How Have Stakeholders' Interests Shaped the National Health Insurance in South Africa?

An Evaluation of NHI: Stakeholder Analysis from 2002 to 2013.

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Introduction

Since the inception of democracy in South Africa, the government's task has been the one of transformation and attempting to bridge the gap between the poor and rich, which is defined along the racial lines. The whites South African benefited from the apartheid system at the cost of the disadvantaged non-whites South Africans. The health care system amongst many other social indicators resembles this divided society of the rich and the poor along the racial lines. The introduction of National Health Insurance (NHI) therefore is seen as the remedy for the dire public health care system, which is categorised with lack of financial and human resource. Whereas the private health care system is well resourced both financially and health personnel and serves less than 25% of the South African population.

This paper seeks to analyse how stakeholders attempt to influence the NHI policy with a hope to have a significant impact to advocate for their interests. This paper also acknowledges that, all stakeholders agree that the South African health system is not sustainable and needs to change to fit the needs of the South African population. However they all differ with regards to how to go about implement a system that is going to benefits everyone. Stakeholders are categorised as Government, labour, private medical schemes, civil society, and academics, local and international experts who seek to contribute towards the development of comprehensive health coverage for all South Africans

The nature of the essay is a chronological analysis from 2002 to 2013 to evaluate how the NHI has been put on the formal agenda for government to consider and how stakeholders engage during that window of opportunity to influence the policy shaping. The paper is divided into four themed chapters, chapter one is focusing on conceptual understanding of key concepts and terminologies that will appear frequently during the dissertation. Chapter two will serve to lay a background of the South African health care system, before 2002 as far back as 1994. Whereas chapter three, will focus on the 2002-2011 period, doing an analysis of how NHI has been evolving from Taylor Committee in 2002, followed by the ANC's 52nd national conference in 2007 to the appointment of new Minister of Health Dr Aaron Motsoaledi in 2009. Last chapter will start from 2011 to 2013, main focus on the release of the NHI policy paper or green paper for discussion by different stakeholders to interact with it.

Chapter One

Introduction:

This segment of the project will focus on unpacking the key concepts and attempt to provide working definitions. The concepts include agenda-setting as a tool of analysis in understanding power dynamics amongst stakeholders in a policy process; and policy windows which allows stakeholders to act in advancing their interests. Furthermore this project will also use terms such as stakeholder and National Health Insurance (NHI).

Conceptual Understanding:

This chapter will mainly discuss the concepts that will appear frequently in this paper in an attempt to provide conceptual clarity. Agenda setting is a tool of analysis which this essay will use in analysing power dynamics amongst stakeholders with a main component of stakeholder analysis. According to Hogwood and Gunns (1984), agenda setting is the process in which problems come to the attention of the governments. This stage is also known as the invention or initiation stage according to Lasswell's model (Howlett, Perl and Ramesh, 2009: 11-13). The main focus of this paper is the period after the National Health Insurance (NHI) Bill was tabled for discussion and consideration by various stakeholders and how it was adapted in response to these comments. Hence this essay will use agenda setting along with stakeholder analysis to understand how stakeholders' interests have shaped the NHI in the South African context.

Furthermore, in order for one to understand what stakeholder analysis is, this paper will first explain what it means by the term "stakeholder" as some scholars refer to actors rather than stakeholders. Firstly, stakeholder means "an individual, group, or institution who has a vested interest in the natural resources of the project area and/or who potentially will be affected by project activities and have something to gain or lose if conditions change or stay the same" (Golder and Gawler, 2005: 01). Therefore, for one to understand how these stakeholders interact and influence the policy one requires a tool of analysis and that is stakeholder analysis. Stakeholder analysis, according to Crosby (1992), is defined as a "method or an approach to

analyse the interests and roles of key players in a specific policy domain" (Mehrizi, Ghasemzadeh and Molas-Gallart, 2009: 428). To put this definition into context this approach will be used to analyse the stakeholders who have invested their interests in the NHI policy domain in the South African context.

