



What are South Africa's universal health coverage alternatives?

26 May 2021

Prof (adj) Alex van den Heever
Chair, Social Security Systems Administration
and Management Studies
Wits School of Governance



NATIONAL HEALTH INSURANCE BILL REVIEW

Expert review of the National Health Insurance bill submitted by the Minister of Health to Parliament in 2019 for submission to Parliament as a response to the request for public comment

https://www.researchgate.net/publication/338717425_NATIONAL_HEALTH_INSURANCE_BILL_REVIEW

Health Policy 120 (2016) 1420–1428



Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol



South Africa's universal health coverage reforms in the post-apartheid period



Alexander Marius van den Heever*

Holds the Chair of Social Security Policy Management and Administration, Wits School of Governance, University of the Witwatersrand, Johannesburg, South Africa

https://www.researchgate.net/publication/303829601_South_Africa's_Universal_Health_Coverage_Reforms_in_the_Post-Apartheid_Period



HEALTH MARKET INQUIRY

FINAL FINDINGS AND RECOMMENDATIONS REPORT

September 2019

<http://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf>

What is our context?



Our public sector



Our private sector



TWO SIDES OF THE SAME COIN?

Five to ten year scenario?



Public sector

Institutionalised corruption resulting in a failure of efficient quality care provision – particularly for major medical services and hospital-related services which continue to decline relative to the population in need

Fiscal pressures result in budget growth below the growth in the catchment population

Medical scheme system

Systemic de-insurance continues, resulting in the failure of financial risk protection for poor risks (pensioners and people with pre-existing conditions) and the exit of private hospital beds and the elimination of lifetime insurance coverage

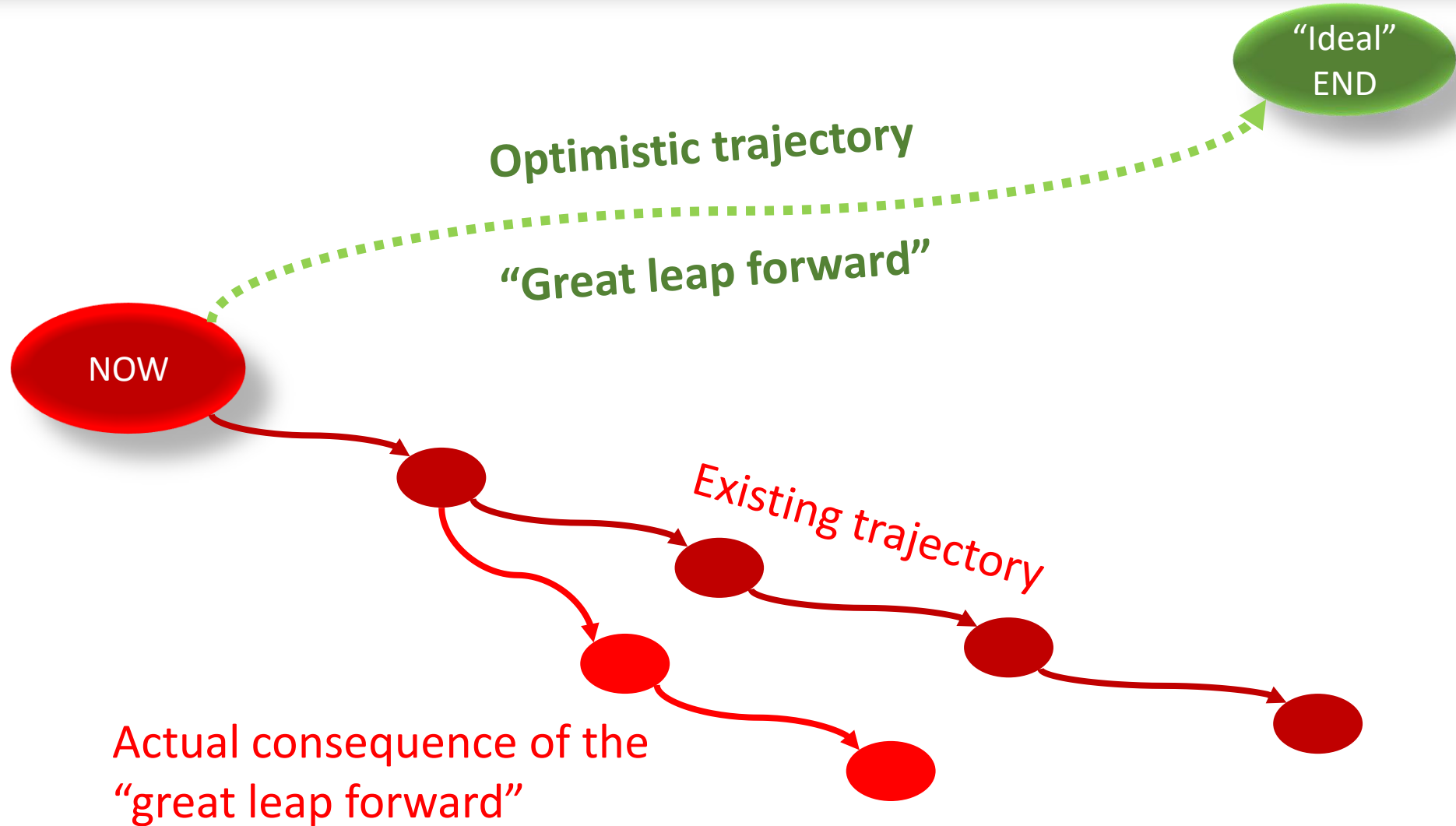
Poor risks for catastrophic health care needs shift to the state



