delivery platform.

It is also important to recognise that the public health sector is the largest provider of services at present and will remain the backbone of the future service delivery system. Public sector services are under severe financial pressure, most evident in the many frozen posts in public health facilities. In addition, there has been limited implementation of the WBOTs in some areas due to funding constraints.[20] In this context, it may be prudent to prioritise purchasing from public providers, and at payment rates that ensure adequate resourcing to achieve the MTBPS's vision of "strengthening the current healthcare system".

As the NHIF's primary role would be to purchase comprehensive services for the entire population, it would surely be preferable to pilot its strategic purchasing function through purchasing comprehensive services from the outset, such as from the pilot delegated management hospitals and newly established CUPs. One of the priority uses of NHI allocations from Treasury should be to establish a well-capacitated NHIF Office and ensure that services purchased from pilot hospitals and CUPs (which could include private PHC providers) are adequately funded. NHIF staffing can be expanded over time as the number of contracted providers increases.

As the macro-economic and fiscal context gradually improves, more CUPs can be established and management authority delegated to more public hospitals, with simultaneous expansion of the NHIF's role in strategically purchasing from each of these hospitals and CUPs. The pace of expansion would be influenced by funding availability.

Once the NHIF is purchasing health services in all geographical areas and for the entire population, medical schemes will be expected to transition to provision of complementary cover. For this to happen, there must be confidence in the UHS, particularly that quality health services are accessible to all when needed. This can be achieved by piloting major reforms; gradual expansion of these reforms along with improved resourcing for public providers; and drawing on private providers to ensure accessible comprehensive services. Given the apparent divergence of perspectives on what reforms should be prioritised for implementation, there is an urgent need for open engagement on how best to sequence and phase in reforms to move towards a UHS efficiently and equitably.

Affordability and sustainability of a UHS

A frequent claim in media reports is that a UHS will be unaffordable. This is largely based on a fundamental misunderstanding of the nature of the proposed reforms, particularly the misconception that medical scheme coverage will be expanded to all South Africans. Given that over R200 billion is spent currently on less than 16% of the population who are currently medical scheme beneficiaries, this would indeed be an unaffordable reform pathway. Even if some 'savings' could be achieved through making medical scheme membership mandatory for everyone, it is simply not feasible to spend over a trillion Rand on health care in South Africa.

The Competition Commission's Health Market Inquiry highlights a range of factors contributing to affordability problems in the 'medical scheme and current private provision model'.[5] To ensure affordability of a UHS, it is essential to explicitly move away from this model, which focuses on curative care; allows direct access to specialists even though most health services could be provided by PHC providers; pays providers on a fee-for-service basis; and is plagued by uncontained increases in provider fees and supplier-induced demand related to over-supply.[5]

International experience, particularly in middle-income countries, indicates that an affordable and sustainable UHS is feasible if the following approach is adopted:

- There must be a strong focus on preventive and promotive services, with Community Health Workers (CHWs) being a key element in the PHC team in this regard.[13] This is particularly important in limiting the increasing incidence of non-communicable diseases in South Africa, as this could pose a long-term sustainability challenge to a UHS.
- There will also need to be a strong focus on primary care services, with strict PHC gatekeeping and adherence to referral pathways. This is essential to ensure that health services are accessed at the appropriate and lowest cost level at which effective interventions can be provided.[14] Further, within PHC facilities, services should be provided by the least skilled health worker capable of providing that service.
- An extensive set of STGs covering the full range of health interventions, medicine formularies or essential drug lists (EDLs) and medical device lists must be developed. Public and private providers contracted by the NHIF must be required to comply with these STGs and lists. This will ensure that the most cost-effective interventions are delivered. New technologies should only be made available after cost-effectiveness and budget-impact assessments have been done.
- The change in provider payment mechanisms outlined in an earlier section will contain costs more effectively than the predominantly fee-for-service payment system currently used in the private sector.
- As a single/monopsony purchaser, the NHIF will have strong negotiating power in establishing and maintaining affordable provider payment rates.
- Selective contracting in geographical areas with an over-supply will limit the potential for supplier-induced demand.

There are also frequent demands to know exactly how much a UHS will cost. It will cost what we can afford in terms of how much funding is available as there will be a global budget cap on the NHIF.[14] The NHIF will be funded through annual allocations from Treasury, and the NHIF as a strategic purchaser will have to operate within the constraints of that pool of funds. This funding limit will influence the pace of transition to a UHS and will ensure its affordability and long-term sustainability. It is critical to recognise that the UHS reforms do not imply 'writing a blank cheque'. The emphasis in costing should be on obtaining accurate cost data for each new phase of roll-out to allow careful budget impact analysis before implementation.

An issue that requires clarification in the NHI Bill is how the activities of the Benefits Advisory Committee (BAC) and the Health Care Benefits Pricing Committee (HCBPC) will intersect, and the involvement of the NHIF in these committees. If they operate in isolation from each other and from the NHIF, this is likely to create unfunded mandates and make the UHS unaffordable and unsustainable. Indeed, the role of the HCBPC requires clarification as it could undermine the NHIF in exercising its purchasing power.

A final issue in relation to affordability is the concern that increased tax funding for the UHS will unduly burden personal income taxpayers. At present, many personal income taxpayers belong to medical schemes and are faced with contributions that account for a relatively high percentage of their income[a,21] and that have increased annually at rates far exceeding inflation for several decades. As the UHS is rolled out and medical schemes move to

a The most recent estimates are that medical scheme contributions range from 15.8% of income before tax credits (and 9.2% after tax credits) for the lowest income medical scheme members to 5.5% before and 4.7% after tax credits for the highest income scheme members. This also indicates that scheme contributions are regressive across scheme members from different socio-economic groups.

providing complementary cover (Box 2), increased personal income tax payments for the UHS will be less than current medical scheme contributions for the majority of current scheme members.