The term National Health Insurance is linked to Universal Health Coverage (UHC) which is what the United Nations is advocating for, was and is also made popular by the United States health policy called Obama Care under the President Barrack Obama administration. According to the Director-General of the World Health Organization (WHO), UHC is defined as, "the single most powerful concept that public health has to offer, it is inclusive, it unifies services and delivers them in a comprehensive and integrated way, based on primary health care" (Chan, 2012). This definition is not particularly different from the one that the South African Minister of Health provides. According to Minister Dr Aaron Motsoaledi, NHI is, "a financing system that will ensure the provision of essential healthcare to all citizens of South Africa and legal long-term residents regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund" (Motsoaledi, 2011). This speaks exactly to the globally acceptable definition of what an NHI or UHC is and this essay will use NHI as a term used in the South African context.

Additionally, there is confusion between Social Health Insurance (SHI) and National Health Insurance. In South Africa particularly, there has been an on-going debate for almost two decades about the possibility of introducing some form of Social or National Health insurance. According to the Health Systems Trust, "mandatory health insurance is often called Social Health Insurance, particularly where only certain groups are legally required to become members and where only those who make insurance contributions are entitled to benefit from the scheme" (McIntyre and van den Heever, 2011: 73). Whereas, "NHI is also a term that is frequently used, especially with reference to a system that is universal, or covers the entire population irrespective of whether they have personally contributed to the scheme or not" (McIntyre and van den Heever, 2011: 73). The latter is defines exactly what SA sought to pursue, however as the research unpacks, clarity will be given in understanding South Africa's version of UHC.

Lastly, this paper does acknowledge that there are many stakeholders involved, however not all are individually going to be discussed. Furthermore this essay will have three main segments; the first one will focus on the background of the South African health system prior the year 2002. The subsequent section will focus on the period between 2002 to 12th of August 2012; this is when the Minister of Health released a Green Paper or rather discussion document for NHI. Thereafter the last segment will mainly focus after the release of the Green Paper to the end of June 2013. The main purpose of this paper is to analyse the way stakeholders contribute towards the development of the NHI policy.

Chapter Two

Introduction

The main aim of this chapter is to give a background of the South African health system. It focuses on how apartheid policy divided services based on race, and how this added to the burden on the post-1994 government in tackling the health sector. Furthermore, it will briefly look into health sector policies that were legislated by post-apartheid governments in combating the disparities of the past. It will touch on how GEAR and other relevant factors such as political and economic factors affected the development of NHI policy, although space does not allow for a full discussion of these factors.

Background of RSA Health Care System pre-2002

Under the apartheid government, South Africa was a segregate, caste-like society with the allocation of state resources uniquely enforced through the legislative means. For instance; "black South Africans in the tribal areas retained the customs and diseases of an impoverished indigenous economy; those black Africans who moved from the country to the cities have exhibited the intermediate patterns of early industrialization in subsistence societies" (Susser and Cherry, 1982: 457). In the struggle for equal rights, for all South Africans, one venerable slogan that was popular amongst non-whites activist was that, "disease knows no colour bar" (Susser and Cherry, 1982: 463). Base on logic, for infectious and parasitic diseases, at least, this was evidently true; the health of white South Africans, regardless of the economic status and social distance from blacks, was directly affected by being in contact with blacks. Furthermore, "in rural areas medical care for blacks is negligible, although the overall ration of doctors to population is estimated at 1 to 1 970, in some areas as low as 1 to 40 000" (Susser and Cherry, 1982: 469). It is important to put this brief history into cognizance when assessing how stakeholders, attempt(ed) to influence the NHI policy development, as it is crucial for understanding the current status of the South African health care.

The discrepancies in human development in South Africa are generally attributable to the racially bigoted economic and social policies of the apartheid regime. These disparities could be fairly classified as unacceptable inequalities, as they continue to reproduce poverty and perpetuate inequality. According to Gilson and McIntyre (2002); "the disparities in socio-economic status have also contributed to inequalities in health status in South Africa; there are significant differences in the incidence of ill-health between groups of different race groups and geographic areas" (Wadee, Gilson, Thiede, Okorafor and McIntyre, 2003: 04). The health policy under the apartheid government, as with all government action, served the dominant objective of preserving economic and political supremacy for white South Africans. As a consequence, "private providers and private insurers play important roles within the health sector, but still predominantly serve the white, higher income groups, leaving the public sector to serve the lower income, largely African population" (Wadee et al, 2003: 08). This is where the private sector has an impact as it attracts most health professionals because it is well funded and serves a small sector of society, which makes working conditions better in contrast to public sector.