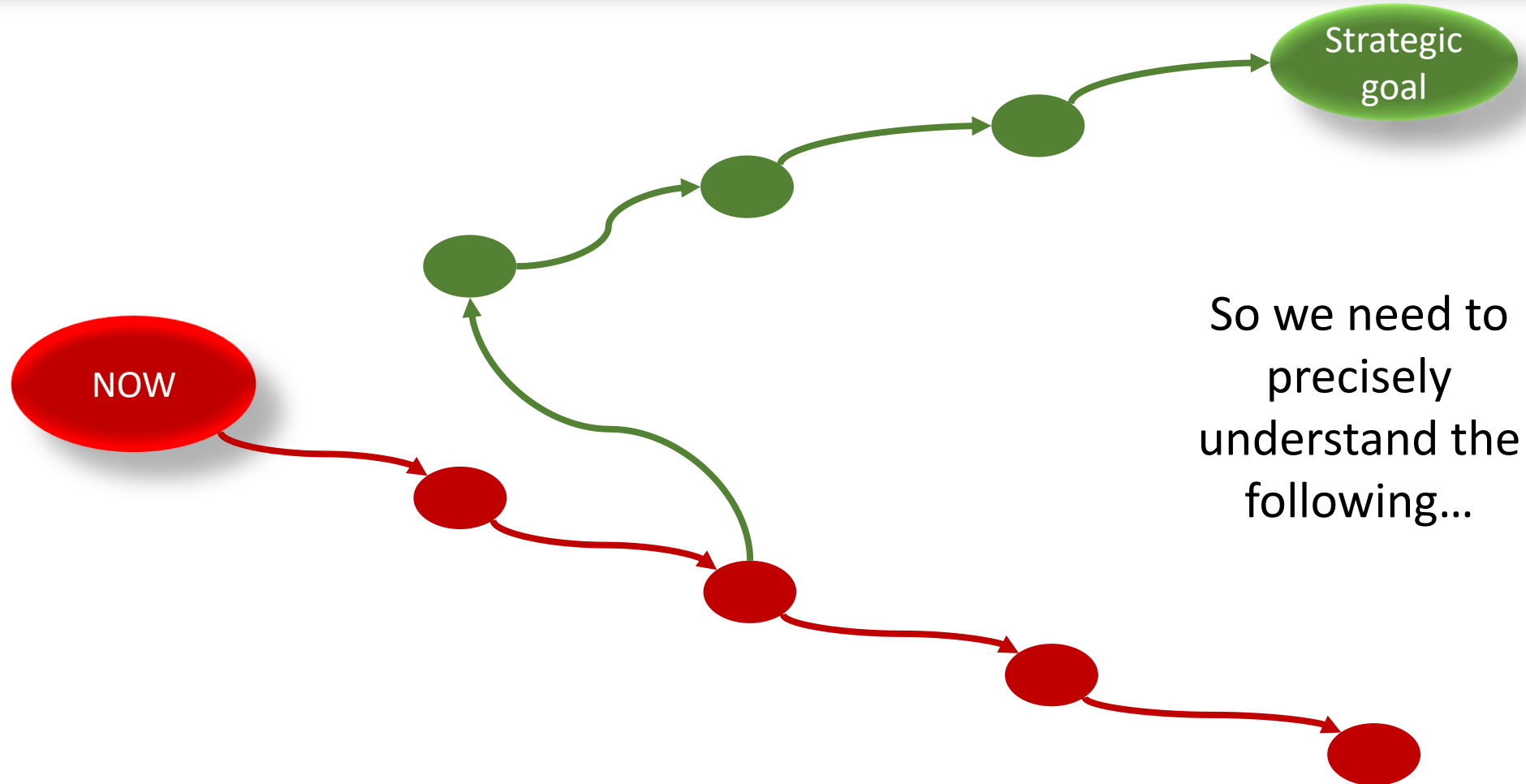
Out-of-pocket market for primary care continues to expand



