UNIVERSAL HEALTHCARE ACCESS COALITION

Universal Healthcare Access for South Africa

Healthcare access in South Africa

– a consensus proposal on a set of achievable strategic healthcare reforms to enable the constitutional entitlement for universal access to all necessary healthcare for all who live in South Africa

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2025

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ABBREVIATIONS

For readability, abbreviations have largely been avoided in favour of writing out the term in full. Below are the instances where abbreviations were used.

CEO	Chief Executive Officer
CMS	Council for Medical Schemes
HMI	Health Market Inquiry
HTA	health technology assessment
NHI	National Health Insurance
NHI Act	National Health Insurance Act
NHI Fund	National Health Insurance Fund
PHF	Progressive Health Forum
PMBs	prescribed minimum benefits
RAM	risk adjustment mechanism
SAMA	South African Medical Association
SAPPF	South African Private Practitioners Forum
UHA	universal health access
UHAC	Universal Healthcare Access Coalition
UHC	universal health coverage

DEFINITIONS

Accountability: When referred to in an institutional or organisational setting, this involves some form of structured system of answerability, from which consequences or decisions may flow.

Bad/good risks: Within any system of insurance, bad risks refer to a person or entity with a high probability of claiming benefits. Conversely, good risks have a low probability of claiming benefits.

Contributory health coverage: This is where the entitlement to health coverage is derived from the payment of a contribution or premium. This contrasts with free services, where the entitlement does not require payment of a specific contribution as they are financed from general tax revenue.

Corporate governance: This refers to designated 'accountability' structures used to supervise the exercise of delegated powers in an organisation or system. The typical arrangement involves the establishment of a supervisory board that oversees an organisation.

Critical care services: These are services required for patients whose medical condition is regarded as 'critical'. Services include properly equipped emergency transport vehicles, properly trained and accredited personnel, accident and emergency departments in hospitals, appropriate surgical theatres and recovery rooms, and intensive care facilities.

District health authority: In this report, this refers to a proposed autonomous district organisation falling within the provincial level of government that would have the authority to provide and supervise the provision of all primary care services in a designated region – in this case a health district. The authority would have a 'corporate governance' structure dedicated to its supervision. All district health authorities would form part of a district health system responsible for the public delivery of primary care in South Africa. This system would be supported by an explicit financing framework.

Efficiency: Economic definitions emphasise three aspects. First are technical efficiencies, which refer only to the optimal mix of inputs and processes to produce some output at the lowest cost. Second are allocative efficiencies, which refer to the most efficient distribution of resources to produce an optimal outcome. Third are dynamic efficiencies, which refer to capabilities for innovation (doing things differently).

Equity: The term 'equity' used in the healthcare context implies that distributional justice and fairness is best achieved through a deviation from the principle of 'equality'. This term implies that, to achieve distributional fairness, resource distributions should favour those in greater need.

Executive (of government): This refers to the *political appointment* made into government positions. At the national level of government, these are ministers or their deputies. Equivalent positions exist at the provincial and municipal levels of government.

Functions (of government): This refers to the various government mandates allocated to departments and public entities. For instance, healthcare services are a function allocated to provincial governments concurrently with national government. Other government functions include education, human settlements and transport.

General taxes: In this report, this refers to the range of *tax bases* that form part of the government system of revenue collection. This includes personal income tax, corporate tax, value-added tax and excise taxes of various forms. No specific entitlement to benefits is derived from general taxes. Expenditure priorities are determined by the legislatures.

Governance: This refers to the structures, processes and practices used by organisations, governments or societies to make decisions, manage resources and exercise authority. It involves setting policies, enforcing rules and ensuring accountability to guide and control activities in alignment with defined goals and values.

Health technology assessment: Developments in health technology need to be assessed on a continuous basis to ensure that products which are harmful and/or do not offer value are not automatically introduced into any system of health coverage. To properly serve the

public interest, organisations that manage health technology assessments must be both technically capable and independent of conflicts of interest.

Mandatory (health coverage): In this report, this refers to a statutory requirement for certain classes of citizen or resident to contribute towards a health insurance arrangement. Within the local context, this would include a requirement to join a medical scheme or, if established, a publicly administered scheme as an alternative. This type of framework is generally understood as a system of *'social health insurance'*.

Minimum essential benefits: All country health systems that pursue universal health coverage/access need to establish mechanisms that can formulate and maintain minimum essential benefit requirements. This typically involves inclusive societal engagements on the benefits that should be guaranteed without access barriers.

Political appointments: All appointments into government structures that derive directly or indirectly from a political party are regarded as political in this report.

Pooling: The term 'pooling' refers to 'risk pooling' or 'insurance'. It includes arrangements where participants contribute directly (through a contribution or premium) or indirectly (through general taxes) to a financial vehicle that pays out to participants when an insured event (such as requiring medical assistance) occurs or a need for a service arises. Government's system of taxation and expenditure is a pooling system, as is any system of contributory insurance.

Pooling for income: This occurs where the system of pooling incorporates a transfer of income from higher-income households to lower-income households. Such transfers can be embedded in the 'contribution', which can be differentiated by income and/or 'expenditure'. Pooling for income on the contribution side is best achieved by governments as they are best placed to implement taxes related to verifiable incomes. Pooling for income on the expenditure side is typically achieved through the exclusion of high-income groups from certain benefits using means tests (mechanisms to determine eligibility for benefits based on the financial means of individuals and/or their households). Means tests are currently used to exclude higher-income households from free access to public hospital services.

Pooling for risk: This refers to arrangements that pay out benefits based on the occurrence of an insured event. The term 'risk' refers to the probability of an event occurring. While this probability or risk may be very uncertain at the level of an individual, it is predictable as an average for the covered group. Contributions to the 'risk pool' are therefore designed to finance the predictable average risk of claiming. Pooling for risk is important where individuals and households face substantial out-of-pocket payments (catastrophic expenses) if uninsured. Risk pooling is not required for routinely experienced minor contingencies which are incurred at the discretion of the insured individual.

Prescribed minimum benefits: This refers to the benefits mandated in the Regulations to the Medical Schemes Act (Minister of Health, 1998). Medical schemes are required to cover prescribed minimum benefits in full, without resorting to co-payments of any form. These benefits also cannot be financed from medical savings accounts (a form of self-insurance typically designed to cover day-to-day care and minor medical expenses) and must be covered by the scheme's 'risk pool'.

Primary care: This refers to first-line diagnostic or treatment services provided on an ambulatory basis to patients. It includes non-specialised in- and out-patient hospital services (in South Africa provided in a district hospital). The term should be distinguished from 'primary healthcare', which, in addition to 'primary care' services, includes non-ambulatory population-based healthcare functions (e.g. environmental health services).

Provincial equitable share allocation: This refers to the equity-adjusted (formula-based) allocation (transfer) made to provincial governments as a *substitute* for provinces exercising their own powers of taxation to finance functions allocated to them by the Constitution (which includes 'healthcare services'). Had the provinces chosen to exercise their powers of taxation from 1996, those provinces with large tax bases would have been able to provide services at disproportionate levels relative to the provinces with weak tax bases and lower levels of taxation. Consideration was initially given to a tax capacity equalisation mechanism, but it would have been too complex for government to manage at the time. The provincial equitable share allocation was therefore a device to achieve more simply what a tax capacity equalisation mechanism would have achieved with considerably more difficulty.

Purchasing healthcare goods and services: 'Purchasing' used within the healthcare context is a catch-all term to refer to all possible arrangements that organise the provision of healthcare services for a designated user population. This can include vertically integrated arrangements, where purchasing and provision is consolidated, and purchaser-provider split arrangements, where the functions of purchasing and provision involve separate legal entities. Internationally, health systems incorporate a mix of vertical and split arrangements, with private insurance systems more likely to default to the latter and public systems to the former.

Reinsurance: This refers to instances where the 'secondary insurer' insures either all or a selection of the liabilities of a 'primary insurer'. The rationale is to transfer the risks for unusual, extremely high-cost and rare events to an insurer with a larger risk pool than the primary insurer. Commercial reinsurance is contingent on a market existing to cover such events. In many cases, *commercial reinsurance* fails to cover important social contingencies, as occurred during COVID. *Social reinsurance*, however, can be used to deepen reinsurance cover beyond what would be possible through commercial reinsurance. Social reinsurance involves government mandating participation by primary reinsurers and regulating the liabilities to be underwritten.