The post 1994 government faced a number of challenges in transforming the sector and overcoming problems which are attributed to apartheid. Studies conducted by Lancet (2009) have shown that there has been, "a greatly increased burden of diseases, primarily related to Human immunodeficiency virus (HIV) and Acquired immune deficiency syndrome (AIDS) and poor health outcomes relative to the country's wealth and health expenditure" (Schaay, Sanders and Kruger, 2011: 04). This burden is associated with social class in the South African context, which boils down to race because of the past. For example, "South Africa faces a quadruple burden of disease consisting of HIV and AIDS, tuberculosis (TB), high maternal infectious diseases and under-nutrition resulting in neonatal and child mortality" (Schaay et al, 2011: 05). In consequence, there has been an increase in the burden of chronic non-communicable diseases; with violence and injuries accounting for an additional cause of early death and disability. This has alarmed the National Treasury, because of fears that increased spending on the Roads Accident Fund and the implementation of NHI will exhaust the already over-stretched budget.

South Africa is the second most unequal country in the world, as measured by the Gini coefficient, and its inequality rating has increased from 0.56 in 1995 to 0.73 in 2005 according to Coovadia (2009). The Gini coefficient is a tool for measuring income inequality, which ranges from 0, representing equality, to 1, which represents the highest level of inequality within a society. There are a number of implications of the social class inadequacy in South Africa on the health sector. According to McIntyre (2010), "access is also adversely affected by the persistently skewed allocation of resources (both financial and human resources) between public and private sectors, with disproportionate financing of the private sector, relative to the number of beneficiaries" (Schaay et al, 2011: 06). Issues of inadequate supply and uneven distribution are clearly illustrated here, "the decrease in the nurse to population ratio, from 149 public sector professional (registered) nurse per 100 000 population in 1998 to 110 professionals in 2007" (Schaay et al, 2011: 06). Despite the improvement of a national human resource strategy in 1999/2000 there still remained a substantial human resource predicament. This then invites the involvement of the labour unions and higher education in an attempt to address this issue.

In recognition of the inadequate infrastructure and huge gap between those who can afford medical care and those who cannot, the White Paper for the transformation of the health system in South Africa was passed. The White Paper states that, "the object of the White Paper is to present a set of policy objectives on which the Unified Health System of South Africa will be based on strategies designed to meet the basic needs, given the limited resources" (DoH White Paper, 1997). This means that government had set a task of creating a unified health system that was capable of rendering quality health care to all South African citizens. This was underpinned by the disparities of the past on which NHI was based upon in its formation. To illustrate, the White Paper further states that, "a detailed policy on health insurance will be published and will thus complement the White Paper" (DoH White Paper, 1997). This was a deliberate attempt to transform the health to be more inclusive of all citizens regardless of race, class and gender.

Furthermore, the then Minister of Health Dr Nkosazana Dlamini-Zuma reiterated that, "it is envisaged that the National Health System will incorporate all stakeholders, i.e. government sector, non-government organisations (NGOs) (including religious and grassroots organizations), the private sector, and especially the communities" (DoH, White Paper, 1997). These were the

main stakeholders recognized when the White Paper was formulated. The White Paper was strongly influenced by the Reconstruction Development Programmes (RDP) objectives, which included but were not limited to developing education and training programmes aimed at recruiting and developing personnel who were competent to respond appropriately to the health needs of the people they served. Hence one of the key objectives was to, "distribute health personnel throughout the country in an equitable manner and establish health care financing policies to promote equity between people living in rural areas and urban areas and between people served by the public and private health sectors" (DoH, White Paper, 1997). This speaks exactly to the principles that NHI advocates, such as creating an essential package of primary health care interventions that will be made universally accessible. This then enforced the need to put an emphasis on reaching the poor who were the most vulnerable.

Understanding the complexities around historical socio-economic challenges that South Africa was facing in the early years of democratic South Africa, the Department of Health in collaboration with Medical Research Council and by invitation of the Human Science Research Council conducted a South African health review. This review contributed strongly to the idea of establishing a comprehensive financial health scheme to address disparities of the past that were recognized then and are still prevalent in the contemporary South Africa. The review started by acknowledging that, "the status of health among South Africans today, is both a product of development of the past and an input into development effort for the future" (Health Systems Trust, 1996: 11). The review also noted and supported the objectives of the RDP and the need for National Health Insurance to address the insufficient resources in the public health care system. For instance the National Health Department recognized the inequalities in health expenditure and promptly acted on it by introducing a discussion around the possibility of implementing NHI.