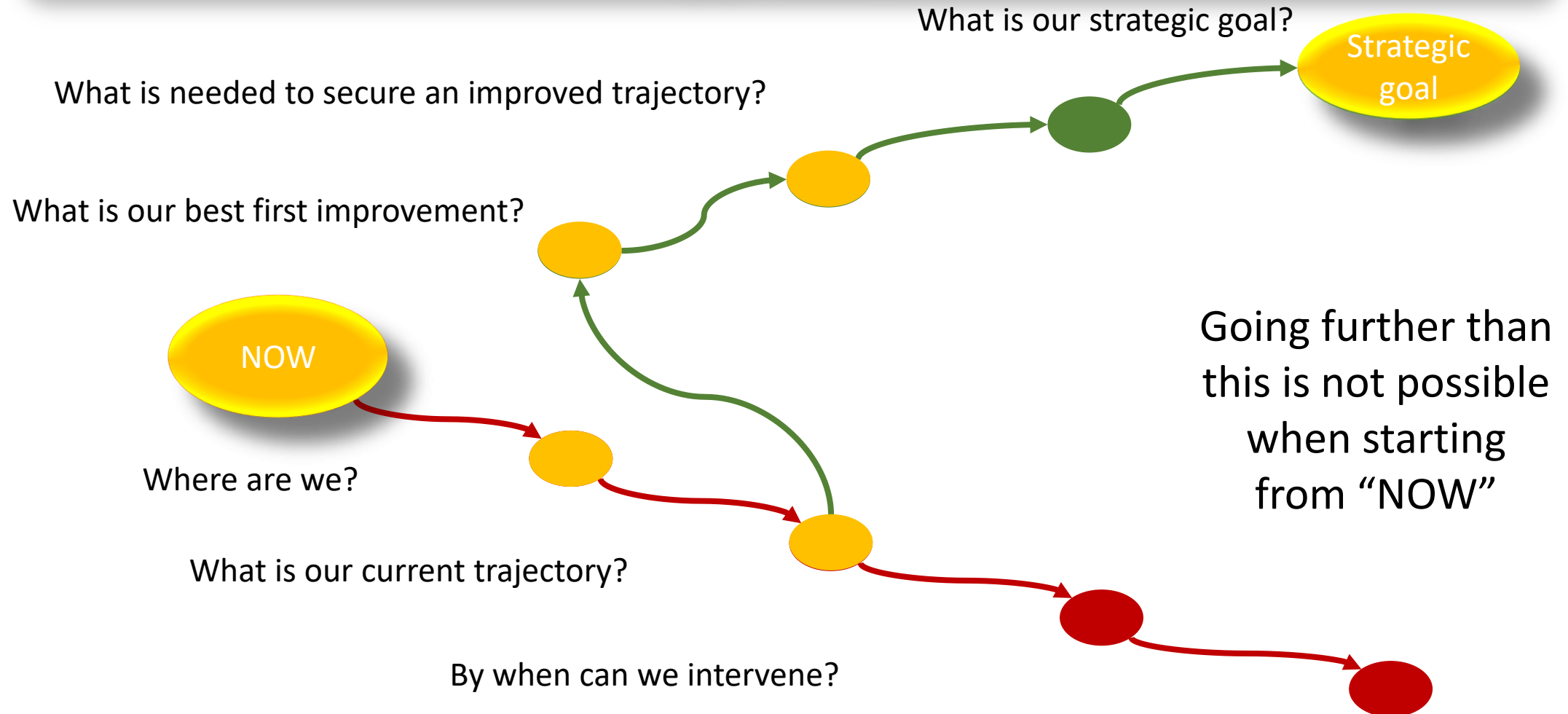
How should we conceptualise a strategic approach?



How should we conceptualise a realisable strategic approach?



How should we conceptualise a realisable strategic approach?



Weaknesses with the current NHI proposals?



- Over-optimistic about the achievability of the ideal end-point
- Misdiagnoses of systemic weaknesses in the health system
- Capability weaknesses in the state to take forward even achievable strategies (largely due to institutionalised patronage that has destroyed the integrity of state structures)
- Retention of unaccountable patronage-based governance approaches for all proposed organisations and regulatory frameworks
- Institutional approaches that involve destroying existing coverage approaches before new ones can be tested and implemented
- Fiscally impossible proposals
- Constitutional challenges likely on financing, role of the provinces, tax credits and existing entitlements (all of which are likely to be successful)

What are the risks associated with alternative reform approaches?



- Government presently lacks the capability to take forward any reform framework –

Even correct approaches...

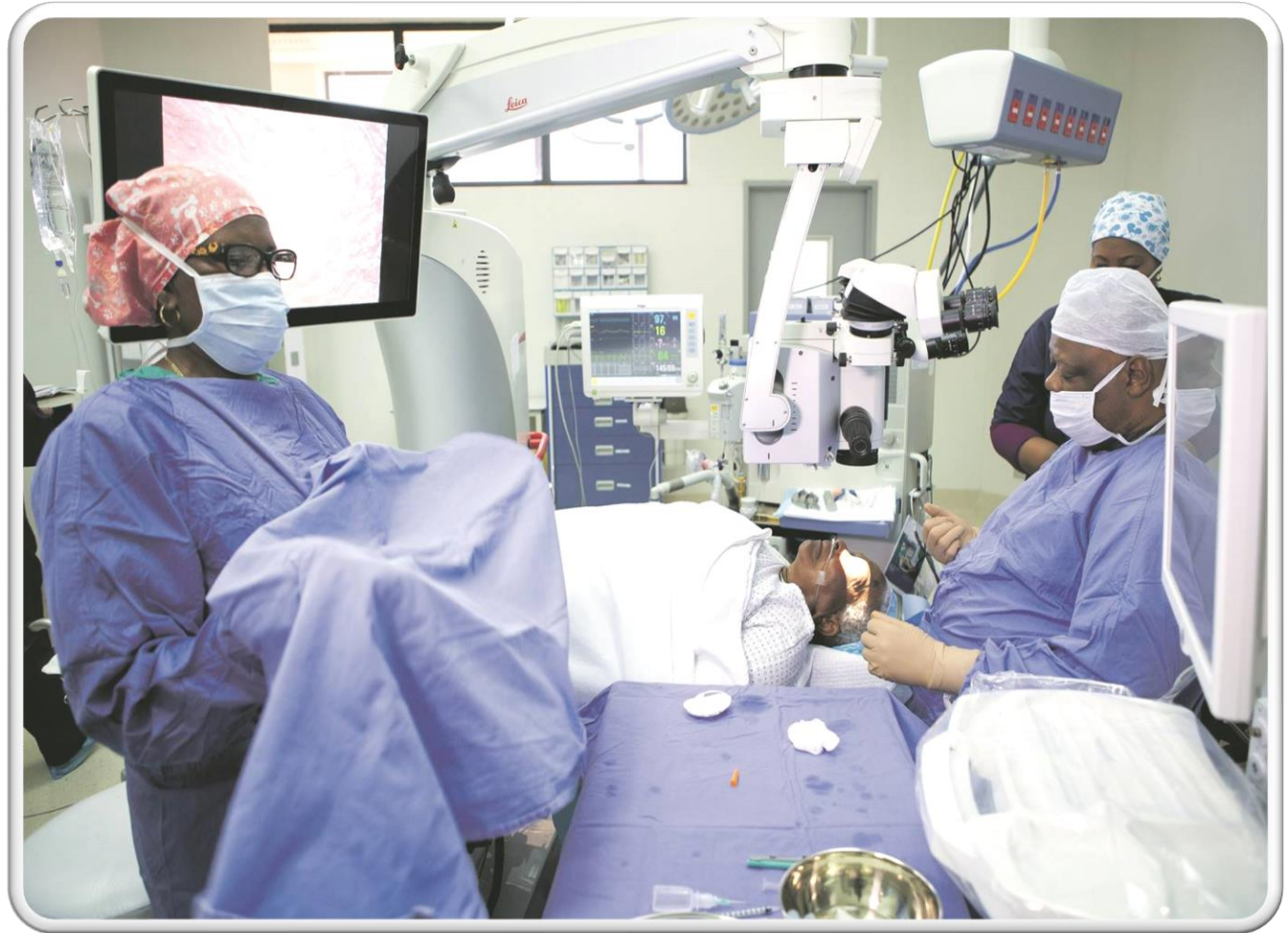
The existing proposals are a proxy indicator of a general capability weakness



