


Research Articles

Universal health coverage financing in South Africa: wishes vs reality

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Background

In 2011, the South African health minister, proposed a national health insurance (NHI) for South Africa with the aim to deliver universal health access and care to all South African residential citizens, with a single fund to cover all people, no matter their income. The first five years were reached at the end of year 2017-2018. In order to achieve universal health coverage (UHC), primary health care (PHC) re-engineering and NHI have been chosen as key strategic interventions to be implemented. These reforms are currently being piloted in 11 selected districts in South Africa since 2011.

Methods

The purpose of this paper is to compare and contrast the proposed South African NHI financing reforms (wishes) versus what has been implemented to date (current financing and service delivery reality on the ground) highlighting potential stumbling blocks. A review of both published and grey literature mainly sourced from the departments of health South Africa, statistics South Africa, world health organisation and world bank reports was carried out. Key documents reviewed included the South African national health insurance whitepaper, South African governmental financial reports, health systems trust reviews, mid-term report on universal health coverage and World Bank report on appropriate universal health coverage financing, progress reports on UHC and published research from leading health economists.

Results

Independent medical schemes, people as taxpayers and as consumers, rampant unemployment, lack of trust in public institutions and regressive aspects of value added tax, budgets, fickle political will, corruption, drivers of private health costs, provincialization as opposed to district health authorities, incompetent leadership and a cocktail of epidemics were revealed as potential stumbling blocks.

Conclusions

As international support for UHC grows pace, the issue of how to finance improved financial protection and access to needed health services becomes ever more urgent. Exploring how the proposed South Africa national health insurance UHC financing reforms compare and contrast with the situation on the ground, helps highlight potential stumbling blocks that need addressing as SA moves towards UHC. The paper concludes by calling for innovative, inclusive and sustainable UHC financing and service delivery solutions and the upholding of political will and commitments made, if South Africa is to achieve UHC by 2026.

The introduction of national health insurance (NHI), aimed at achieving universal coverage, is the most important issue currently on the South African health policy agenda.¹ In 2011, the then health minister, Aaron Motsoaledi, proposed a national health insurance for South Africa with the aim to deliver universal health care and access to all South African residential citizens, with a single fund to cover all people no matter their income. NHI is based on the principle of the constitutional right of citizens to have access to quality healthcare services that are delivered equitably, affordably, efficiently, effectively and appropriately based on social solidarity, progressive universalism, equity and health as a public good and a social in-

vestment.² National health insurance aims to transform the financing of healthcare in pursuit of financial risk protection, by eliminating fragmentation, ensuring technical and allocative efficiencies in how funds are collected, pooled and used to purchase services, thus creating a unified health system that will move closer to the goal of UHC and sustainable development goals (SDG) by 2030.^{2,3} The goal is to extend population coverage, improve the quality and quantity of services that the population are entitled to, provide financial risk protection to individuals and households whilst reducing the direct costs that the population are exposed to when accessing healthcare. It also aims to protect individuals and households from out-of-pocket expenses and finan-

cial catastrophe related to healthcare.^{2,4}

CURRENT SOUTH AFRICAN CONTEXT

South Africa's health system is largely inefficient and unequal. Despite certain areas of progress in the country since 1994, disparities in wealth and health are among the widest in the world.⁵ South Africa spends 8.5% of its gross domestic product (GDP) on health care, or around R332 billion in monetary terms; half is spent in the private sector catering for the socio-economic elite. The remaining 84% of the population, who carry a far greater burden of disease, depend on the under-resourced public sector.⁶ Those with the means can access first-world health care through the private sector, while many people who cannot afford this service, are left to rely on governmental hospitals and clinics. The service through government institutions is largely unreliable and fails to offer adequate specialist services.⁷ The intent of the reform is also to integrate the existing private schemes into NHI since medical aids are making huge profits and consumers in the private sector too, are not getting fair value for their money.⁸