To further illustrate the aforementioned point, the review report stated that, "in an attempt to start to tackle these inequities; the Health Ministry initiated a Committee of Inquiry into a National Health Insurance System" (Health Systems Trust, 1996: xv). The report of the commission of inquiry itself is not available; however one of the recommendations was to improve health care using some of the required resources from the private sector. Hence the commission strongly

recommended that, “some of the required resources for primary health care being derived from the spin-offs of mandatory health insurance coverage for a defined hospital package for all employees” (Health Systems trust, 1996: xv). The current tabled NHI Green Paper has been criticized for being unclear on defining the package of NHI by all those involved, mainly the private sector and academics.

The committee of inquiry into a National Health Insurance System for South Africa was mandated to design a system that would be universal and promote equal access in accordance with the South African Constitution. They further recommended sources of financing to ensure that NHI gets implemented. These recommendations were, “an increased allocation to health from general tax revenues, dedicated funding to the public health sector from excise duties and/or value added tax, payroll taxes, imposition of user charge on voluntary private health insurance contributions” (Health Systems Trust, 1996: 75). These recommendations were aimed at tackling the lack funding and sustainable sources for funding NHI.

Furthermore, to tackle the issue of human resources, which according to the report of the committee of enquiry was a big challenge, they had recommendations. When it came to policy directions, it was mentioned that, “emphasis is being placed on the optimal utilization of existing health personnel, including those acquired from outside South Africa, and distributing personnel equitably throughout the country” (Health Systems Trust, 1996: 87). However, there were objections raised by different stakeholders such as Junior Doctors’ Association of South Africa about the recommended strategies of going about distributing health personnel equally. One of the recommendations by the Department of Health was, “the introduction of compulsory public service by doctors for two years” (Health Systems Trust, 1996: 91). The objection to this was that, it should at the very least do not be made compulsory as it would promote migration of health personnel.

Nonetheless, the Department did receive constructive feedback, such the suggested introduction of incentives to attract doctors to rural areas. The forms of incentives were discussed and recommended, “Such incentives could be in the form of improved working conditions, continuing education and improving their physical, communication and personnel conditions, including the provision of housing” (Health Systems Trust, 1996: 91). Another alternative that

the Department was considering was engaging in bilateral agreements with foreign countries to recruit their doctors or agreements with the Department of Higher Education and universities to increase the number of graduates. The Department of Higher Education and Training is one of the key stakeholders needed to ensure that there are enough health personnel.

Moreover, the African National Congress (ANC) in 1994 released a National Health Plan for South Africa that shared similar principles with NHI. Similar to most transformation documents for South Africa, the document start by acknowledging that, "the South African government, though its apartheid policies, developed a health care system which was sustained though the years by the promulgation of racist legislation and the creation such as political and statutory bodies for the control of health care professions and facilities" (ANC, 1994). These bodies were established and managed with the objectives of marinating racial segregation and discrimination in the South African health care system. Furthermore the ANC health plan stated that, "all legislations and institutions have to be reviewed with a goal of redressing the harmful effects of apartheid health care services and encouraging and developing comprehensive health care practices in line with international norms, ethics and standards" (ANC, 1994). This speaks exactly to the World Health Organisation (WHO), as it was one of consultants during the formation of the ANC health plan. The ANC's health standards, amongst many are the implementation of Universal Health Care (UHC) or NHI in the South African context.

Furthermore, the key issues addressed in the health plan were the mobilization of resources and the acknowledgement of the fragmented apartheid system, which consisted of four departments, one for each race. The plan also emphasized that mechanisms would be crafted and implemented to ensure that those patients who were not insured were not refused access because of their inability to pay for services. The ANC health plan also recommended that the public health will continue to be funded through general tax revenue (ANC, 1994). This funding method would also cover those who are not insured in private medical schemes. However, the National Treasury did not welcome this method, arguing that government was operating on an already far-stretched budget and it was not sustainable.