What are the hard realities?

- The **fiscal position of government** does not allow for the consolidation of the health system under one general tax-funded scheme in any of our lifetimes
- The public sector is too **infused with patronage** to coherently reform for the foreseeable future
- The private sector is likely to shrink – **increasing the levels of over-capacity on the private provider side** of the system
- Private assets are however **more likely to exit the system** than to be used/absorbed by the public system
- The public system will **decrease in availability** as demand increases without additional resources

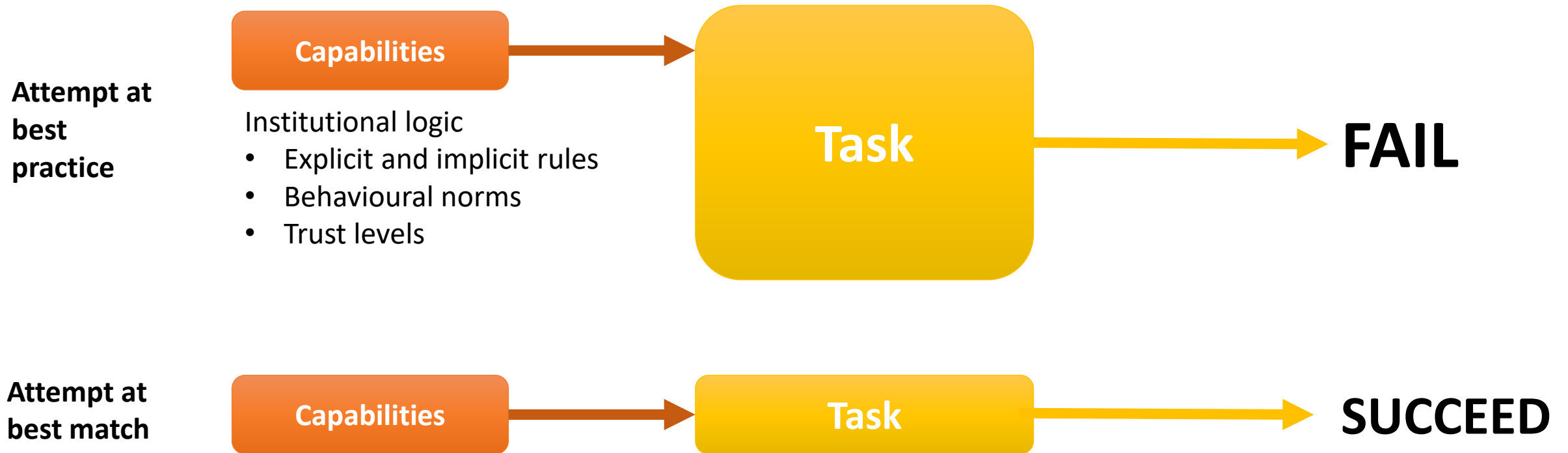
How should
we think about
the problem?



Policy choice – “best practices” versus “best matches”



Best practices may be *context-specific* and involve *capability requirements that are not present* locally



Requires considerable understanding of the local context and possible solutions

How do we understand the problem?



Public sector

Resource allocation (not pooling)

Multi-level government financing (system of conditional grants required to institutionalise national priorities)

Governance of provincial administrations (elimination of political appointments and the establishment of a permanent public administration)

Institutional architecture

- Functions to be centralised
- Functions to be decentralised

Accountability to users

Private sector

Pooling

- Income transfers (vertical transfers)
- Risk (horizontal transfers)
 - Prospective
 - Retrospective