Risks: Reference to 'risks' within an insurance context conveys the probabilistic nature of a covered event. Insurers typically categorise applicants and policyholders into risk groups based on their likely claiming behaviour. If permitted, premiums/contributions can be set based on the claims profile of such designated groups. This is referred to as 'risk-rating'. Risk-rating has been prohibited in the system of medical schemes in South Africa from 2000.

Risk equalisation: This is a mechanism used in many universal coverage/access systems[1] to ensure that no health insurer faces a different profile of risk to that of the overall system. This is achieved through mandatory formula-based inter-insurer transfers related to the different risk profiles of the various insurers relative to the average for the system, related

[1] See, for instance, (Van Kleef, Schut, & Van de Ven, 2018). Countries using forms of risk equalisation and related forms of risk adjustment include, but are not limited to, Australia, Belgium, Columbia, Germany, Ireland, Israel, the Netherlands, Switzerland and the United States (as part of the Affordable Care Act known as 'Obama Care') [I have rearranged the countries into alphabetical/neutral order.].

to a mandated set of minimum benefits. The mechanism is administered by a public authority. Such arrangements can integrate income cross-subsidies with risk-related cross-subsidies.

Scalable: This refers to the ability of an intervention to be incrementally implemented over time. To prevent shocks to the institutions of government and society, policies are typically designed to be scalable.

Social health insurance: This refers to 'contributory' insurance arrangements that have been corrected for market imperfections to cover a larger group of people for a wider range of benefits than would be possible exclusively through private voluntary insurance. Social insurance systems include public schemes and regulated private markets (typically involving risk equalisation and other government subsidy schemes). The term 'social' is applied as the pooling is structured to meet societal needs rather than those of a specific commercial insurer. Government intervention is merely required to ensure that the expanded scope of coverage is sustainable.

Social reinsurance: This refers to non-commercial publicly established reinsurance arrangements where primary insurers are mandated to contribute to a secondary insurer to cover a set of statutory benefits. Social reinsurance effectively expands the coverage potential of a set of primary reinsurers by sharing coverage of high-cost, rare events that could destabilise smaller risk pools.

Tax capacity: This refers to the point at which further increases in tax rates by government would prove counterproductive. Each tax base used by government to raise revenue has a ceiling capacity (tax capacity), which, if exceeded, would result in declining revenues due to evasion, avoidance and declines in economic output.

Uniform patient fee schedule: The public health system makes use of the uniform patient fee schedule to bill private patients and medical scheme members when they use public health services. This fee schedule incorporates a means test which allows lower-income households to receive free services.

Universal health access: In this report, the term ‘universal health access’ is used instead of ‘universal health coverage’ to emphasise access to services in remote and underserved areas. As with the term ‘universal health coverage’, the term also includes the concept of financial risk protection to address access barriers related to financial hardship. However, ‘coverage’ is a term typically applied to contributory insurance-related systems and may therefore be confusing.

Universal health coverage: The term ‘universal health coverage’ has been popularised by the World Health Organization. It refers to health system arrangements which ensure that all individuals and communities have access to the health services they need – ranging from health promotion, prevention, treatment, rehabilitation to palliative care – without experiencing financial hardship. This concept emphasises quality, accessibility and affordability of healthcare services for everyone, aiming to improve health equity and protect people from financial risk due to medical expenses. It refers to a goal rather than a particular approach. Healthcare systems are invariably heterogeneous, with multiple ‘subsystems’ used to ensure the goal is achieved. Many of these subsystems evolve over time, with varying levels of government involvement.

Universal unconditional subsidy: This report refers to a proposed universal unconditional subsidy which would involve a streamlining of the existing implicit subsidy provided to public sector users accessing free care and the tax credit provided to medical scheme members. The proposal in this report recommends that the tax credit be revised to become an explicit allocation of government directed through a risk equalisation fund. In this way, the ‘contributory system’ would participate in the system of income cross-subsidies to support low-income contributors. However, the subsidy would not be paid to individuals, as is the case at present, but would be allocated via social pooling arrangements to *indirectly* support the households most in need of participating in the contributory system. The subsidy would be unconditional, as it would not be subject to any eligibility-related conditions.

UNIVERSAL HEALTHCARE ACCESS COALITION

The Universal Healthcare Access Coalition (UHAC) is comprised of national organisations in the healthcare sector representing a substantial proportion of healthcare professionals in the health system.

The purpose of this coalition is to establish a public space to convene strategic conversations on health system reform.

The promise of an integrated, sustainable and responsive healthcare system is a democratic dividend to which South Africa and her people are entitled.

There has, however, been little by way of effective public or private sector healthcare reform for almost two decades, contributing to a weakening trend in the health systems' performance.

As a response to this policy vacuum, the reform framework outlined in this report was developed through a process convened by the UHAC.

It offers a considered response to the unmet imperative for productive health systems reform with the aim of enhancing universal access to healthcare consistent with section 27 of the Bill of Rights.

While this report has been developed at the initiative of the UHAC, it has been made available to interested stakeholders outside of the coalition with an invitation to both comment on and co-develop a constructive health system reform framework for South Africa.

It is anticipated that this process will continue indefinitely as a space for the difficult conversations that tend to be avoided by both government and stakeholders.

Signatories to the report:

- South African Medical Association
- Progressive Health Forum
- South African Private Practitioners Forum
- Radiological Society of South Africa
- Association of Palliative Care Centres
- Association of Plastic Reconstructive and Aesthetic Surgeons of South Africa
- Board of Healthcare Funders
- Chiropractic Association of South Africa
- Clinical Psychology Forum
- CPC/Qualicare
- Day Hospital Association of South Africa
- Emergency Medicine Society of South Africa
- ENT Society of South Africa
- Faculty of Consulting Physicians of South Africa
- Iso Leso Optics
- Izandla consulting Physiotherapists
- National Pathology Group
- Ophthalmological Society of South Africa
- Paediatrician Management Group
- Podiatry Association of South africa
- Psychiatry Management Group
- Society of Medical Laboratory Technology of South Africa

- Society of Radiographers of South Africa
- South African Association of Audiologists
- South African Dental Association
- South African Gastroenterology Society
- South African Optometric Association
- South African Orthopaedic Association
- South African Society of Anaesthesiologists
- South African Society of Obstetricians and Gynaecologists
- South African Urological Association
- Surgicom
- The South African-Speech-Language-Hearing Association
- Universal Healthcare

EXECUTIVE SUMMARY

This report outlines a consensus framework developed through a process convened by the Universal Healthcare Access Coalition (UHAC) to address critical weaknesses in South Africa's healthcare system. Prompted by the President's indication of an openness to engage on constructive reform proposals, this report offers pragmatic, scalable and equitable solutions to enhance healthcare access building on rather than undermining the existing and well-established parts of the health system.

CONTEXT AND PROBLEM STATEMENT

The National Health Insurance (NHI) proposals are assessed as not feasible and potentially detrimental to healthcare access. The NHI plans lack alignment with the current healthcare system, neglect necessary reforms, and fail to address governance and equity issues in public and private healthcare. For over two decades, systemic weaknesses – including governance failures, inadequate service delivery and inefficiencies in both public and private healthcare – have remained unaddressed.

KEY CHALLENGES

The South African health system is characterised by performance failures in both the public and private health systems because of poor government stewardship and governance.

The consequence has been extreme system polarisation (between public and private), which will be exacerbated by attempts to base the entire system of universal access/coverage on a tax-financed approach.

Over several decades government has failed to develop efficient frameworks that maximise resource mobilisation that are able to combine the tax-financed systems with those financed by explicit contributions.

Public sector

Governance failures: Political interference compromises leadership and performance in the health system.

Primary care deficiencies: Fragmented structures and lack of accountability undermine service delivery.

Hospital services: Poor leadership and governance have eroded the quality of public hospital services.

Healthcare workforce: The absence of a strategic plan for workforce development impedes progress.

Critical care: No framework ensures universal access to emergency and critical care services.

Private sector

Market inefficiencies and regulatory gaps have resulted in escalating costs and a reduced sustainability of medical schemes. The 2019 Health Market Inquiry (HMI) highlighted failures in stewardship, market structure and regulatory enforcement.

REFORM FRAMEWORK

The proposed framework for the South African health system acknowledges one simple and unavoidable fact. An effective system of universal access/coverage in South Africa cannot be exclusively financed by general taxes in any foreseeable future fiscal scenario.

Instead, the health system requires an institutional design that must rely on both tax funding and the contributory system (i.e., the system dependent on contributions over-and-above tax funding).