Powerful historical and social forces, such as vast income inequalities, unemployment, poverty, racial and gender discrimination, the migrant labour system, the destruction of family life and extreme violence characterize South Africa.⁹ In addition, the country is faced with a quadruple burden of diseases, HIV/AIDS, Tuberculosis, high maternal neonatal and child morbidity and mortality, rising burden of non-communicable diseases and high levels of violence and trauma. These diseases negatively impact the poorest groups of the population.¹⁰ Leadership and governance challenges remain prevalent in the various levels of the public sector despite efforts by government to inculcate a culture of good leadership and governance, the knowledge and skills amongst managers is still very inadequate.^{2,6,10} Ongoing assessments of public sector facilities continue to reveal quality problems in the areas of staff attitudes, waiting times, cleanliness, drug stock-outs, infection control, and safety and security of staff and patients, despite efforts that have been made to address these challenges.^{2,11} Only a third of state facilities pass muster, which means a small number of these institutions would be able to provide good quality healthcare at the moment.¹² NHI plans to address such issues and in general increase the health of the population. Healthier people, inevitably live longer, work longer and will no doubt benefit the economy.⁴

Two vehicles that have been selected to achieve UHC are NHI and PHC re-engineering. Healthcare services will be provided through an integrated system involving accredited and contracted public and private providers. The PHC services include health promotion, disease prevention, curative (acute and chronic clinical) services, rehabilitation and palliative services (including social services). PHC Re-engineering will be implemented through four streams namely; municipal ward-based primary health care outreach teams (WBPHCOTs); integrated school health programme; district clinical specialist teams; and contracting-in of private health practitioners at non-specialist level under the leadership of district health management offices (DHMOs). The planned interventions outlined will be undertaken throughout the 14-year phased implementation of NHI (2012-2026).⁴

PLANNED NATIONAL HEALTH INSURANCE FINANCING REFORM

NHI supports changes in service delivery by a series of financing and management changes designed to raise more funds, manage the funds efficiently and effectively, increase pooling and purchasing. It is worth mentioning that the health financing system does not act alone in achieving UHC goals, hence coordinated policy and implementation across health system functions are essential for making progress on the desired objectives, such as improving the quality of care (Box 1).

Box 1. National health insurance reforms aims²

1. To move beyond the existing fragmented public and private health financing systems to create a common modern universal health financing system which is cost-effective, trusted by citizens and provides protection against costly health services
2. To move from voluntary to mandatory pre-payment system
3. To raise additional revenue for healthcare
4. To improve pooling arrangements so as to better spread risk and improve cross-subsidisation
5. To purchase from a mix of public and private providers
6. To use economies of scale and purchasing methods to achieve cost-efficiency
7. To deliver quality services and continual improvements in health outcomes

UHC means that people have access to the health care services that they need without undue financial hardships. UHC is commonly understood to consist of three interrelated components: the population covered, the range of services made available; and the extent of financial protection from the costs of health services.¹³⁻¹⁵ The purpose of this paper is to compare and contrast the proposed South African NHI financing reforms (wishes) versus what has been implemented to date (current financing and service delivery reality on the ground), highlighting potential stumbling blocks on the road to UHC. The paper concludes by calling for innovative, inclusive and sustainable UHC financing solutions and upholding of political will and commitments made if South Africa is to achieve UHC by 2026.

METHODS

The findings presented in this paper are from a review of both published and grey literature mainly sourced from the departments of health South Africa, statistics South Africa, world health organisation and world bank reports. Key documents reviewed included the South African national health insurance whitepaper, South African governmental financial reports health systems trust reviews, mid-term re-

port on universal health coverage and world bank report on appropriate universal health coverage financing, progress reports on UHC and published research from leading health economists.