Governance issues

There is an understandable lack of trust in government and legitimate governance concerns given the last decade of extensive misuse of public funds and weak governance. But this should not prevent efforts to make substantial progress towards fulfilling the Constitutional commitment that "everyone has the right to have access to health care services".[22]

Instead, the focus should be on how to ensure good governance. There will hopefully be many submissions to the Parliamentary Portfolio Committee on Health with valuable suggestions on how the process of appointing the NHIF CEO, and appointments to NHIF governance bodies and related committees, can be done in a transparent and accountable way. Similarly, there are likely to be many submissions on how proposed governance structures can be broadened to ensure the inclusion of a range of health sector actors, particularly civil society groups that have played a critical role in exposing corruption and insisting on accountability. However, international experience has found that having representation of specific interest groups has made oversight and governance structures "incapable of making hard choices or serving as an adequate and timely forum for decision-making". International experience also indicates that rather than securing the interests of specific economic groups, representation should incorporate a range of social actors, increase transparency, and involve technical experts.[23] The emphasis should be on individuals whose interest is serving the public good. Internationally, there is growing emphasis on governance "being grounded in citizen/population representation".[11]

Transparency and accountability can also be promoted through annual public reports that are accessible to the public. The reports should not only indicate how public funds have been used but also the NHIF's performance in expanding access to quality health services in line with the

Box 2: Role of medical schemes/private health insurance in a universal health system in South Africa

There has also been debate about the most appropriate future role for private health insurance (PHI), i.e. medical schemes in South Africa. At present, PHI in this country is completely out of line with the rest of the world. The WHO's Global Health Expenditure Database[a] indicates that PHI as a share of total current spending on health is higher in South Africa (47%) than in any other country in the world. Globally, the share of total health spending on PHI averages at a mere 4% and it accounts for more than 20% of health spending in only six countries and for more than 10% in only 25 countries. The PHI share of financial resources for health in South Africa is particularly disproportionate given that less than 16% of the population benefit from these resources.

This not only creates substantial disparities in financial resources for health across socio-economic groups but also impacts on the functioning of the overall health system. For example, it promotes a maldistribution of health professionals, with far higher health professional to population ratios for those covered by PHI than for those who are not members of PHI, drawing healthcare resources away from those who need them most. International experience[15] highlights other challenges where PHI does not focus on complementary cover, such as: higher incomes for health professionals serving PHI members, which creates constant upward pressure on overall health expenditure; preferential treatment for PHI members (e.g. going to the head of the queue, receiving longer consultations, etc.); and wastage of capacity and resources trying (generally unsuccessfully) to regulate PHI and providers effectively. It also fragments risk in the overall health system, which is difficult and costly to address successfully via risk-equalisation or risk-adjustment mechanisms.

As indicated earlier, the medical scheme model is not an affordable basis for a UHS in South Africa and it is, therefore, not an option to make scheme membership mandatory. Complementary PHI would 'right-size' the relative share of total health expenditure on PHI, bringing South Africa in line with the international norm. It also avoids the adverse impacts on the overall health system outlined above; it is in line with the fundamental principle of UHS, namely social solidarity and maximal income and risk cross-subsidies; and it is more effective in promoting efficiency, affordability and equity in the overall health system.

a https://apps.who.int/nha/database

healthcare needs of the population. While it is inappropriate to specify the indicators and other information to include in such reports within the NHI Bill, these details should be specified in regulations.

Finally, governance and accountability structures should not only be seen to be important at the level of the NHIF, but also at the service-delivery and management levels. The delegation of management authority to individual hospitals and CUPs must be accompanied by appropriate mechanisms to promote good governance and accountability to local communities. If managers of hospitals and CUPs are to meet the priority health needs of their communities through provision of quality services, then inputs from the community are required.

Conclusion

Some stakeholders criticise the NHI Bill for not reflecting or taking account of their inputs on the Green and White Papers, which were the forerunners to the Bill. In reviewing submissions on these Papers, policy-makers will have had to assess carefully whether each input was in line with the ultimate goal of the reforms, namely to move to a UHS. If aspects of the NHI policy were opposed or criticised, but either no alternative was suggested, or the alternative suggested would detract from progressing towards a UHS, it is unclear how these inputs could have been accommodated.

It must be recognised that many of the criticisms of the proposed reforms are coming from the perspective of seeking to protect vested interests or a privileged position and are generally at odds with the principle of social solidarity that underpins a UHS.

The health system status quo is not acceptable; 25 years since our first democratic elections, very little has changed for the worst-off in our society. Indeed, inequalities in income and across many sectors have increased. Taking explicit policy steps to move toward a UHS will not only improve access to quality health care for all but will contribute to the redistributive agenda of the country.

There are undoubtedly ways in which the NHI Bill can and must be improved. However, the policy approach explained in this chapter is fundamentally in line with international experience on how to progress to a UHS as speedily as possible. Instead of trying to prevent progress to a UHS, if those criticising the NHI Bill truly believe that the underlying policy approach is incorrect, the onus is on them to provide detailed proposals for systemic change and demonstrate how it will achieve a truly UHS. The focus of the public conversation should be firmly placed on how best to achieve a UHS.

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