However, it is also recognised that tax financed and contributory systems work differently and require well-functioning but distinct governance frameworks.

Given this, effective government stewardship requires the development of interventions that recognise these differences while at the same time aligning them with overarching system goals.

This framework, if implemented, would therefore seek to stabilise the existing large health systems while at the same time institutionalising a developmental pathway that will progressively de-segment the overall health system.

Guiding principles

Separation of functions: Decouple pooling (income and risk) from purchasing for greater accountability and efficiency.

Equity and scalability: Implement equitable resource distribution while enabling incremental expansion of coverage and services.

A three-pronged approach

To achieve the required system goals, three strategic measures are needed.

Separation of 'pooling' from 'purchasing': Equitable resource allocation outcomes rely on fair pooling systems which are most logically situated and executed at a national level. Purchasing functions, by way of contrast, to be efficient - involve localised operational decision-making supported by independent localised supervision. The functions of pooling and purchasing must therefore be separated to enable the achievement of equity and efficiency objectives.

Optimise the performance of free public services: Strengthen governance and ensure quality healthcare for households unable to afford their own coverage with three important features: hospital and district authority autonomy; close localised supervision; and the removal of interference from the executive of government in appointments, procurement and operational decisions.

Optimise the performance of the contributory system: Establish contributory health insurance for income-earning households, incorporating public and private entities under a cohesive framework. Contributory systems supplement the maximum levels of coverage

attainable financed from general taxes. This system needs to be properly regulated to address known market failures to and to maximise coverage.

PROPOSED INTERVENTIONS

Public healthcare

Decentralise the decision-making for health service delivery through the establishment of an autonomous district health system and autonomous public hospitals. This autonomy would include the delegation of wide decision-space for all operational decisions, including revenue generation, workforce planning and execution, procurement and the maintenance of facilities.

Establish independent governance structures for provincial health services, health districts and hospitals. Independence here means, structural independence from the conflicts of interest of members of the executive of government.

- These governance changes seek to enhance performance for any given level of resourcing.
- The decentralised framework ensures that decisions are made faster and more efficiently when closer to the served population.
- The governance framework ensures substantially improved leadership seen together with accountable decision-making.
- The separation of powers from the executive removes opportunities for systematic corruption and associated poor leadership appointments.

Because of these changes, the performance levels of both the public and private systems will converge over time. Importantly, the autonomous public hospitals, arising from their ability to retain revenue, will be able to contract directly with medical schemes and benefit directly by accessing additional revenue streams.

Mandating medical scheme membership for higher income groups will also ensure that that any unfunded 'buy down' into free public health services cannot occur. Instead, any increased utilisation of public hospital services by medical scheme members will always be funded by medical schemes.

Contributory system

Implement risk equalisation and social reinsurance mechanisms to stabilise medical scheme costs and ensure equitable access.

These pooling interventions are needed to: avoid and largely eliminate medical scheme incentives to discriminate based on health status; provide lifetime coverage[2] certainty to contributors; redirect competition from unproductive features (age, gender, health status and broker remuneration) to productive features (cost and quality of health coverage).

Introduce a publicly sponsored commercial medical scheme as a competitive alternative to private schemes to strengthen healthy over unhealthy competition. Such interventions are implemented to ensure that there is always a scheme of last resort available where the market is unable to respond effectively on its own.[3]

Mandate standardised benefit packages, implement a multilateral tariff negotiation structure, and progressively implement mandatory coverage – beginning with higher-income groups and large employers.

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[2] This refers to the objective to ensure cradle-to-grave coverage in the medical scheme system. While not specified in detail in this report, this includes the establishment of cross-subsidies to support post-retirement coverage when incomes drop and health needs increase. This is discussed in more detail in (McLeod, 2007).

[3] The value of public sponsorship as that key public value objectives, measures and governance arrangements can be embedded in the founding rules of the scheme. Public sponsorship is not the same as public ownership. This would not be a state scheme. As a default scheme, it would promote competition with established schemes on healthy features, such as the cost and quality of coverage. This would include strategic contracting imperatives (with both the public and private provider systems), and the protection of life-long coverage in the medical schemes system.

National health functions

Strategic interventions are required at the national level to ensure effective government stewardship such that the goals of universal health access/coverage are aligned across all parts of the system.

Inclusive trust-based stakeholder engagements are needed to design and execute priority interventions to reverse the downward trajectory of the health system.

A strategic engagement is required to *establish a multi-level governance framework that separates the executive of government from the operations of all public health organisations* (regulators, health facilities and provisional health administrations).

Form an *independent organisation for pooling functions* such as subsidy allocations, risk equalisation and social reinsurance.

Regulatory mechanisms for quality control, clinical governance, system transparency and technology assessment are required. Although certain arrangements do exist for these functions, they are far from adequate.

An inclusive process is needed to develop *national a framework for universal access to critical care services*.

A governance framework for strategic health workforce planning and execution is needed to address information deficits, planning and execution deficits, workforce supply gaps (short- and long-term) and planning and execution misalignment.

A strategic engagement and associated process is needed to *establish regional agreements and the associated technical requirements to ensure that cross-border patient flows* to use South Africa's free public health services are fully funded by regional governments.

GOVERNANCE AND IMPLEMENTATION

A key measure to improve governance involves the de-politicisation of healthcare supervision and delivery through:

- *independent supervisory boards* for public health organisations; and
- *an appointments authority* to oversee executive and administrative roles, ensuring competence and accountability.

EQUITY AND EFFICIENCY

The framework provided here aligns equity objectives with fiscal constraints by prioritising low-income households for access to public resources and enabling higher-income earners to contribute through insurance. Decentralised purchasing mechanisms and strategic governance reforms would enhance efficiency and service quality across both sectors. Importantly, it would allow the public health system to access alternative revenue streams sourced from medical schemes.

CONCLUSION

The proposed reforms provide a balanced, pragmatic pathway to address the systemic weaknesses in South Africa's healthcare system. By focusing on governance, equity and fiscal sustainability, a framework is proposed to foster a more integrated, responsive and effective health system that upholds the constitutional right to universal health access. The scalable features of this framework allow it to evolve over time to de-segment the public and private systems without undermining the revenue generating potential of the contributory system.

PURPOSE

This report has been prepared as a response to the willingness expressed by the President of the Republic of South Africa for workable and constructive health reform proposals that promote the goals of universal health coverage.

> "Government remains committed to engaging with all stakeholders in good faith on the process of healthcare reform, and to finding workable solutions that will advance quality and affordable healthcare for all."[4]

The context for this request includes widespread concerns with the inadequacies of the National Health Insurance (NHI) proposals as reflected in the National Health Insurance Act (NHI Act) (Republic of South Africa, 2023), the deteriorating state of the health system and the long-standing policy vacuum.

The concerns with the NHI Act lie at three levels:

- First, the proposals are not in harmony with the current health system, including both the public and the private subsystems, and are regarded as harmful to health access.
- Second, the NHI proposals, both within the NHI Act and those yet to be implemented, are generally recognised as lacking both feasibility and any possibility of improving health access.
- Third, because of the NHI process, no health system reforms of any substance have been implemented since 2004 (for 20 years), leaving in place many weaknesses that could have been addressed and now require urgent attention.

This report provides a consensus position involving representatives of a substantial part of the South African health system. The proposals offer a strategic reform framework and pathway that can improve universal health access (UHA) in a manner that is equitable,

[4] See https://www.thepresidency.gov.za/president-ramaphosa-meets-leadership-business-unity-south-africa-national-health-insurance.

feasible, scalable and financially sustainable. An important feature of this report is that it builds on proposals that take cognisance of official positions and proposals that have been presented to government over the past 30 years and takes as its practical point of departure the present system.[5]

[5] See, for instance, (African National Congress, 1994; CMS, 2008; Development Bank of South Africa, 2008; Ministerial Task Team on Social Health Insurance, 2005; National Department of Health, 1995, 1997a, 1997b, 2002, 2008; Schemes, 2006; Taylor Committee, 2002).

CONTEXT

OVERVIEW

While South Africa technically complies with the requirements for universal health coverage/universal health access (UHC/UHA), with the entire population able to access either free public services or prepaid coverage through a medical scheme, considerable weaknesses exist that have remained unaddressed by government for at least two decades. A non-exhaustive outline of these weaknesses is provided below.