The world health report 2010, summarizes three broad financing strategies as: "more money for health" (raising more funds); "strength in numbers" (larger pools); and "more health for the money" (improving efficiency and equity in the use of funds through reforms in purchasing and pooling as well as actions not directly related to health financing).¹⁶

We utilized this framework as a guide. Each national health insurance financing proposal mechanism as set out in the whitepaper was analysed in respect to key broad health financing functions namely revenue generation, pooling and purchasing, comparing and contrasting proposed NHI Financial reforms, wishes vs reality, current South African financing and service delivery situation on the ground. Potential stumbling blocks were identified and discussed with evidence from literature bearing in mind that South Africa, like many countries, still faces problems with access to quality health services, cognizant of the fact that financing policy alone cannot address these problems.¹⁶

DISCUSSION

POTENTIAL STUMBLING BLOCKS TO NHI REFORMS

Financing universal health coverage (UHC) is not only about how to generate funds for health services. It is also about how these funds are pooled and used to purchase services¹⁷ hence it is important to consider contextual factors that may limit or enable what can be implemented and achieved in a given country.^{17,18} We will discuss the proposed national health insurance financing reforms point by point and compare the wishes in the white paper vs reality on the ground as well as highlight potential stumbling blocks to achieving them (see **Online Supplementary Document** for a summary table of wishes versus reality of the UHC financing in South Africa).

NHI FINANCIAL REFORM POINT 1: TO MOVE BEYOND THE EXISTING FRAGMENTED PUBLIC AND PRIVATE HEALTH FINANCING SYSTEMS

NHI plans to do the above through among other measures combining the existing medical schemes into the larger universal scheme covering everyone, so as to create one large pool. The legislation is yet to be enacted but some stumbling blocks seem to lie ahead e.g. the resistance from the medical schemes themselves, a very strong and influential player in the South African health sector.¹⁹

POTENTIAL STUMBLING BLOCK 1: MEDICAL SCHEMES AS A KEY STAKEHOLDER

Private medical schemes have been reported as standing in the way of the government's proposed National Health Insurance (NHI). The health minister, on the other hand reiterated that the purpose of the NHI is not to destroy the private healthcare sector, but to make it possible for more South Africans to access quality healthcare stressing that his point is that private healthcare has a lot of resources which are not available to everyone. The above statements reveal some tensions and how these are playing out in impeding or promoting UHC is not very clear.²⁰ The monopolistic position of private hospital companies (used primarily

by white and wealthy population groups) gives companies' power in the health system and strong interests in purchasing reforms and this is likely to give them at least covert power in UHC policy debates.¹⁹ With the proposed NHI reforms medical aid scheme membership is likely to decline to about 10% of population and this is not likely to bode well with those with vested interests.¹⁹

POTENTIAL STUMBLING BLOCK 2: PEOPLE AS TAXPAYERS AND CONSUMERS OF HEALTH SERVICES

The poor state of many public healthcare services is another shortfall. Many medical scheme members, who are faced with spiralling above-inflation annual contribution with schemes announcing double-digit contribution increases for 2017, are afraid to resign from their schemes and rely on state medical care because of the long lines of patients waiting to be seen, and the inconsistency of the quality of care they are likely to receive if they are hospitalised among other reasons. For low-cost benefit options to become a reality, fundamental changes need to be made to the Medical Schemes Act of 1998 with regards to the payments for the 270 prescribed minimum benefits (PMBs), the treatment of which all schemes have to cover. This contributes to large contribution increases. On the other hand, if people resign from medical schemes because of the high cost, they become reliant on state healthcare, adding to the burden of the already overloaded and understaffed public health service. On a positive note, many people feel they would support the proposed NHI if the state could prove that it is capable of revamping the existing state healthcare system.²⁰ This revamping phase began in 2012 and the results are mixed.¹² Reforms to the public system and its ability to contract out will need to work to give people confidence in the NHI and the new system. There is also the lack of progress in establishing the structures for community participation in primary healthcare service delivery- clinic committees and hospital boards. While all the districts were reported to have hospital boards and clinic committees, there is little detail about how these bodies function and the extent to which they facilitated meaningful community participation.²¹

NHI FINANCING REFORM 2: TO MOVE FROM VOLUNTARY TO MANDATORY PREPAYMENT SYSTEM

Transforming the health care financing system also requires changing how revenue is collected to fund healthcare services and, even more importantly, how generated funds are pooled and how quality services are purchased.^{2,22} The key focus of the NHI reforms is therefore to create a single, publicly owned and administered strategic purchaser that will actively purchase healthcare services on behalf of the entire population from suitably accredited public and private providers.