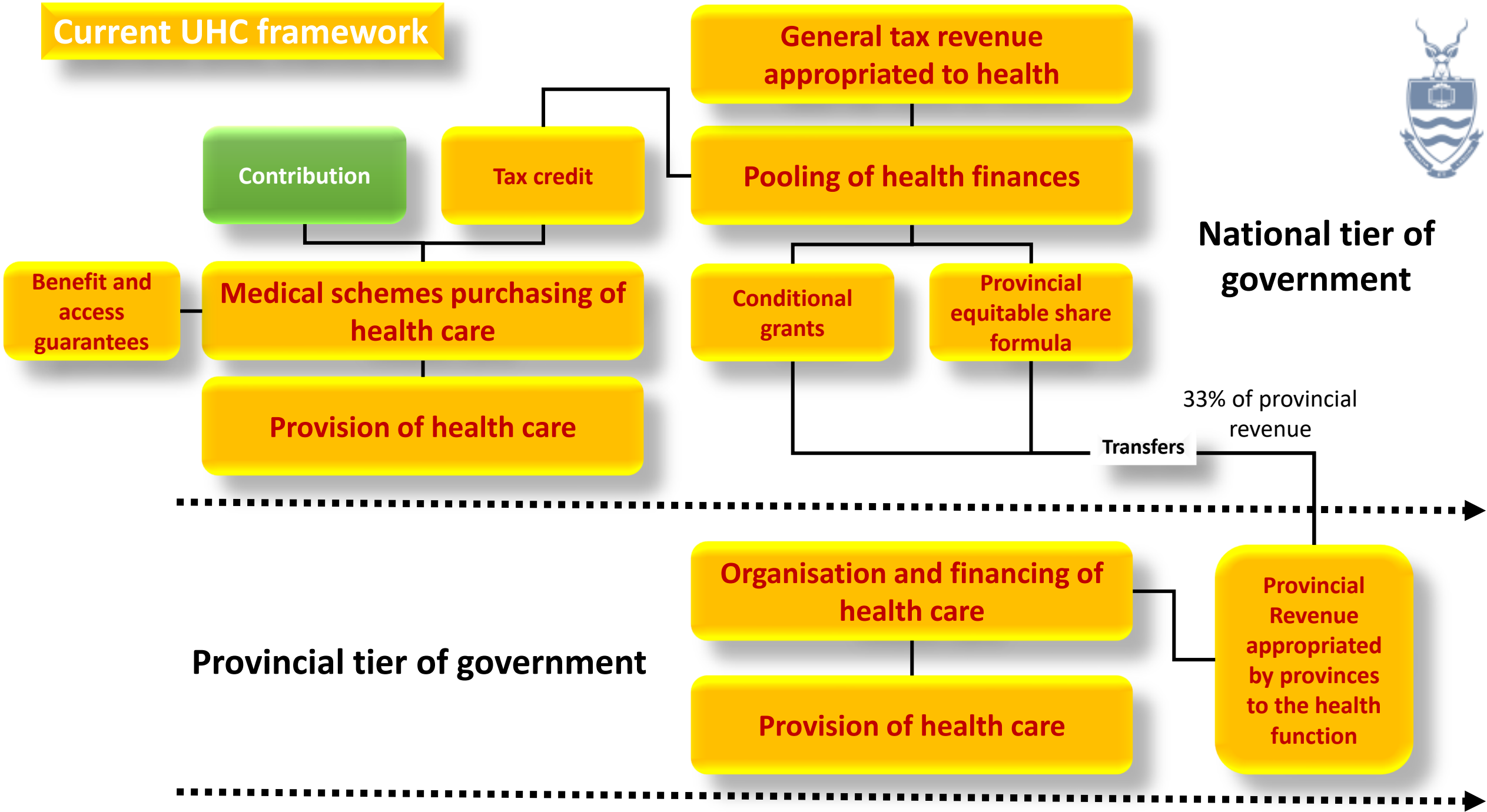
Transparency of choice for users

- Funder level
- Provider level

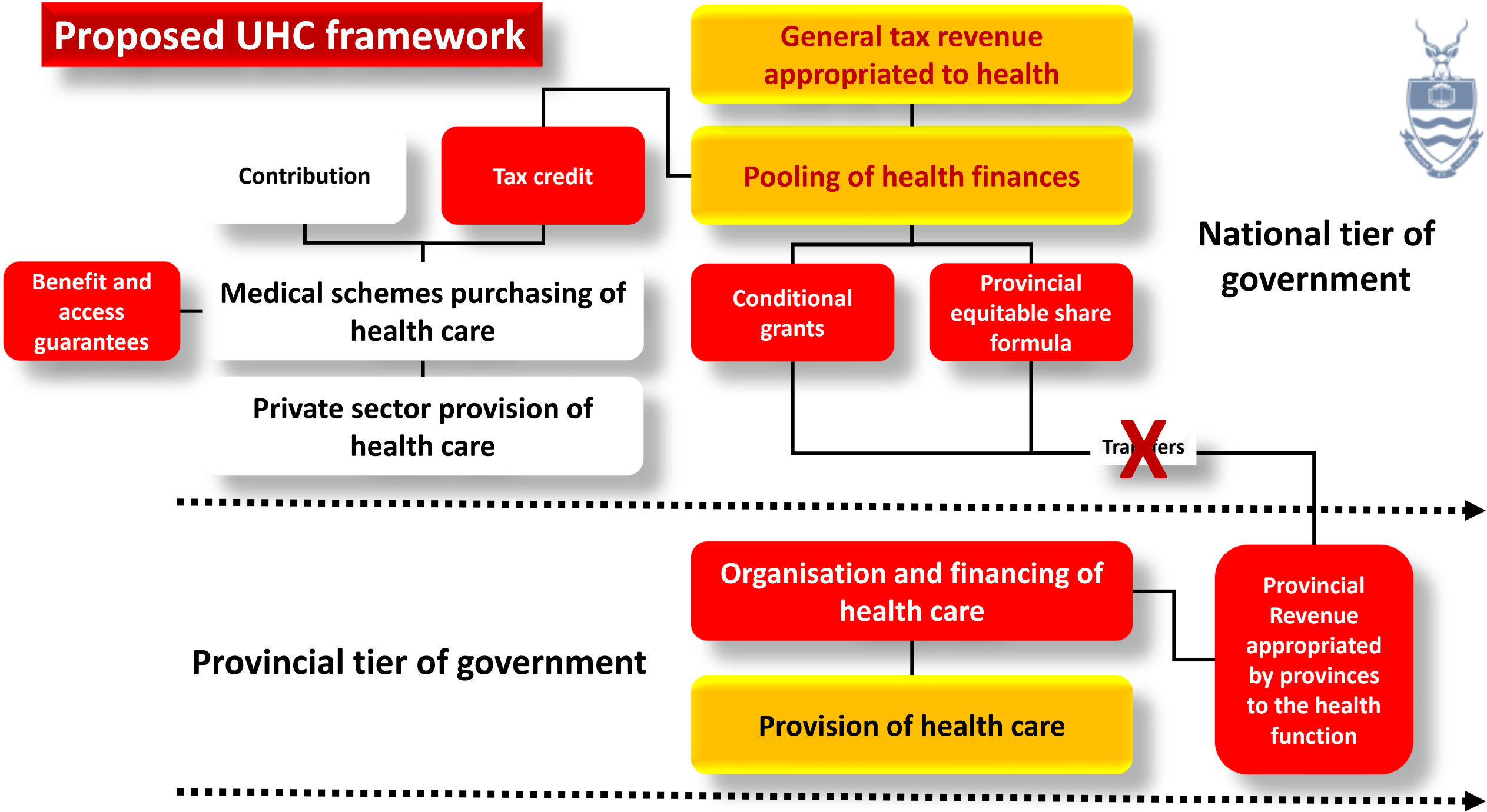
Governance of the institutional framework (regulators)