PUBLIC SYSTEM

Governance

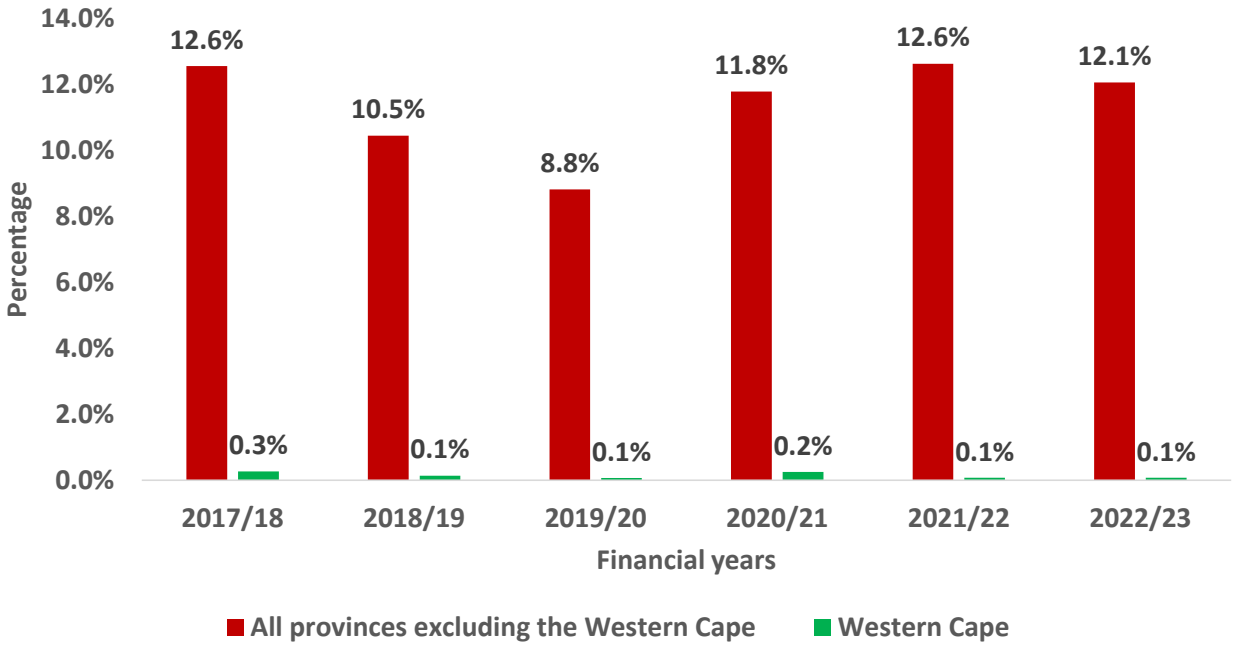
The long-term effects of weak systems of governance in the public sector have resulted in widespread inefficiency and a deterioration in the quality of care provided in many (though not all) public sector institutions.

The public health system remains poorly governed, with exposure to systemic corruption enabled by the failure to separate the roles of the executive of government from the administration and delivery of public health services. This has impacted on the quality of those selected for leadership roles and how they are held to account for performance. As a result, instead of continuous improvements, the public health system is characterised by annual declines in performance.

Irregular expenditure levels provide a proxy indicator for corruption. The combined irregular expenditure for eight of the nine provinces from 2017/18 to 2022/23 consistently averages around 12.3% (around R9 billion per annum) of non-personnel expenditure compared to 0.1% for the Western Cape. The difference in performance between the Western Cape and the other eight provinces is reasonably attributable to governance differences.

The equity considerations for provinces plagued by systemic corruption are considerable. Public resources intended for the population that depends on the public sector are effectively wasted, with the result that services are poorly managed and delivered.

Figure 1: Irregular expenditure expressed as a percentage of non-personnel expenditure: all provinces excluding the Western Cape with the Western Cape reflected separately



Sources: [6]

Primary care

At the primary care level, there are regular complaints of long waiting times to be seen and even longer waiting times at pharmacies. The standard experience is that many elderly people must arrive at the primary care facilities in the early hours of the morning and wait till the end of the day to receive their medication. Drug stockouts at many facilities are a perennial issue. Working people are required to give up a day's wages every time they visit the clinic. Many complaints of lack of facilities (clean toilets etc.) are a regular refrain from

[6] The data sources are from the annual reports of all the provincial health departments from 2016/17 to 2022/23 (Eastern Cape Department of Health, 2015/16-2022/23; Free State Department of Health, 2015/16-2022/23; Gauteng Department of Health, 2015/16-2022/23; Kwazulu-Natal Department of Health, 2015/16-2022/23; Limpopo Department of Health, 2015/16-2022/23; Mpumalanga Department of Health, 2015/16-2022/23; North West Department of Health, 2015/16-2022/23; Northern Cape Department of Health, 2015/16-2022/23; Western Cape Department of Health, 2015/16-2022/23).

service users. *The relationship between district-level services and provincial hospital services is poorly governed impacting on the efficiency of upward and downward referrals.*

Whereas government had prioritised the implementation of a decentralised and well-governed district health system in the 1990s, very little was ever implemented. Instead, district health services are now characterised by fragmented decision-making structures, weak financing approaches, organisational incoherence and, importantly, are not accountable to the communities served. The proposed district approach as outlined in the NHI Act further fragments the primary care system, which will remain without an effective system of accountability for performance but with ever-deepening pre-existing governance weaknesses.

Hospital services

Hospital services appear to be overrun in most instances, with clinicians struggling to find beds to admit severely ill patients. Efficiency within the hospital system, efficient use of staff and patient flows need to be improved significantly. There is a serious lack of equipment, a lack of maintenance of equipment, and supplies (e.g. surgical supplies) are often out of stock. Public sector hospitals do not have stock management systems in place that make for timely supplies replenishment. Cancellations of surgical and other procedures are all too common. Hospital infrastructure has deteriorated with neglect over the last three decades in most hospitals. Building maintenance is a problem arising from provincial works departments carrying this function instead of the hospitals themselves. Bathrooms and toilets are not well maintained, and simple necessities such as hot water in winter are never guaranteed, even in large tertiary hospitals. *There are numerous reports of rats and cockroaches in public sector hospitals, and failures of waste management, linen management as well as supplies and food services. High levels of medico-legal claims point to a concerning decline in the quality of care, especially in maternity services (leading to cerebral palsy in newborns). The delays between diagnosis and treatment of cancer are particularly concerning. The administration and financial management of hospitals and facilities has fallen behind the minimum standards required for organisations with budgets of several billion rand.*

Public hospital services in almost all provinces are compromised by poor leadership arising from weaknesses in the governance framework. There is furthermore a general absence of any strategic vision. Information on hospital services is weak, with nothing routinely made available in the public domain – suggesting that this information is not valued for the purposes of strategic decision-making. The corporate governance design of public hospitals has also exposed them to corruption, with appointments directed by members of the executive rarely pursued to serve the public interest. Had effective reform of the public hospital system proceeded from the mid- to late 1990s, public hospitals would have been able to serve both the public and the medical scheme populations today.

Healthcare workforce

There is presently no strategic vision for the South African healthcare workforce or any mechanism to enable the execution of such a strategy. A strategic misalignment therefore exists between improvements in conditions of employment, the funding thereof, and the realisation of any medium- to long-term set of goals.

The relationship between healthcare facilities, the provincial health administrations, academic and training institutions, and the financing of nationally determined improvements in conditions of employment is poorly framed and one of the central features of this misalignment. Furthermore, the poor management of many public health facilities compromises the teaching and training needs of the health system. Central to this incoherence is the absence of any strategic workforce planning and execution capabilities in the national and many of the provincial health departments.

Critical care services

Ambulance services in townships and rural areas have deteriorated significantly throughout most parts of the country. Archaic administration systems and poor filing systems often mean that patient records are lost, leading to poor continuity of care. The absence of a unique patient identifier and electronic medical records is a source of inefficiency and frustration for clinicians and users alike.

In the entire period from 1994, government has not been able to develop a framework for ensuring universal access to critical care services consistent with Section 27(3) of the Bill

of Rights – which purportedly provides some guarantee of access to emergency services, but in practice does not.

PRIVATE SYSTEM

The medical scheme system in South Africa is regulated to avoid extreme forms of discrimination against persons with a poor health status. This includes the system of community rating, open enrolment, prescribed minimum benefits (PMBs) and measures to avoid the unfunded 'dumping' of medical scheme-covered patients on the public system.