General tax is the preferred option of funding.²³ The fiscal context in a country affects the ability of a government to mobilize public revenues overall, which in turn affects the level available to fund health services.²¹ The fiscal situation in a country is affected by a wide range of factors, including the level of poverty and economic growth, the composition of the labour market.²¹ What has been allocated so far to achieve UHC in South Africa? The White Paper released in December 2015, fails to lay out or discuss any specifics such as how much insurance premiums are going to cost. Only estimates are given as to what it might cost to bring the National Health project to life. The cost of im-

plementation is estimated to be at R225 billion by 2025, but with the economy still under a large amount of pressure, many South Africans are wary about whether this can be done.²¹

POTENTIAL STUMBLING BLOCK 1: RAMPANT UNEMPLOYMENT

It is worth noting that there are 13.1 million South Africans who have regular work – just 41 per cent of the working-age population. Of these, just over 8 million have formal, non-agricultural employment. To achieve the average emerging markets employment ratio of 56 per cent, and taking into account population growth, South Africa would have to create 9 million jobs over the next 10 years. The unemployment rate is particularly high for young people.²⁴ Only 39% of South Africans have a job with half of the population between 18 and 25 unemployed, thereby constraining the tax base.²⁵ So one stumbling block is where will the money come from?²⁰ How can premiums be collected from an informal sector where it is complex to work out whether people can afford to pay or not? Who will pay for those who cannot afford in a country with high unemployment levels and such a small tax base?

NHI FINANCING REFORM 3: TO RAISE ADDITIONAL REVENUE FOR HEALTHCARE

The government also offers to explore other sources of funds e.g. to raise up to 5% of the GDP in additional taxes. What could stand in the way here is that South Africa already has a high per capita expenditure on health (8.8% of GDP in 2014 according to the World Health Organisation) considering that the average income of South Africans is fairly low. South Africa spends more on health per capita than many other African countries, yet these countries achieve similar or better positive health outcomes. Van den Heever argues that there is no precedent elsewhere that such a proposal - to raise up to 5% of GDP in additional taxes will address the weaknesses in the current health system.²⁶

POTENTIAL STUMBLING BLOCK 1: LACK OF TRUST IN PUBLIC INSTITUTIONS AND REGRESSIVE ASPECTS OF VAT

Proposals for increasing government revenues include the introduction of a payroll tax, a surcharge on taxable income, and increases in VAT. This money would go into a pooled NHI fund which will be publicly administered. Fears exist that this money might not be used as intended, coupled with feasibility concerns that these proposals are not implementable as.²⁰ An additional concern is that the regressive aspects of a value-added tax increase would contradict the principles upon which NHI is based.² As of April 2018 value-added tax (VAT) was raised by one percentage point to 15%.²⁷ It remains to be seen if this additional revenue is injected into UHC.

POTENTIAL STUMBLING BLOCK 2: BUDGETS

The global financial crisis and subsequent recession have exposed vulnerabilities and structural imbalances in major economies. Income levels have diverged sharply in many countries including South Africa. The recent slow pace of economic growth is also a fundamental factor that has con-

tributed to the slow pace of poverty alleviation.²⁵

Access to opportunity in South Africa is no longer cast rigidly along racial lines, but for poor communities the barriers to progress still seem insurmountable. Marginalised communities around the world now have access to advanced information technology and aspire to a better life, yet stable earning opportunities, income security and modern infrastructure amenities remain out of reach for hundreds of millions of people.²⁸

Spending on the health sector has grown strongly over the past years, from R63 billion in 2007/08 to R102.5 billion 2010/11. Expenditure was expected to grow to R113 billion in 2011/12 and R127 billion in 2013/14 – an average annual growth rate of 7.5 per cent. The function is allocated an additional R18.7 billion over the medium term (R3.6 billion in 2011/12, R6.5 billion in 2012/13 and R8.6 billion in 2013/14).²⁸ South Africa's real gross domestic product fell by 2.2% in the first quarter of 2018.²⁹ 2.2% fall is the largest quarter-on-quarter decline since the first quarter of 2009.³⁰ How this will affect NHI is yet to unfold.

