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Critical Analysis of the South African Universal Health Coverage Policy in Relation to the World Health Organization's Universal Health Coverage Matrix

Mametja S[1,2]*, Semenya M[1], Letshweni M[1], Hattingh J[1] and Moloabi S[1]

[1]Government Employees Medical Scheme
[2]University of Pretoria, South Africa

***Corresponding author:** Selaelo Mametja, Government Employees Medical Scheme, Vutomi House, 124 Mercy Avenue, Menlyn Maine Precinct, Waterkloof Glen Ext 2, Pretoria, South Arica, Tel: (+27)012 366 5038; Email: Selaelo@gems.gov.za

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Abstract

South Africa is a highly unequal country. The most significant contributors of the poverty index are living conditions (47.5%) and health (39.5%). The country has a two-tiered health system, in which the healthcare system consists of the private sector funded by voluntary health insurance (VHI) and the public sector funded by taxes. Over the last two decades, government transfers as a proportion of total health expenditure (THE) increased significantly from 36% in 2000 to 59% in 2019. Health expenditure per capita and as a percentage of GDP has risen steadily over the period. In South Africa, VHI only covers high-income groups within the private sector leaving shortages of human resources in the public sector. In 2011 the Government published the National Health Insurance (NHI) green paper to introduce a healthcare financing system that will ensure that everyone has access to efficient and appropriate healthcare, based on health needs regardless of ability to pay. This was followed by the white paper, published in 2017, and the National Health Insurance Bill (NHIB) in 2019. The NHIB is currently still undergoing the comments process.

Methods: This manuscript uses the WHO framework to critically analyse the South African universal health coverage policy, known as the National Health Insurance policy in relation to World Health Organization's (WHO) framework for health financing and Universal Health Coverage.

Findings: The National Health Insurance (NHI) Bill is aligned with the WHO's universal health care financing framework. The Bill aims to transform the fragmented two-tiered health system, the public and private, unified and equitable health system, revenue rising will consist mainly of public funds, which will be pooled into a single source to enable strategic purchase of services. The Fund will define the benefits once implemented. When finally implementeqd, the legislation will enable efficient and equitable healthcare financing; and access relative to need.

Conclusion: The study found that the NHI policy is aligned with WHO's framework on universal coverage and the desirable attributes. When implemented, the NHI policy will enable South Africa to achieve the intermediate objectives and final goals of universal coverage

Keywords: National Health Insurance (NHI); Universal Healthcare (UHC); Equity; Healthcare Financing

Abbreviations: VHI: Voluntary Health Insurance; THE: Total Health Expenditure; NHI: National Health Insurance; NHIB: National Health Insurance Bill; WHO: World Health Organization's; HDI: Human Development Index; HE: Health Expenditure; PFMA: Public Finance Management Act; DOA: Division of Revenue Act; UHC: Universal Health Coverage; OOP: Out of Pocket Expenditure; DRG: Diagnosis Related Groups; CUPS: Contracting Units for Primary Health Care.

Introduction

South Africa is a highly unequal country, with a Gini coefficient of 0.61 and a human development index (HDI) of 0.70. Although the country has above average HDI of sub-Saharan countries, the HDI level is below the global average of 0.75. South Africa has an inequality-adjusted HDI of 0.47, equity adjusted. Inequality in South Africa is attributed mainly to the history of apartheid [1]. In 2014, 50% of population lived in poverty [2]. In South Africa, the wealthiest 10% held 71% of the wealth, while the poorest 60% owned just 7% of the wealth. In the wake of the Covid-19 pandemic, unemployment stood at a record high of 34,9% in the third quarter of 202 [3]. In 2016 SA had a multidimensional poverty index of 0.025, experienced by 6% of the population. The most significant contributors of the poverty index are living conditions (47.5%) and health (39.5%) [4].