While these measures mitigate important weaknesses in the medical scheme system, they do not address the overall systemic cost increases, excessive profits made for administration/managed care[7], enforcement of medical scheme rules and related legislative requirements[8], access for low-income households, post-retirement coverage[9], income protection for those experiencing temporary loss of income, and system-wide transparency for covered households and intermediaries (funders and providers).[10] It is well recognised that ensuring sustainable systems of protection in contributory systems requires ongoing considered stewardship by government, as healthcare markets cannot self-correct.

While South Africa was on a path to implement such a framework, it has moved backwards on the assumption that the proposed National Health Insurance Fund (NHI Fund) will provide all coverage for the entire population. As this is an unattainable goal, the private

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[7] See HMI (2019, p. 34). "We have found that the high barriers to entry in the administrator market has meant there has been little-to-no entry for several years, despite some incumbent administrators earning very high profits while assuming limited risk relative to either the funders or providers."

[8] This includes but is not limited to compliance with the coverage of PMBs and their ongoing official review by the National Department of Health.

[9] See, for instance, McLeod (2007) for the post-retirement protection approaches that can be enabled through a system of risk equalisation in South Africa – and forming part of a comprehensive system of social security.

[10] It is worth noting the various analyses that have identified preconditions for the effective regulation of private health insurance systems for them to form part of systems of universal health coverage; see, for instance, (McGuire & van Kleef, 2018; Shi & Liu, 2018; W. van de Ven, Hamstra, van Kleef, Reuser, & Stam, 2022; W. P. M. M. van de Ven et al., 2013; van den Heever, 2024; Van Kleef et al., 2018). The research findings from a wide range of international settings are supported by the domestic investigation into the private health system performed by the Competition Commission (HMI, 2019).

health system retains an incomplete system of structural regulation, with predictable consequences for coverage and the quality of coverage.

The exhaustive analysis of the private health system by the Competition Commission through the HMI[11] reinforced the findings of earlier inquiries and expert panels. These included the fact that market failures incentivise poor purchasing arrangements that drive cost increases which can only be addressed through government intervention aimed at the key structural points of the system.

> "We have found there has been inadequate stewardship of the private sector with failures that include the Department of Health not using existing legislated powers to manage the private healthcare market, failing to ensure regular reviews as required by law, and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive." (HMI, 2019, p. 30)

All the various inquiries and expert panels (from 1995 to 2019)[12] have made broadly similar recommendations based on extensive technical work and wide industry engagement.

A consistent feature of all the proposals is that market corrections are achieved without resort to centralised purchasing approaches.

The failure to engage with the HMI report has delayed implementation of key structural reforms needed to correct for the market failures, leaving medical scheme members exposed to, among other things, *avoidable* systemic cost increases.

Because of this strategic failure, more people remain dependent on the fixed resources of the public subsystem than necessary – despite being able to productively contribute, or at least co-contribute, towards their own healthcare coverage.

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[11] See HMI (2019).

[12] See a selection of official reports produced from 1995 to the 2019 (Armstrong et al., 2004; CMS, 2008; HMI, 2019; Ministerial Task Team on Social Health Insurance, 2005; National Department of Health, 1995, 1997a, 1997b, 2002; Taylor Committee, 2002).

REFORM ASSUMPTION – THE EQUITY OBJECTIVE

The realisation of equity objectives in a health system relies on two forms of 'pooling'.

- First, **incomes are pooled** – through the system of general taxes. Here, transfers occur from higher-income households to support lower-income households.
- Second, **risks are pooled** – through both the general system of taxation and pre-funding arrangements (medical schemes). Here, everyone contributes to finance the needs of those needing care at any point in time.

Within the South African context, income pooling is optimised through the effective exclusion of higher-income taxpayers from free access to public hospital services.[13] While not excluded from access to these services, higher-income groups are, however, required to pay the full cost of hospital services rendered.

Risk pooling is implicit in the public sector – as the resources are deployed exclusively for the use of patients in need of care at any point in time. In the private sector, risk pooling occurs through medical schemes, where members make monthly contributions but only claim benefits when in need of medical services.

Private risk pooling (insurance) regimes and social insurance differ from tax regimes in that the benefit entitlement derives from a contribution. If the contribution is not paid, there is no entitlement to the benefits. There is no such quid pro quo in tax regimes. It is for this reason that there is a *willingness to contribute* to health insurance, in contrast to a tax contribution – provided that the private benefit entitlement is regarded as having value.

The more effective the system of private risk pooling, therefore, the more efficient the system of income pooling (provided the public services are provided efficiently). This arises because

[13] The uniform patient fee schedule, which is the public health system's tariff schedule, requires that higher-income groups and medical scheme beneficiaries pay the full cost of public hospital services.

income earners cease to be users of the public health system if their contributory coverage is affordable and sustainable.

From a fiscal perspective, therefore, given that discretionary increases in tax revenue are always constrained when at tax capacity (which is the case at present)[14], all improvements in government revenue are best prioritised for those in greatest need. In this instance, this would be for income-compromised households rather than those with adequate incomes.

It is furthermore important to understand that inequity does not merely arise from a misallocation of resources. Corruption and poor leadership arising from weaknesses in the governance framework for public services disproportionately harms those dependent on public services. Ensuring that an effective system of pooling exists is therefore important, but by no means sufficient to address equity considerations. It must be accompanied by an appropriate governance framework.

When at tax capacity, therefore, there is no scenario in which equity objectives can be enhanced through attempts to use the tax system to cover higher-income groups. Given this, equity objectives can best be achieved only through prioritising the deployment of public resources on income-compromised households while at the same time protecting the sustainability of health systems based on contribution-derived entitlements. However, to ensure that equity objectives are properly met, equitable resource allocations must be accompanied by appropriate governance frameworks.

[14] See, for instance, National Treasury (2024, p. 33)

REFORM FRAMEWORK

OVERVIEW

Flowing from the reform assumption, South Africa's equity objectives are best achieved through two primary interventions:

- The first is a properly governed system of free public services for households unable to contribute towards their own coverage.
- The second is a properly governed system of health insurance for households able to contribute towards their own coverage.[15]

If both systems are properly governed, both the coverage and the equity objectives of the health system will be optimised and superior to any alternative set of options.

A central feature of this proposal is that the functions of 'pooling' (for income and risk) and 'purchasing' are separated, with the former occurring at the national level of government and the latter happening closer to the served population (provinces, social insurance funds and medical schemes) – for accountability and efficiency purposes.

Strategic pooling decisions should therefore ensure that resources are equitably distributed across all regions and income groups. In the contributory system, households should be able to co-contribute over and above any publicly distributed subsidy, with mandatory contributions required for higher-income groups.