Governance of the private actors (accountability to users and the general public)

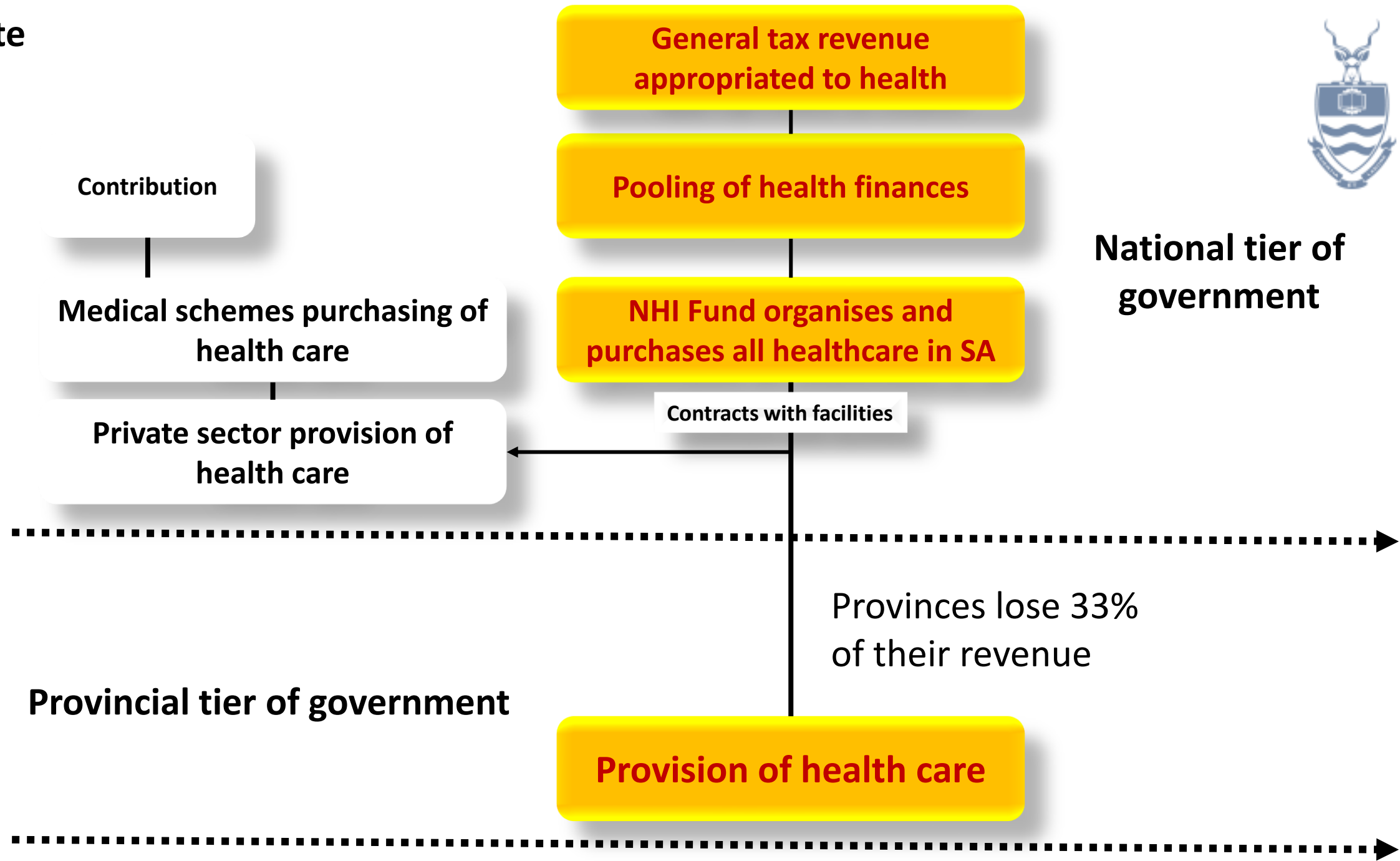
Current UHC framework



Proposed UHC framework



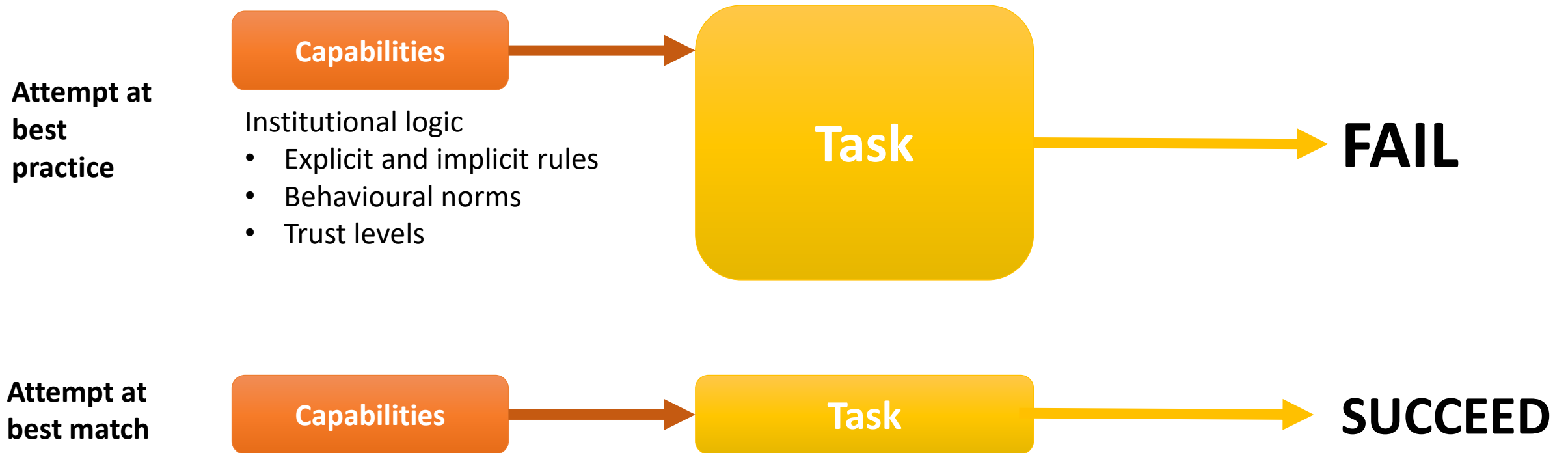