POTENTIAL STUMBLING 3: POLITICAL WILL IS FICKLE

UHC is viewed as a political choice and not a technical one. The technical means are there. Different countries will take different routes but UHC is within reach if citizens are empowered for health care.¹³ It's not just the government or the politicians that are responsible. NGOs, advocacy groups, and international organizations also have a role to play in calling attention to persistent inequities and to other issues that are detracting from UHC financing. Everyone has their role in translating these commitments into action.¹⁵ Political will is fickle, and requires constant vigilance to sustain, especially in low- and middle-income settings, governments face myriad competing priorities.³¹ How this political will will be sustained in the South African context is not clear. A collective political will from local to national government is critical for the sustainability and the effectiveness of the system as it draws resistance from other sectors.³² In 2018, South Africa elected a new President. How will this political change affect NHI?³¹

NHI FINANCING REFORM 4: TO IMPROVE POOLING ARRANGEMENTS SO AS TO BETTER SPREAD RISK AND IMPROVE CROSS-SUBSIDISATION

National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families. It is envisaged to create a unified health system by improving equity in financing, reducing fragmentation in funding pools, and by making health care delivery more affordable and accessible for the population and ultimately eliminate out-of-pocket payments when the population needs to access health care services. In the long run, households will also benefit from increased disposable income as a result of a significantly lower mandatory prepayment.⁴

POTENTIAL STUMBLING BLOCK 1: MEDICAL SCHEMES INDEPENDENT

In the current system of medical schemes, only those belonging to medical schemes are able to access health ser-

vices in both the private and the public sectors or access at high out-of-pocket costs. There are more than 100 medical schemes in South Africa, and each scheme has a number of benefit packages, so there is considerable fragmentation into many small risk pools. There is no risk pooling between the tax-funded pool and the medical schemes. The public-private mix is the main equity challenge: while schemes cover less than 14% of the population about 60% of funds are in the private sector.³³ Even those with Medical Insurance are usually denied access to health care before the year ends because they are supposed to have run out of benefits. The biggest share of out-of-pocket payments is attributable to medical scheme members, either in the form of co-payments or on services that are not covered under the benefit package.¹⁷ In spite of this, health care services from the private sector are perceived as faster and better making people willing to sacrifice. The problem however is that the amount people spend on medical schemes is not state-controlled, as it is currently a private transaction between individuals and healthcare providers and/or medical schemes. Medical scheme members are unlikely to hand over these high contributions to the state to fund the NHI²⁰ without the assurance of an equivalent service in return. For a detailed review please refer to table 1 UHC wish vs reality above. The longer-term role of medical schemes is a more complex issue.^{22,34} The consequences of health care providers being the 'price makers' in the private health sector context in South Africa is precisely what the Competition Commissions' Health Market Inquiry is grappling with at present.^{22,34}

NHI FINANCING REFORM 5: TO PURCHASE FROM A MIX OF PUBLIC AND PRIVATE PROVIDERS

NHI plans to purchase services for all; and will be an entity that actively utilises its power as a single purchaser to proactively identify population health needs and determine the most appropriate, efficient and effective mechanisms for drawing on existing health care service providers.² Currently nine provincial health departments are the major purchasers of the public sector health services and the majority of tax funds flow via these financing intermediaries. Purchasing of services is relatively passive.¹⁷