South Africa has a two-tiered health system, mirroring the inequalities in the country. The Healthcare system consists of the private sector funded by voluntary health insurance (VHI) and the public sector funded by taxes. Sources of health expenditure (HE) include government transfers (59%), voluntary health insurance (34%), out of pocket expenditure (OOP) (6%) and external aid (1%). Over the last 19 years, government transfers as a proportion of total health expenditure (THE) increased significantly from 36% in 2000 to 59% in 2019. Health expenditure per capita and as a percentage of GDP has risen steadily over the period. Despite the increase in THE to 9% of the GDP, SA has a universal health coverage index of 67. Voluntary health insurance covers only 14% of the population and yet accounts for 34% of THE [5,6]. There are no cross-subsidies between voluntary health insurance and the government pools. In addition, the Government passes back medical tax credits to voluntary health insurance beneficiaries. In South Africa, voluntary health insurance covers high-income groups. It tends to concentrate health care professionals to private health sectors, with the unintended high cost of health care and shortages of human resources in the public sector. In the private health sector, the predominant mode of healthcare purchasing is fee-for-service, which promotes the supplier-induced demand [7].

General taxes and moneys appropriated by Division of Revenue Act (DORA) 09 of 2021 are used to fund the public sector. National Treasury equitably allocates funds to the nine Provincial treasuries for further allocation to their respective departments. The conditional grant is directly paid to health departments [8]. The Public Finance Management Act (PFMA) 1 of 1999 provides efficient and effective management of revenue, expenditure, assets and liabilities and articulates responsibilities of persons entrusted with financial management in that Government to regulate financial management in the national Government [9].

While government transfers have steadily increased over the last 20 years, the percentage of medical schemes beneficiaries relative to the population has largely remained stagnant. In 2020, during the pandemic, the proportion of the population covered by medical plans reduced from 16% to 14%. In addition to stagnation in growth, many pensioners fall off the voluntary health insurance at a point when their health needs increase [10]. In 2020, there were 74 medical schemes in the country.

The Health Market Inquiry investigated market failures in private healthcare and concluded that the medical scheme industry is highly fragmented. The sector is inefficient, lacks information on health outcomes, competition on price, cost and quality, and tends to cherry-pick the healthiest. These findings indicate that the private sector covers low-risk and high income, whilst the public sector is left to fund the elderly, the vulnerable, unemployed and those with low income.

South Africa has a high out of pocket payment estimated at about 6%, with many uninsured middle class paying healthcare out of pocket. Medical scheme beneficiaries incurred R 30 billion in out of pocket expenditure in 2020 [5,10].

The South African economy has been operating with negative fiscus over the recent years, with government expenditure exceeding revenue in every year since 2008, and as a result the debt levels have increased by approximately 700% from R577 billion in 2007 to R4.1 trillion in 2021 [11]. The debt to GDP ratio has increased dramatically from 47% in 2016 to 56% in 2019 and projected to reach 83% by the year 2026 [12]. These trends are not exclusive to South Africa, as Sub-Saharan African countries' debt to GDP ratios have also been increasing over the years, from 35% in 2014 to 55% in 2019 and a high of 63% during the COVID-19 pandemic [13]. Given that 21 cents of every Rand collected in revenue is spent on servicing debt, the SA Government's medium-term fiscal policy aims to reduce the budget deficit to 4.9% in 2024/25 and stabilise the debt-to-GDP ratio to 78.1% in

2025/26 [11]. The goal is to increase the relative share of non-interest expenditure, such as healthcare, infrastructure, etc. in order to stimulate economic growth and reduce unemployment. A report by World Bank ranked South Africa as the 39th largest economy out of a total of 217 countries measured by 2020 GDP, US$302 billion, thus indicating that restructuring of the expenditure can have significant positive impact on healthcare and infrastructure spending [14].

Public health policy, in the form of laws, regulations, and guidelines, has a profound effect on health status, however there is a considerable gap between what research shows is effective and the policies that are enacted and enforced [15-17]. This article aims to critically analyse the South African Universal health policy in relation to WHO framework on Universal Coverage.

In 2011 the Government published the National Health Insurance (NHI) green paper to introduce a healthcare financing system that will ensure that everyone has access to efficient and appropriate healthcare, based on health needs regardless of ability to pay [18]. The white paper was published in 2017 for further public comments [19]. The National Health Insurance Bill (NHIB was published for comments in 2019 [20]. The Government invited comments for all three policy processes. When writing this article, the NHIB was still undergoing the comments process.