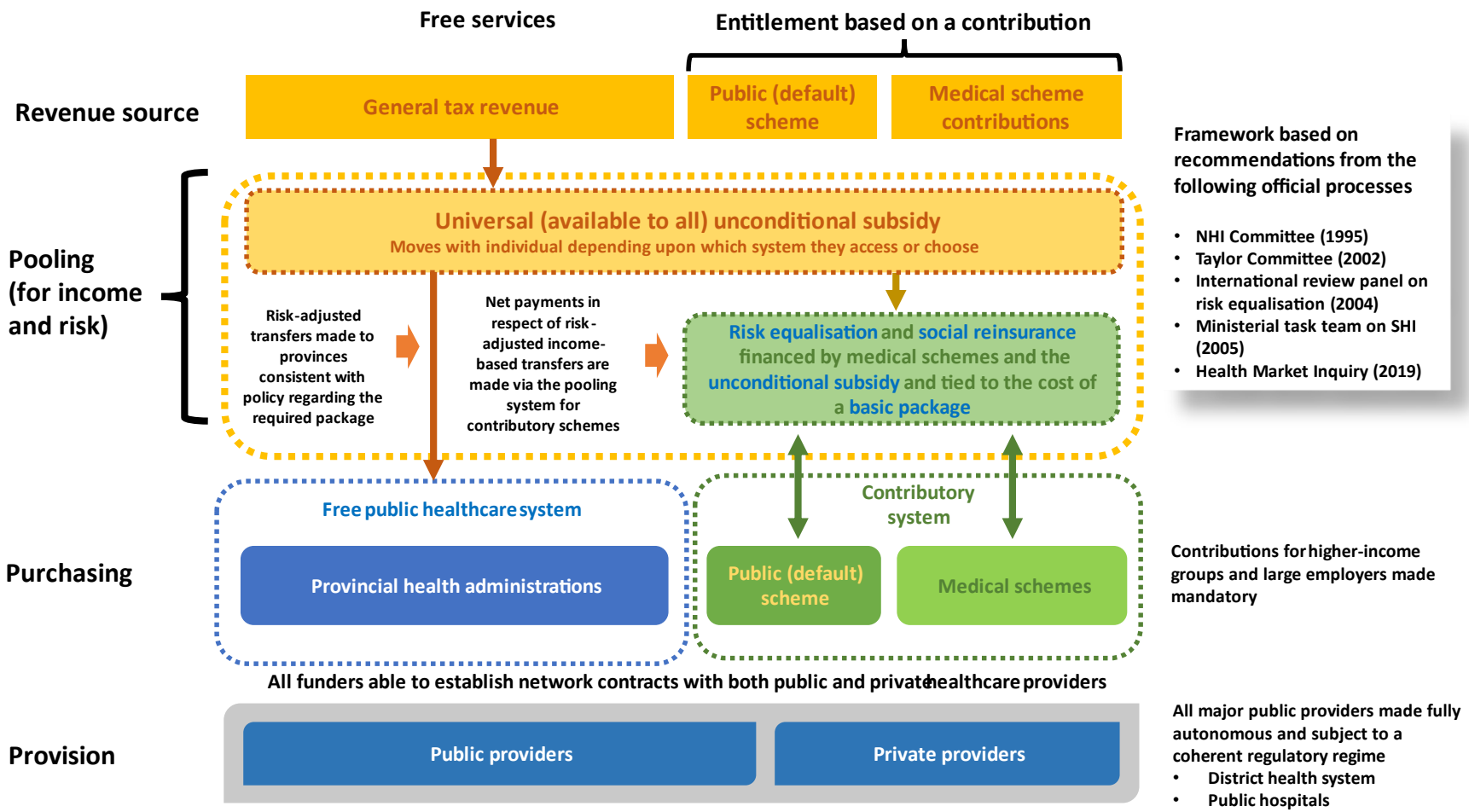
The purchasing function needs to be decentralised with a high degree of local autonomy – both in the public and in the private systems. In this way, complex decisions regarding service provision and contracting can be made by authorities and organisations most competent to make them. In this way, the goals of 'equity' and 'efficiency' are optimised in a manner that cannot arise when the functions are collapsed into one. Importantly, with this

[15] Systems of contributory health insurance include formal publicly supervised social insurance funds and regulated private health insurance systems.

framework, the equity goals can be scaled up over time with no disruption to the complex systems of purchasing and service provision (provincial health systems, social health insurance and medical schemes).

This framework also takes into consideration that the private contributory system is a necessary feature to effectively mobilise more revenue for health coverage for all income groups than would be possible if exclusive reliance were placed on general taxes and the public health system.

Figure 2: Summary illustration of the proposed reform framework



NATIONAL HEALTH FUNCTIONS

National health functions should focus exclusively on the establishment of an enabling framework for a decentralised system of health purchasing and provision.

Equity considerations are therefore addressed through the pooling regime as a specialised technical function of government.

The following is required to establish the enabling framework for decentralised purchasing and provision:

- First, an **independent organisation is required to manage the pooling functions** of the health system. These pooling functions include:
    - the determination of the **health component of the provincial equitable share allocation** in support of the work of the Financial and Fiscal Commission as well as National Treasury;
    - the determination and allocation of an **equitable basic subsidy, forming part of the unconditional universal subsidy, for medical scheme members** (to replace the existing tax credit), which can be designed to prioritise lower-income contributors[16];
    - the determination and supervision of the **criteria for the allocation of conditional grants for tertiary services as well as teaching and training subsidies** (to provincial hospitals and tertiary academic institutions) linked to a well-planned and well-governed workforce strategy for South Africa;

[16] This was originally proposed in the Taylor Committee of Inquiry (Taylor Committee, 2002).

- the **determination, supervision and operation of a risk equalisation mechanism[17] for medical schemes** and related contributory social health insurance schemes (in accordance with the recommendations of the HMI); and

- the **determination, supervision and operation of a social reinsurance mechanism[18] for medical schemes** and related contributory social health insurance schemes (in accordance with the recommendations of the HMI).

- Second, the **establishment of independent public organisations** is needed to:

  - **determine the minimum essential packages of services** that must be provided through free public services and covered by the regulated system of medical schemes;[19]

  - **perform health technology assessments** (HTAs) to support the determination of minimum packages of services;

  - **establish a configuration of national-level independent regulators** to supervise information production, quality of care[20] and clinical governance systems, professional standards, and the licensing of medical products;[21]

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[17] Risk equalisation ensures that all the individual risk pools of medical schemes or participating funds are equalised through a system of inter-scheme/fund transfers. This removes competition based on demographic characteristics, compelling schemes/funds to compete for membership on the cost and quality of coverage provided.

[18] Reinsurance occurs where a secondary insurer insures the liabilities of a primary insurer. This is a standard commercial practice where infrequent high-cost events could exceed the self-insurance capabilities of a primary insurer. Social reinsurance involves the introduction of a non-commercial secondary reinsurance arrangement in which all primary insurers are compelled to participate. Mandating social reinsurance avoids free riding by participants and the abdication of large primary insurers. Seen together with risk equalisation, the entire contributory system would be subject to system-wide pooling for all mandated benefits.

[19] This would replace the proposals to establish 'ministerial committees' – which are not independent, lack a proper governance framework and can be politicised.

[20] Note that the Office of Health Standards Compliance is currently not designed to be independent of political interference and is inadequate as a regulator of quality.

[21] This is not currently in place, as existing regulators are compromised by conflicts of interest (inter alia through political appointments) and are insufficiently empowered to address the complex regulatory requirements of a health system.

- establish a statutory framework to **independently manage and regulate the appointments to all independent supervisory boards** proposed for national and provincial governance structures to ensure a complete separation from the executive level of government; and

- **establish a publicly[22] operated independent default medical scheme** designed to provide a competitive alternative to commercial and employer/industry medical schemes in case they do not offer affordable and/or properly administered plans.

FREE PUBLIC SERVICES

South Africa's system of free public services is provided and supervised at the provincial level of government in accordance with the Constitution. There are no inherent problems with this approach.

[22] While there is reference to the 'public' nature of such a scheme, this does not imply that it would be government-run or a 'state' scheme. The term is used to clarify that the scheme would be subject to statute in the framing of its rules but be run independently of government. The statutory framework would ensure that the scheme has a clear public-value purpose in how it engages in offering competing coverage to pre-existing commercial schemes. A scheme established in this way would be able to incorporate rule designs that promote public interest objectives while nevertheless competing against pure commercial schemes. In this way it serves to both discipline the market and expressly serve social protection objectives through its offerings.

Public healthcare services are always best *supervised*[23] near the served community.[24] However, South Africa's provincial health services are poorly governed[25], with performance compromised by the conflicts of interest that result from members of the executive exerting influence over appointments and procurement.

Provincial health services

In accordance with the Constitution, the authority to administer public health services should remain a provincial competency.

If properly governed, provincial health services can provide good-quality, comprehensive services on an improving basis over time.

The following will establish an enabling framework to ensure effective governance leading to effective and continuously improving performance:

- First, **political appointments must have no direct or indirect influence** over administrative and service-level appointments and procurement. This is not currently in place.

[23] Here, 'supervision' refers to systems of accountability.

[24] While it may be argued that centralisation offers the opportunity for scale economies, this is rarely the case. Large, complex organisations and systems generate diseconomies of scale, resulting in significant efficiency failures.

In large, complex systems such as health systems, therefore, decentralisation – where local or regional entities manage healthcare delivery – improves responsiveness, efficiency and accessibility. This allows healthcare systems to better address the unique context-specific needs of diverse communities by adapting services to local health challenges, cultural practices and resource availability. Decentralisation reduces bureaucratic delays by enabling faster decision-making at the local level, which is crucial in addressing urgent health issues or emergencies. It also encourages community involvement, potentially leading to higher service quality and accountability. Additionally, decentralised provision can enhance resource allocation by directing funds and services precisely where they are most needed, reducing waste and improving overall health outcomes.

Decentralised arrangements benefit from agglomeration economies – which favour bottom-up forms of self-organisation supported by top-down enabling frameworks.

[25] This refers to structural weaknesses that lead to poor leadership, misconduct and corruption. It does not refer to aberrant instances of misconduct. Structural weaknesses in the governance framework lead to systemic failures that can only be addressed with structural reforms.