POTENTIAL STUMBLING BLOCK 1: ALLEGED CORRUPTION IN THE HEALTH SYSTEM

South Africa currently faces issues of looting, corruption, factionalism and nepotism.^{9,24,35} A further layer of complexity has been added with the centralised implementation and direct management of the pilot NHI districts by the national department of health. The implementation process has challenged the authority of the provincial health departments, who are responsible for policy implementation. Although the NHI pilot district implementation is accompanied by strong political stewardship, only time will tell whether these reforms will result in significant decentralisation and its intended health service benefits.⁶

An earlier analysis of the underlying factors behind over-spending in provincial health departments pointed to serious management flaws and leadership gaps, particularly with regard to the health department's core business of service delivery and the quality of such service delivery.¹⁰ Fragmented health service planning, often unrelated to financial and human resource requirements; inadequate health programme linkages, co-ordination and integration both within the national health department, and between

national and provincial health departments; and 10 de facto health departments rather than one strong national health system, mitigated optimal performance of the health system.¹⁰ Years later the situation seems not to have changed.³⁶

Over the four-year period from the financial year 2009/10 to 2012/13, around R24 billion of combined provincial health expenditure was classified as irregular by the auditor-general of South Africa. In the 2012/13 financial year alone, irregular spending amounted to around 6% of combined provincial health expenditure in South Africa.³⁶ There were also varying and erratic expenditure patterns in the nine provinces. The reality is that it is not known how much of the irregular expenditure is due to corruption, because of difficulties with direct measures or validated indicators to measure corruption.³⁶ One can only postulate different scenarios: a worst-case scenario where R24 billion was lost due to corruption over a four-year period, or the best-case scenario where R24 billion was lost due to ineptitude or incompetence of public servants and inefficient management systems; the consequences of either of these scenarios are equally disastrous for the public health sector, and the people whom it serves.³⁶ Suboptimal audit outcomes for the nine provincial health departments have also been reported.⁶

The fault lines mentioned above have negative consequences for implementation of policies including UHC, and could explain the large gap between these policies and their implementation, making it difficult to achieve the desired results.⁶ Many inefficiencies emanate from mismanagement and maladministration.²⁵ Raising sufficient money for health is imperative, but just having the money will not ensure universal coverage, nor will removing financial barriers to access through prepayment and pooling. The final requirement is to ensure resources are used efficiently.²³

NHI FINANCING REFORM 6: TO USE ECONOMIES OF SCALE AND PURCHASING METHODS TO ACHIEVE COST-EFFICIENCY

NHI Fund will assess the population needs to determine health service requirements and to ensure that the required services are available through purchasing these services from accredited public and private providers.⁴

POTENTIAL STUMBLING BLOCK 1: DRIVERS OF PRIVATE HEALTH COSTS

While medical schemes themselves are not run for profit, private healthcare facilities are. Private hospitals have shareholders and are profit-driven. There is also no limit to what private healthcare practitioners may charge.²⁰ These two things, together with medicine and equipment costs and the falling rand, contribute to spiralling medical scheme contributions, regardless of where it is obtained. The consequences of health care providers being the 'price makers' in the private health sector context in South Africa is precisely what the Competition Commissions' Health Market Inquiry is grappling with at present.^{22,22} Those with vested interests are bound to resist proposals that will result in the decline of profits.¹⁹

NHI FINANCING REFORM 7: TO DELIVER QUALITY SERVICES AND CONTINUAL IMPROVEMENTS IN HEALTH OUTCOMES

The NHI fund will be responsible for purchasing and paying for all health service needs in the country.⁴ Only 30% of the public health institutions have passed muster meaning very few facilities will be accredited to provide care while as the costly private sector is characterized by escalating costs.¹² Legislation and other tools have not yet gone far enough to regulate the private health care sector. Service delivery reforms have produced mixed results and only a third of the public facilities have passed muster. It is also important to highlight that accreditation status is very dynamic with quality of services sensitive to leadership and staff changes. There has also been a lack of adequate infrastructural improvement in the pilot districts. Progress in reforms being piloted has been slow due to poor coordination between the National Department of Health (NDoH) and the Department of Public Works.²¹