Methodology

This manuscript uses the WHO framework to critically analyse the South African universal health coverage policy, known as the National Health Insurance policy in relation to World Health Organization's (WHO) framework for health financing and Universal Health Coverage [21]. In this article we critique the following attributes of the NHI policy: revenue raising, pooling of resources, purchaser-provider payment and benefits, and whether the NHI policy addresses the desirable attributes necessary for the achievement of UHC policy intermediate objectives and goals. According to WHO, universal health coverage (UHC) means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course [22].

The UHC framework on health care financing builds on the health system framework based on empirical evidence and normative standards. The healthcare financing has 4 core functions which are revenue raising, pooling of funds and purchasing of health services and benefit design [21]. The framework consists of desirable attributes necessary for health systems to achieve intermediate objectives of equity in resource distribution, efficiency, transparency and accountability. These intermediate objectives will further achieve final coverage goals, namely, utilization relative to need, financial protection and equity in finance and quality [23].

Findings

The National Health Insurance (NHI) aims to transform the fragmented two-tiered health system, the public and private, into a unified health system as envisaged by the 1997 White Paper on the Transformation of the Health System in South Africa [19]. The National Health Policy papers introduced NHI as a strategy to finance equitable universal healthcare by pooling funds into a single fund to enable access to quality health services and provide financial protection for all South Africans based on their health needs and irrespective of their socio-economic status [18-20].

Revenue-Raising and Sources

The WHO framework suggests that advancing UHC requires reliance on public sources to boost absolute per capita spending levels. The most preferred source of financing is general revenue, followed by payroll taxes, and the least preferred is voluntary health insurance. The desirable attributes for revenue-raising will require mandatory funding based on public funding sources, which is predictable over a number of years. The fiscal measures should be in place to create healthier behaviour incentives for individuals and firms. The public flow of funds must be stable, and budget execution should be high.

NHI Bill suggests moving away from reliance on voluntary insurance contributions to mandatory contributions and increasing dependence on public revenue. The four funding sources are outlined in the draft Bill: a) general tax revenue, including the shifting funds from the provincial equitable share and conditional grants into the fund. (b) Reallocation of funding for medical scheme tax credits (c) payroll tax (employer and employee); and (d) ear-marked surcharge on personal income tax.

The fund will prioritise the timely reimbursement of health care services to achieve equity; and establish mechanisms and issue directives for the regular, appropriate and timeous payment of healthcare service providers, health establishments and suppliers.

Pooling of Resources

The WHO's UHC framework desirable attributes require that Pooling structures and mechanisms should be able to redistribute prepaid funds and risk pools needs to be large

and diverse.

The NHI policy intends to move away from the two-tiered system by advancing unitary fund, consisting of publicly aggregated resources across the population so that individual users can access health services without financial risk. The sources of funding will further take into consideration the social solidarity principle where "appropriated from money collected and in accordance with social solidarity to enable cross-subsidisation between the young and the old, the rich and the poor and the healthy and the sick".

The fund will be a single purchaser of health services. Further to promote the unitary role of the fund, the voluntary health insurance will thus play a complementary role by financing services not reimbursed by the fund.

Purchasing of Health Services

The WHO framework desirable attributes require that resource allocation to providers reflects population health needs, provider performance, or a combination thereof. Purchasing should be tailored to support equitable access to service and incorporate mechanisms to ensure budgetary control and ensure good quality care. The flow of funds to the providers needs to be influenced by the population's health needs. The payment mechanism should adjust for risk factors and incorporate payment and service mix performance.

NHI Bill separated the functions of healthcare providers and a purchaser. The Bill provides for the transfer of funds directly to the accredited and contracted central, provincial, regional, specialized and district hospitals based on a global budget or Diagnosis Related Groups (DRG). DRG groups similar diseases together for the payment of the condition, and therefore a DRG based reimbursement system enables payment relative to the severity of conditions treated. Management of hospitals will be decentralized to improve effective functioning and sustainability.