Ultimate



Policy choice – “best practices” versus “best matches”

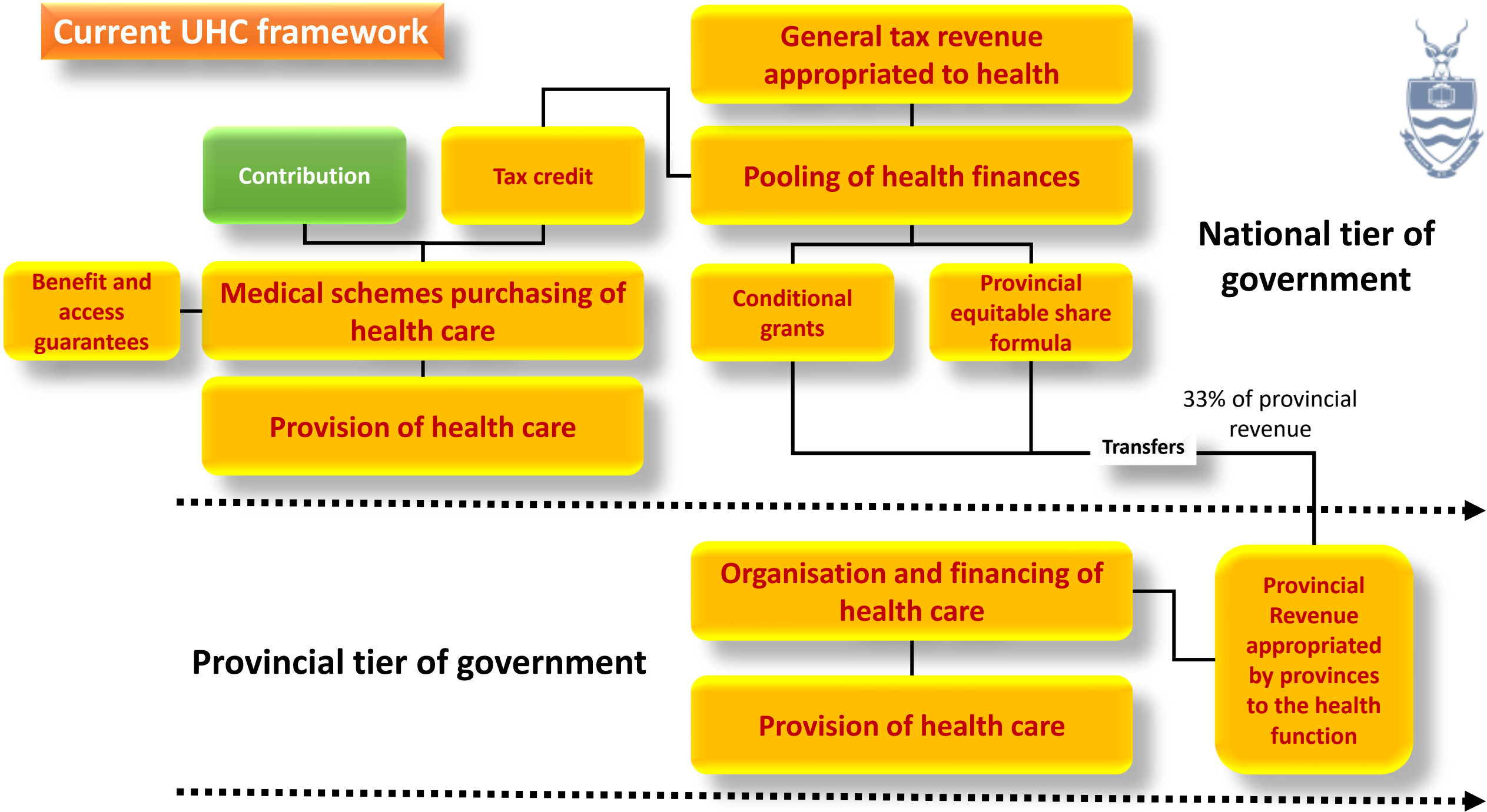


Best practices may be *context-specific* and involve *capability requirements that are not present* locally