POTENTIAL STUMBLING BLOCK 1: PROVINCIALIZATION AS OPPOSED TO DISTRICT HEALTH AUTHORITIES

Additional challenges derive from the constitutional autonomy of provincial health departments as these create conditions for different interpretations of what constitutes a district health system and the structures and mechanisms that are most appropriate to ensure implementation.³⁷ The current districts are not functioning as decentralised authorities as originally intended; the head of the provincial department of health remains the accounting officer, and there are marked variations in financial and human resource delegations across provinces.³⁸ The problems are exacerbated by human resource shortages, suboptimal stewardship and leadership, and political contestations that collectively slow progress towards quality services and ultimately accreditation, an NHI requirement. According to the White Paper on NHI, primary health care re-engineering is at the core of revitalising and strengthening the South African health system and this is dependent upon a well-functioning district health system. 22 years into democracy, South Africa still does not have a fully functional district health system.⁴ A functional DHS is expected to ensure the delivery of quality, equitable PHC services,³⁹ improve health outcomes for all South Africans⁴⁰ (but especially those worst off), address the social determinants of health, involve communities, and change the power relations between the centre (province) and the periphery (the district).⁴¹ Formal mechanisms of accountability such as district councils and clinic or community health centre committees are either absent or not playing a meaningful role. In addition, district hospitals still function separately from and are poorly co-ordinated with PHC services in many places. Without the appropriate delegations, district health managers cannot make decisions. Hence, the perceived benefits of decentralisation, namely accountability to communities, improved health outcomes and access to quality services, have not been realised.³⁷ The largest public spending is by provincial departments of health at 3.8 per cent of GDP and the largest private spending channel is through medical schemes (3.7 per cent of GDP).^{4,42} Funds are allocated from central government to provinces (for all sectors) using a needs-based formula and then each province has autonomy to decide on how it will allocate these funds to individual sectors e.g. health and education.³³ Provinces therefore command both financial and administrative pow-

er.

There are concerns about the undoubtedly lengthy process required to implement many of the NHI reforms such as delegating management authority to all public hospitals and organisations such as PHC services.^{22,34} A DHS is pivotal to UHC according to WHO, which emphasizes the well-functioning of the entire health system of which the DHS is a part. Whether the financial and ideological challenges will undermine this intent in South Africa, is not known. The roll-out of NHI programs to all districts may require a rethinking of the salience of the DHS.²¹

POTENTIAL STUMBLING BLOCK 2: INCOMPETENCE AND FAILURE OF LEADERSHIP AND GOVERNANCE AT ALL LEVELS OF THE HEALTH SYSTEM

According to Rispel 2016, there are fault lines in the health sector that have negative consequences for patients, health professionals and policy implementation. These include: tolerance of ineptitude and leadership, management and governance failures, lack of a fully functional district health system, which is the main vehicle for the delivery of primary health care (PHC), inability or failure to deal decisively with the health workforce crisis.⁶

Rispel 2016, goes on to highlight the problem of ineffective management, incompetence and failure of leadership and governance at all levels of the health system, exacerbated by a general lack of accountability despite there being many committed, competent, hard-working health service managers and health professionals, contributing to change and doing an excellent job in implementing transformative health policies.⁶ These fault lines stand in the way of improved public sector services to compete with the private sector, let alone to get the needed accreditation to become an NHI provider.

POTENTIAL STUMBLING BLOCK 3: HIGH HIV BURDEN AND A COCKTAIL OF EPIDEMICS

South Africa has the highest number of people on ARVs. Nearly 3million of the 6.4million people infected get free treatment and the new test and treat approach the health system will need substantially more nurses. This means a doubling or tripling of health workers an expensive, difficult and time-consuming exercise that will pay off if the country invests now in treating more people. If South Africa were to offer ARVs to everyone who qualifies under the government guidelines, it would cost R50-billion, more than double the R21-billion the state currently spends.¹¹ The effect of the HIV epidemic on UHC efforts cannot be underestimated.