Funds for primary healthcare services will be transferred to Contracting Units for Primary Health Care (CUPS) at the sub-district level. CUPS' roles include identifying healthcare service needs in terms of the demographic and epidemiological profile of their respective sub-districts. The fund will reimburse the emergency medical services using a severity adjusted fixed fee and Public ambulance services through the provincial equitable allocation.

NHI will only purchase healthcare from accredited and contracted services providers. The Bill stipulates requirements to be accredited by the fund; this includes accreditation by professionals, other applicable regulatory authorities and the Office of Healthcare Standards. The providers need to have the ability to provide the defined health services, submit required health information, and adhere to national pricing schemes and approved formularies and protocols. In addition, after consultation with the Minister of Finance and National Council, the Minister of Health will determine payment mechanisms to procure healthcare services from accredited and contracted health care service providers, health establishments, or suppliers. The healthcare providers will be required to provide the fund with information some of which include quality of care information.

When effectively implemented, monitored and strategic purchasing will enable equitable access to good quality of care.

Benefit Design

Benefit design refers to decisions about those health services and goods to be funded from public revenues. Benefit design also involves decisions about the conditions which must be met to access publicly funded benefits [23]. The population should clearly understand the entitlements and obligations. Adoption and service benefit changes should be subjected to cost–effectiveness; budgetary impact and defined benefits should be aligned with available revenues. Benefit design includes explicit limits on user charges and protects access for vulnerable groups.

NHI fund will purchase all health services for the user, free at the point of care, meaning no co-payments are applicable. The rights and responsibilities of users are clearly outlined in the draft Bill. The users will be entitled to services purchased by the fund. Their rights include receiving information about health benefits, not being refused care on the unreasonable ground, and being unfairly discriminated against. The users may exercise the rights to complain about the quality of health services and appeal the fund's decision. The users have duties to register with the service provider and follow referral pathways.

In addition, the NHI Bill provides for the establishment of three advisory committees by the Minister. The Benefits Advisory, Health Care Benefits Pricing, Health Technology Assessment and Stakeholder Advisory committees. The Benefits Advisory Committee will be responsible for determining benefits, health services, and new services to be reimbursed by the fund, considering cost-effectiveness. The HealthCare Benefits Pricing Committee will determine the price of healthcare services to the fund. The constituency of both committees will include political representation and experts, and the Health Technology Assessment Committee will serve as a precursor of the Health Technology Assessment Agency. The Bill, however, is not coherent about

explicitly defining and publishing benefits either by using positive or negative lists, the need for budget impact analysis, affordability of services and requirements for a sustainable healthcare system.

Discussion

In our critical analysis, we found that the National Health Insurance Legislation will enable most of the UHC framework's desirable attributes. The public source of financing and effective risk pooling will result in equity in the distribution of resources and finally utilization relative to need and financial protection. Reallocation of the medical tax credit is the most progressive way of ensuring equity in access to public funds. The sources of revenue are predominately public resources consisting of general taxation, employee and employee payroll contributions and an ear-marked surcharge. They are aligned with international standards notable in countries with high Universal Health index coverage income countries such as UK and Norway.

Effective risk pooling requires large and diverse risk pools; thus establishing the unitary health system in South Africa will achieve the requirements for large and diverse risk pools. Arguments have been advanced that medical schemes should continue financing the high-income groups. However, such a funding mechanism is not sustainable for individuals, especially when they lose income due to unemployment or retirement. The Council for Medical Scheme's industry report has shown that coverage for the elderly decreased after the age of 59 when health needs arise [10].

Moving towards a unitary system will require a systematic redress of inequities in the supply side, such as health professionals and health facilities. During the public hearing, many submissions supported NHI as means to equitable healthcare financing system [24]. South Africa has been planning social reforms for a unitary health system from as far back as 1948 as informed by the Pholela experiments, and articulated in the Gluckman Commission on National Health Services. The progress was thwarted by the apartheid policy in 1948 [25].