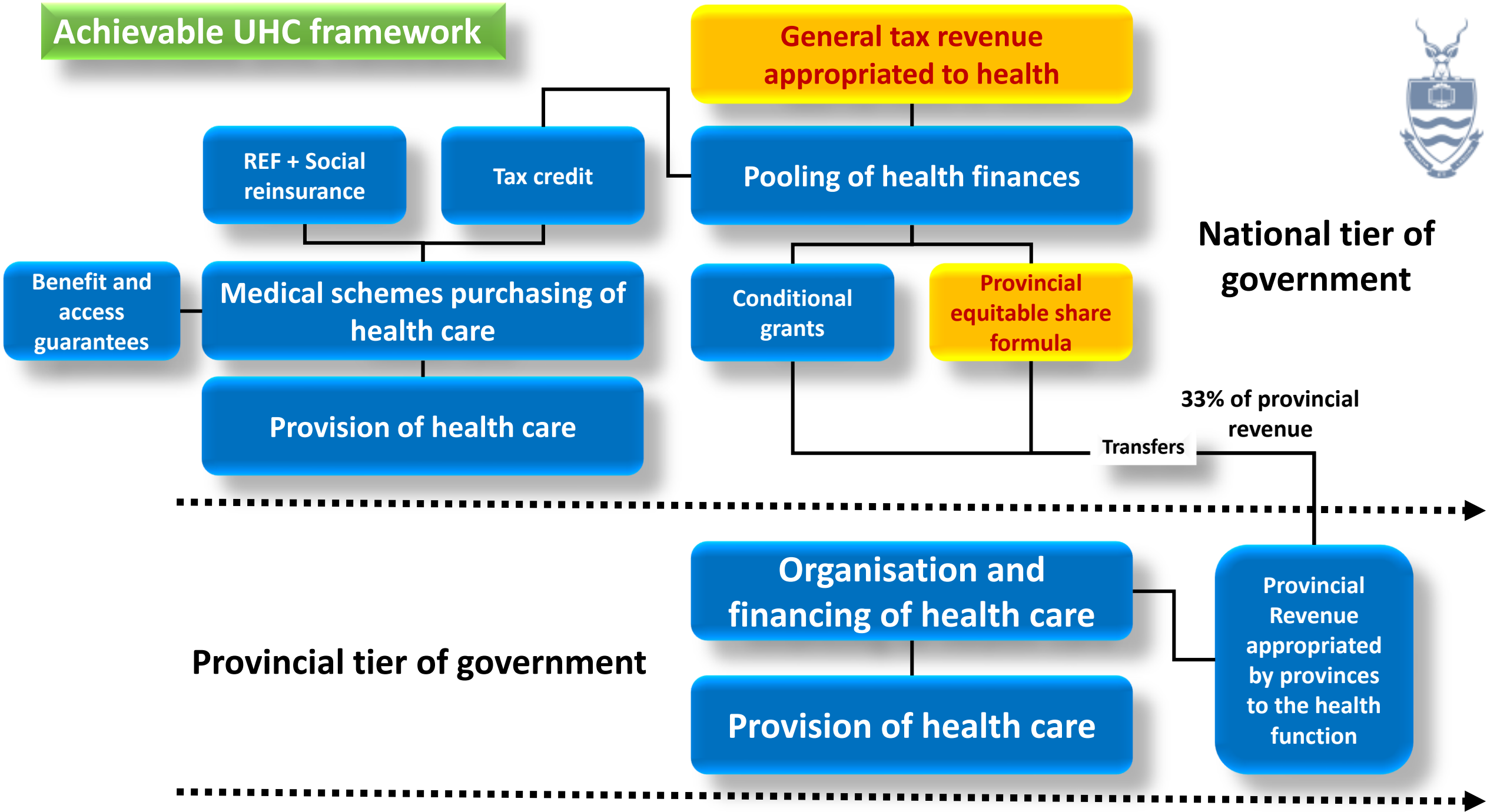


Requires considerable understanding of the local context and possible solutions

Current UHC framework



Achievable UHC framework



Non-contributory regime

Contributory regime

Revenue source

General tax revenue

SHI contributions

Medical scheme contributions

Pooling

Universal (available to all) unconditional subsidy

Moves with individual depending upon which system they choose

Conditional risk-adjusted transfers made to provinces consistent with policy regarding the required package

Net payments in respect of risk-adjusted income-based transfers are made via the pooling system for contributory schemes

Risk equalisation and social reinsurance financed by medical schemes and the unconditional subsidy and tied to the cost of a basic package

Transfer based on the cost of an emergency insurance package

Purchasing

Provincial health administrations

SHI scheme

Medical schemes

Pooling, direct and indirect purchasing

National emergency insurance scheme (dedicated universal package)

All funders able to establish network contracts with both public and private providers

Provision

Public providers

Private providers

Framework based on recommendations from the following official processes

- NHI Committee
- Taylor Committee
- International review panel on risk equalisation
- Ministerial task team
- Interdepartmental Task Team on Social Security
- Health Market Inquiry

Includes a publicly sponsored open medical scheme separate from the SHI fund

Medical schemes and the SHI must reinsure for emergency cover through the fund while remaining liable for the benefit and excess costs

All major public providers made fully autonomous and subject to a coherent regulatory regime

- District Health System
- Public Hospitals



Thank you