With the introduction of a massive ARV program, non-communicable diseases are now the single largest cause of death. The 2015 overview of cause of death graphically depicts what is known as the quadruple burden of disease (HIV, maternal mortality, violence and NCDs), whereby South Africa faces substantial mortality in all four of the main categories of cause of death.^{22,34} Public health infrastructure is poorly located, inadequate and under-maintained.²⁴ South Africa currently falls short of UHC goals in many respects, including its system inputs (particularly physical infrastructure), outputs (e.g. health service utilisation rates), outcomes (inadequate service coverage) and impact-poor health status.⁴³ Health system needs evolve over time. A health system that was designed for a 20th century demographic and epidemiological South Africa cannot serve us well any more⁴⁴ calling for a health system overhaul led by innovative leadership.⁴⁴

LIMITATIONS AND STRENGTHS

We would like to acknowledge that our presentation of potential stumbling blocks to NHI monetary reforms are an attempt to raise awareness but our list is not exhaustive. There might be other stumbling blocks we did not allude to in our paper. WHO identified in its World Health Report (2010)²³ that the area that is likely to have the greatest impact on improving equity will concern reforming the health financing system.³ To the best of our knowledge, this is one of the first papers to compare and contrast the proposed NHI financing reforms in South Africa (wish) with the situation on the ground (reality) highlighting potential stumbling blocks. It is very important for countries to track progress towards national goals including UHC.⁴⁵

CONCLUSIONS

Progress towards UHC has been reported in some NHI pilot districts.²¹ Sustaining change and preserving gains achieved in the move towards UHC in South Africa is a mammoth task. Policy implementation is not linear and unintended consequences, resistance by some interest groups, need to be negotiated and managed particularly the private sector with vested interests.¹⁹ There are ambitious reforms planned for financing and purchasing arrangements through the NHI.⁴⁶ There are ambitious reforms for reforming PHC re-engineering to raise the quality of services in the public health system under the NHI.⁴⁶ There are many stumbling blocks that have been discussed – partly whether there is the political will to see the reforms through, whether the tax and service delivery systems can be reformed enough including eliminating corruption and improving leadership and efficiencies, whether powerful groups such as the medical schemes, the elite and the private hospitals will allow come to the table and put their weight behind the NHI reforms. We reckon that South Africa has a relatively high per capita spending on health, if only the funds available are pooled and well managed, access to quality health services for all South Africans can be guaranteed.⁴³ UHC is viewed as a political choice and not a technical one. The technical means are there but different countries will take different routes.⁴⁷ UHC is within reach if citizens are empowered and political will is present.⁴⁷ Innovative and sustainable UHC financing and pressure to the state to uphold the political will and commitments are called for if South Africa is to achieve UHC by 2026. Cur-

rently there is an imbalance in power within an unregulated health system, in favour of health care providers. Achieving UHC requires the right policies⁴⁸ many of which South Africa is yet to implement. Some of the unresolved issues are: the economy is unsustainably resource intensive²⁴; the public health system cannot meet demand or sustain quality currently; public services are uneven and often of poor quality; corruption levels are high; and South Africa remains a divided society.²⁴

The underlying political and social determinants that undermine access to care must also be tackled to achieve the broader equity and effectiveness goals of UHC.⁵ Achieving UHC for all populations requires the harmonisation of political, social, economic, and health leadership, as well as mature health systems capable of ensuring efficiency and equity.⁴⁹ As South Africa moves into putting legal, institutional frameworks and systems for UHC implementation into place,⁵⁰ caution has to be taken as political trade-offs are made on the road to UHC, the needs of less powerful groups may not necessarily given priority.³ The market won't work – it doesn't work well in the health context.⁵¹ How much South Africa takes heed of the above words of wisdom is yet to be seen.

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