The Bill adequately provides for purchaser-provider split which follows international practices, particularly in England, Italy and Portugal [23]. The provider-purchaser split enables the separation of function and creates quasi-markets in the public sector provision. When provider purchaser arrangements are based on optimal contract theory, they result in an increase in stability in the market [26]. Generally, what tends to happen is that the purchaser has the power to drive the prices lower and expect providers to achieve health outcomes over real price paid. On the other hand, weak management capacity associated with decentralized power can expose the population to out of pocket payments. Thus as South Africa proceeds with NHI, it ought to learn from the best practices and ensure that financial pressures are evenly distributed between purchasing and provisioning. The contracts should be enforceable by increasing severe punitive measures in the legislation supported by leadership development in governance, accountability and stewardship of resources in the entire health ecosystem.

The NHIB makes provision for setting up of an effective information system, however, this system should be efficient and collect comprehensive data to enable monitoring of utilization of health services and quality of healthcare delivered by the providers. The information system would later provide rich evidence for risk-adjusted alternative reimbursement mechanisms such as DRG-based funding allocation, capitation and payment for performance.

Constraints in fiscal space have also been cited as a reason not to proceed with Universal coverage(24). The basis in itself is not sufficient enough as some countries have implemented universal coverage during severe fiscal constraints [27]. There is vast literature that shows investment in health has improved economic growth through job creation, provision of healthy labour force, and reduction of illness-induced poverty [28].

Recently, the British National Health System Confederation has published an article on NHS' role in economic and social recovery, advancing argument on how a strong and resilient health system is a necessary catalyst to economic growth and narrowing the socio-economic and health gap created by the pandemic [29].

It can thus be argued that implementing NHI in South Africa during this constraint period is as necessary as ever to increase the resilience of our health system, improve efficiency and protect people against ill-health induced poverty.

The benefit design should promote an efficient service delivery platform, priorities cost-effective interventions, and be subject to budget impact analysis and affordability. The Bill provides for appropriate appointments; prohibit co-payment and outlines conditions of access such as referral system and consideration of cost-effectiveness analysis. However, the Bill does not outline the criteria for budget impact analysis and affordability assessment. The two criteria are necessary as the depth and width of universal health coverage must be aligned to available funding. This alignment is particularly important in South Africa as NHI may be implemented in the fiscal constraint environment. The establishment of the anticipated Health Technology Assessment Agency will further strengthen the separation

between health technology analysis and funding. Therefore, to ensure transparency in benefit design, it is necessary to define regulations or guidelines defining the criteria for cost-effective assessment, budget impact analysis, and affordability, and link this criteria to financial protection equity efficiency [23].

Revenue raising, pooling of funds require a general overhaul of the service delivery platform, stewardship, governance and oversight. South Africa needs to improve management and stewardship of resources across all the stakeholders in the health ecosystem, including politicians, government officials, providers and users. Whilst the laws are in place to improve governance, it is crucial to enforce the rules and policies. The NHI Bill provides for deterrent measures however, these measures may not be sufficient to deter large cooperates and restore justice to the system.

Limitations

The Fund will only develop the benefits after the enactment of the Act. It is thus difficult to assess whether the entitled benefit package will enable equitable access to healthcare, irrespective of the employment status, socio-economic circumstances, geographic location, and level of income. It isn't easy to anticipate allocation of funds to the providers. According to the Bill, this will be stipulated in the subsequent regulations. Whilst SA has good forecasting mechanism in terms of mid-term expenditure framework, it is important to ensure that sub-national structures and providers have capabilities and will have flexibility to manage expenditures and comply with Public Finance Management Act.

Conclusion

The study found that the NHI policy will enable most of the UHC framework's desirable attributes and can assist South Africa to achieve UHC. The transformation will require a systematic redress of inequities in the supply side, made up of amongst others health professionals and health facilities. The NHIB adequately provides for purchaser-provider split which follows international practices and enables the separation of function and creates quasi-markets in the public sector provision. The NHIB makes provision for setting up of an effective information system. Constraints are found within the fiscal space and the affordability analyses. It is necessary for legislation to define criteria for cost-effective assessment, budget impact analysis, affordability, and to link these criteria to financial protection equity efficiency.

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