- Second, **facilities should have autonomy** over the execution of their mandates, subject to a strong, localised accountability regime. This is not currently in place.[26]

- Third, the **maintenance of healthcare facilities and equipment must be entirely financed and managed by the relevant facility Chief Executive Officer (CEO) or Facility Head.** The practice of allocating this function to provincial or national works departments must be discontinued. This is not currently in place.

- Fourth, within the provincial competency to administer public health services, **a system of autonomous district health authorities should be established** subject to localised governance arrangements (independent supervisory boards) with the authority to appoint and remove the relevant district authority CEO. Through these governance arrangements, the referral relationships (upward and downward) between district services and provincial hospitals must be substantially improved. This is not currently in place. The districts will be able to contract directly with private medical practitioners and related services in addition to planning, supervising and managing their own service mix.[27]

- Fifth, **all hospitals should be subject to localised governance arrangements** (independent supervisory boards) with the authority to appoint and remove the relevant hospital CEO. This is not currently in place.[28]

- Sixth, **academic hospitals should be subject to a localised governance arrangement**, incorporating roles for universities in both supervision and

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[26] Autonomy implies that the relevant facility has wide decision-space to directly control all decisions necessary to properly run their organisation. This would include all budgeting and financial control arrangements, revenue collection and the deployment of such revenues, all workforce decisions, clinical governance, the maintenance of the facility and all procurement. It is because of this wide decision space that localised boards with full powers of supervision are required to ensure accountability.

[27] Autonomy in the case of district health authorities implies wide decision-space to directly establish arrangements that include publicly provided services and privately provided services - either on contract or via public private partnerships. In this way private medical practitioners can be contracted by district authorities as and when needed.

[28] While it could be argued that there is an additional expense arising from the establishment of supervisory boards, this must be weighed against the false economy resulting from poorly supervised facilities which have poor leadership, poor performance, and lose billions of rands through systematic corruption.

management, designed to take account of their complex role in providing a combination of national and supra-regional functions (teaching, training and tertiary services) and provincial functions (level 1 and 2 services). This is not currently in place.

Healthcare workforce

A governance framework for the strategic planning of South Africa's healthcare workforce needs to be implemented.

This framework should address the following:

- First, **workforce information** from both the public and the private health systems **must be systematically collected and collated** on a routine basis.

- Second, **systematic engagements are required with the health system** to determine workforce supply shortfalls and surpluses.

- Third, **technical work is required** to support the development of long-term plans for workforce needs.

- Fourth, the **conditional grant framework for academic health services, teaching platforms and service platforms needs to be revised** from general block grant allocations to specific-purpose allocations. This needs to support the execution of the strategic plan and be updatable annually based on properly determined priorities.

- Fifth, the **remuneration for all health professionals required to undergo in-service training and supervision – whether medical, nursing or allied – must be ring-fenced nationally** through specific-purpose conditional grants. This is to insulate these posts from provincial austerity measures that impact on the long-term needs of the country.

While this proposal is specific, a **national engagement with all relevant stakeholders is required** to move this process forward.

Critical care services

An inclusive national process must be established to implement a properly governed national framework to ensure access to critical care services for all in South Africa.

The specifics of such a framework could be outlined here, but it would have little value in the absence of a **properly convened government process** to establish a feasible and implementable policy framework.

This process needs to include all relevant stakeholders presently responsible for financing and providing critical care services.

CONTRIBUTORY HEALTH INSURANCE

Contributory systems apply exclusively to income-earning households and include social insurance funds and regulated private funds. These systems either supplement or substitute for benefits or subsidies that are financed through general taxes. *They mobilise revenue for coverage over and above what would be possible from general tax revenue, thereby expanding the range of universal coverage*.

Health reforms invariably build on existing systems to expand coverage. The medical scheme system in South Africa has been in existence since the late 1880s and has proven to be highly resilient in terms of both coverage and the early adoption of new technologies. Given this, it provides a strong platform for expanded coverage through a well-considered combination of strategic interventions.

There are two approaches to the mobilisation of additional coverage for healthcare outside of the system of general taxes.

- First, there are the **publicly administered social health insurance schemes.** Unlike many of its peer countries, South Africa lacks a complete social insurance tier for the health system.

- Second, there are the **regulated private health insurance schemes** (domestically referred to as ‘medical schemes’). This framework, although mature in South Africa, lacks key strategic interventions necessary to optimise the social protection

imperatives required of this tier. Importantly, when subject to nationally determined pooling arrangements (risk equalisation, social reinsurance and mandatory participation), private markets then form part of a system of 'social health insurance'.

A third class of contributory health insurance is purely voluntary and less regulated – as social coverage goals are not imperative, provided that the first and second forms of coverage are in place.[29]

The purpose of the contributory system is to supplement tax revenue-financed health coverage, which is subject to hard fiscal ceilings.

For this objective to be achieved, the contributory system must be protected from excessive cost increases and incentives to discriminate against individuals with pre-existing health conditions and/or categorised as having a poor health status ('bad risks').

The main strategic interventions needed to complete the contributory regime of the South African health system consistent with coverage objectives are as follows:

- First, **two key pooling systems** need to be introduced in accordance with the HMI proposals: (1) risk equalisation[30], to even out the demographic variations across all medical schemes and generate competition on the cost and quality of coverage; and (2) social reinsurance, to lower the barriers to entry for new entrants by pooling the costs of extremely high claims across the entire industry.

[29] If the medical scheme system is poorly regulated, the 'third class' of health insurer will begin to provide coverage of essential care in an unregulated for-profit market, resulting in the exclusion of 'bad risks'. This tier of the health system is only less relevant to universal access/coverage if the first two approaches are poorly governed.

[30] It is important to note that the risk equalisation mechanism was fully developed and in an implementation phase in 2008. It was being tested through a 'shadow' phase, with full implementation expected after the passage of the Medical Schemes Amendment Bill submitted to Parliament in 2007/2008. The risk adjustment criteria and methodology, developed in 2003 through a consultative process, was evaluated by an external review panel of international experts on risk-equalisation from six different countries. Their technical review was provided to the South African government in 2004 following an extensive engagement with both government and stakeholders (Armstrong et al., 2004).

- Second, an **independent, publicly established and administered scheme** is required as a default option[31] for health insurance, in competition with traditional medical schemes. This scheme would seek to develop a mix of public and private provider networks to optimise affordable coverage. It would also act as a competitive constraint on medical schemes that fail to manage the value-for-money of their coverage arrangements.

- Third, an **independent information regulator** should be established to progressively develop high-quality performance reporting of health service providers (which would include both public and private sector providers).[32]

- Fourth, **mandatory contributory coverage** should be progressively implemented, beginning with high-income groups and large employers.[33]

- Fifth, an independent (separate from the executive) **statutory authority should be established to administer multilateral negotiations to set standardised prices and tariffs** used in the private health system in accordance with the recommendations of the HMI. This would stabilise the prices and tariffs used in fee-for-service reimbursement.

- Sixth, the system of **prescribed minimum benefits (PMBs) must be deepened** in accordance with the recommendations of the HMI[34] to ensure that a sufficiently comprehensive mandatory package of healthcare benefits is covered to address five objectives:

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[31] Such arrangements operate as 'market makers' that apply countervailing market pressure on incumbents in complex markets subject to high entry barriers. Such schemes are not social insurance schemes, but rather form part of a system of social insurance. As with other public arrangements, the senior decision-makers in the scheme should in no way be influenced by the executive of government. Also, they would operate without any special considerations in a level playing field in competition with conventional medical schemes. As participation in this scheme is a choice and not compelled, it would have to offer value-based offerings to attract and retain membership rather than poor coverage and/or cut-rate health service provision.

[32] This forms part of the HMI recommendations for supply-side regulation, which are extensive (HMI, 2019, p. 258).

[33] This was also proposed, in largely similar fashion, by the Taylor Committee of Inquiry in 2002 and the HMI in 2019.

[34] See HMI (2019, p. 236)

- First, to remove opportunities for health insurers (medical schemes) to discriminate against ‘bad risks’ through benefit design.
- Second, to compel medical schemes and related insurance arrangements to manage their benefits more efficiently by removing opportunities to evade or avoid the liability.
- Third, to ensure that all benefits involving catastrophic expenses are properly covered.[35]
- Fourth, to aid system-wide pooling, as mandated benefits form the basis of systems of risk equalisation and social reinsurance.
- Fifth, to prevent any unfunded ‘dumping’ of members onto the free public services.

This framework ensures that, when an insured person makes use of a public service, that utilisation is fully funded by the insurer (whether social health insurance or a medical scheme).[36]

INDEPENDENCE OF PUBLIC HEALTH ORGANISATIONS

To improve governance and leadership within the public health system, it is necessary to ensure that a clear separation is established between members of the executive arm of government and the administrations/organisations responsible for administering, regulating and delivering healthcare services.

[35] While not all benefits can be covered, ‘proper’ coverage in this instance refers to what a well-capacitated *independent* authority has determined should be covered, considering efficacy, appropriate pricing/costs and societal values. The term ‘independent’ means structurally free from conflicts of interest.

[36] This is different to the National Health Insurance (NHI) configuration which attempts to compel the contributor to move across to the public system together with their contribution. This alternative is more efficient, as the funding flows to the public sector when the public sector becomes the chosen provider. Although this is unlikely for most provinces in the short term, the proposed governance reforms for provincial health services should considerably improve their desirability over time.

It is proposed that government initiate an inclusive process to formulate specific proposals to achieve an effective separation of powers between the executive and the relevant public health administrations/organisations.

Important options to consider include:

- First, **independent supervisory structures (governance designs) for all health regulators, autonomous hospitals and the proposed autonomous health districts** should be established, which would have the powers of appointment and removal of the organisational heads.

- Second, an **independent appointments authority** separated from the executive arm of government (national, provincial and local) should be established to manage and vet the appointments to all the relevant supervisory structures.

- Third, the independent appointments authority should be required to **determine the required competencies and fit-and-proper requirements** for the relevant supervisory structures after inclusive consultations with affected stakeholders.

HEALTH MARKET INQUIRY (HMI)

A process is required to properly take forward the detailed recommendations of the HMI which was concluded in 2019. No process has existed to date to address the recommendations, with important implications for the governance of the private health system.

While certain of the key recommendations of the HMI are already included in the proposals regarding the 'contributory' health system described above, it is worthwhile noting the full range of recommendations, some of which are included here:

- The establishment of a supply-side regulator for healthcare

    - "The entity will be a stand-alone special purpose public agency, with the mandate to fulfil a specific economic or social responsibility of government." (HMI, 2019, p. 214)

- Economic value assessments
    - “To inform practice and to curb waste on procedures, equipment and medicines that are not beneficial, and may not be cost effective, the [supply-side regulator] should have a Health Technology Assessment function (HTA) to produce guidelines for both the private and public sector, though these may differ.” (HMI, 2019, p. 222)
- Health service pricing
    - “The HMI envisages that funder and practitioner [fee-for-service] bilateral arrangements will be phased out as soon as possible. Bilaterally negotiated [fee-for-service] tariffs will be replaced by the implementation of the interim, and then permanent, multilateral negotiating forum, which will apply to as many service delivery modes as rational.” (HMI, 2019, p. 225)
- Outcomes measurement and reporting
    - “The lack of outcomes information seriously impairs competition, limits consumer’s choice and prevents value-based contracting with funders. There is need for radical improvement in the availability of reliable, comparable and meaningful information on healthcare outcomes, in both the private and public healthcare sectors.” (HMI, 2019, p. 231)
- Supply-side recommendations specific to practitioners (HMI, 2019, pp. 234-235)
    - The functioning of practitioner associations.
    - A review of the ethical rules of the Health Professions Council of South Africa.
    - A review of the medical curriculum and the Health Professions Council of South Africa.
- Recommendations for the competition authorities (HMI, 2019, pp. 235-236)
- Recommendations for funders:

- A standardised benefit package and a review of the prescribed minimum benefits (PMBs).
    - "The introduction of a single, stand-alone, standardised, obligatory 'base' benefit package will replace the current Prescribed Minimum Benefits but will retain the same philosophy, that these are the minimum conditions/services that must be covered and paid for in full by medical schemes." (HMI, 2019, p. 237)
- Medical scheme governance.
    - "To improve governance and to align schemes' interests with those of consumers, we propose that the remuneration packages of executives, principal officers and trustees be linked more explicitly to the performance of schemes." (HMI, 2019, p. 238)
- Brokers.
    - "Members will be required, on an annual basis, to declare if they wish to use the services of a broker. For those that do, the scheme will facilitate the payment to the broker. Members who chose not to use the services of a broker will pay proportionally lower scheme membership fees." (HMI, 2019, p. 239)
- A risk adjustment mechanism[37] and income cross-subsidisation.
    - "Alongside the standardisation of benefits, a risk adjustment mechanism (RAM) must be implemented. A RAM will make financial adjustments across schemes to mitigate the risk-profile-related effects on scheme costs. This will remove the current incentive for schemes

[37] Note that this is merely different wording for a risk equalisation mechanism.

to compete on low level competitive factors such as attracting a younger population." (HMI, 2019, p. 239)

- Mandatory medical scheme membership.
    - "We recommend that mandatory scheme membership, when introduced, should start with the highest income bands and progressively include additional income groups as more of our recommendations are successfully implemented and the cost of joining a scheme decreases." (HMI, 2019, p. 240)
- Low-income groups.
    - "To address the needs of low-income scheme members, it is recommended that the current tax credit regime be reconstituted to take the form of a contribution subsidy. It is crucial to integrate both risk and income adjusted subsidy." (HMI, 2019, p. 240)

REGIONAL INTEGRATION

South Africa will, on an indefinite basis, continue to experience cross-border flows to make use of free public health services. This is an inevitable reality of the regional context. It is imperative that government ensure that public services are properly financed without compromising the human rights of all involved.

It is therefore proposed that government initiate a regional discussion to establish a financing framework for regional governments to fund the costs of their citizens' usage of South Africa's public health services.

For this to be effective, however, South Africa's public hospitals must fully implement billing systems that will enable the proper invoicing of foreign citizens. This is not the case at present.

PROCESS CONSIDERATIONS

A prerequisite for the successful implementation of any systemic health reform in South Africa is the establishment of inclusive, trust-based processes of policy engagement and policy execution.

Internationally, health reforms involve the co-production of policy solutions that include social actors and key stakeholders. It is therefore proposed that an inclusive process be developed that can support government in the development and implementation of reform proposals as outlined in this report.

CONCLUSION

The framework proposed here is pragmatic, addresses the core systemic weaknesses of the current health system, and can be implemented within the existing fiscal envelope. The equity objectives of the health system fit naturally into the income- and risk-pooling arrangements proposed.

The institutional separation of pooling from purchasing in the manner proposed is also understood as the most efficient approach to achieve equity and efficiency objectives.

- First, the **technical achievement of equity objectives is superior** to options that wish to consolidate all purchasing of healthcare into a single monopoly fund financed by general taxes. Importantly, progressive improvements in pooling for both income and risk are scalable.

- Second, **decentralised purchasing is considerably more efficient** than centralised purchasing. Centralised purchasing is prone to diseconomies of scale – which is a particular risk in public monopolies.

- Third, **extraneous tax increases are not required** to achieve the equity outcomes, as resort is made to moving income earners off the government balance sheet by establishing a sustainable enabling environment for income earners to contribute towards their own coverage.

- Fourth, the proposed **governance reforms of the public health system will address the systemic performance failures** that presently plague public service delivery.

- Fifth, the **structural cost increases in the system of medical schemes will be addressed** through the system of industry pooling, fair price determination, and competition from public funds and service providers.

In addition to the above framework, very significant policy processes have been neglected for the past 20 years. These now need to proceed, making use of inclusive consultative processes of engagement – otherwise they will not succeed.

These include addressing the following key areas:

- a **governance framework for free public services**, related public health authorities and regulators;
- an **independent technical authority to make determinations on minimum and essential benefit frameworks** for both the public and the private health systems as well as a resource allocation formula for free public health services;
- an **independent appointments authority** for supervisory (governance) arrangements for all strategic public health entities;
- a system that can ensure **universal access to critical care services** consistent with the Bill of Rights;
- a **governance framework for managing the training of health professionals** for South Africa; and
- a **multilateral regional agreement framework to address the financing of cross-border utilisation** of free public health services in South Africa.

While the framework proposed here requires implementation over a few years, the processes needed to execute the framework can begin immediately – provided they are adequately capacitated. Required from government, therefore, is a sincere commitment to inclusive and properly governed processes to achieve outcomes that are unambiguously in the public interest.

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