Furthermore, the ANC health plans features were also adopted in the RDP White Paper. RDP was a macro policy guide for South Africa, which later was replaced by Growth, Employment

and Redistribution (GEAR). For example, an objective of the RDP programmes was to, "provide free health care for children under six and mothers pre and post-natal at state facilities and to provide clinics especially in rural areas and informal settlements to ensure availability of free health services" (RDP White Paper, 1994: 47). This was influenced by the ANC stance on providing free health care, mainly to those who were previously disadvantaged through taxing those who could afford private health care. The issue of access and provision of health care was also supported by the South African Constitution which states that, "everyone has the right to have access to health care services, including reproductive health care" (RSA Constitution, 2009: 12). The Constitution further gives provisions that obligate the state: "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights" (RSA Constitution, 2009: 12). However, the realization of these rights would be impossible to implement without the funding and personnel to ensure that the state was delivering to its constitutional mandate.

The shift from RDP to GEAR negatively affected the health sector and other social development sectors such as education, which feed into the health sector. There was no doubt that RDP was geared more towards spending to develop the underdeveloped areas of the country and disempowered masses because of apartheid policies. However, GEAR replaced RDP as a response to the Asian financial crisis which affected South Africa, because South Africa is also part of the global market. According to Bond (2000); "it became clear that the country's economic and fiscal difficulties would impede the realization of the RDP's goals" (Visser, 2004: 08). Given that the ANC has committed itself to fiscal discipline and macroeconomic balance, it left no space to properly implement policies such as those of free health care and emphasis on meeting basic needs.

Acknowledging the difficulties that government was facing it was recommended that, "in order to calm domestic capital and foreign currency markets, the government embraced a conservative macro-economic strategy, GEAR" (Visser, 2004: 08). Implicitly, GEAR was calling upon government to cut down on spending, to allow private sector to lead the economy and provide services on behalf of government through privatization, and to reprioritize the social service delivery budgets. For example, "the welfare spending fell from 9.6% of the total budget in

1998/9 to 9.3 in 2000/1, on health spending from 12.2% to 11.7% respectively" (Visser, 2004: 11). Consequently, the Department of Health's budget was trimmed down and private medical schemes dominated. Public health professionals were dissatisfied with working conditions and as a result many left for the private sector or opportunities abroad.

There were lots of critics of this shift, such as Congress of South African Trade Unions (COSATU), South African Communist Party (SACP), academics such as Bond (2000), Terreblanche (2003), and Webster & Adler (1998). The criticisms were based on argument that government cannot allow private sector to be the key delivering engine of services. For instance, "private health insurance is for the well off, in contrast to universal health care for those who cannot afford private health care" (Visser, 2004: 01). The move was arguably not popular politically and one of the reasons that intensified the gap between the poor and the rich, those who could afford private health care and those who could not. The then-President of COSATU Mr John Gomomo stated that, "we reject its approach to fiscal and monetary policies which continue to see major cuts in government spending on social security" (Gomomo, 1997). This was after the realization that GEAR was benefiting the private sector, the poor remained poor and the public health sector was getting worse in terms of infrastructure, working conditions for workers and service delivery.

To conclude this chapter, this segment discussed the evolution of the health sector from apartheid to the democratic government. The chapter mainly focused on how the health sector was structured pre-1994 and what underpinned the changes post-1994 and challenges that were delaying the progress of adopting a comprehensive health care system. Furthermore, it discussed the way in which macroeconomic policies have affected the health sector, both financially and in terms of human resources and other international events such as Asian financial crisis. During this discussion, stakeholders such as the DoH, National Treasury, labour unions, private sector and academics seemed to be active in the period leading up to the 2002 Commission of Inquiry into Comprehensive System of Social Security led by Professor Vivienne Taylor.

Chapter Three

Analysis of the NHI Development (2002-2011 August 12)

Introduction

The focus of this chapter will be on stakeholders involved in the NHI process. It will look at who the main stakeholders were and their influence on the NHI policy. Using agenda-setting as a framework it will also assess how the issue was put on the agenda and policy windows. The key policy windows that this chapter will emphasise are the Taylor Commission Report, the 52nd ANC National Conference outcomes and the appointment of Dr Motsoaledi as Minister of Health. The main analysis will be on how stakeholders reacted to these policy windows.

Taylor Commission Report:

The Commission of Inquiry into Comprehensive System of Social Security for South Africa, also known as the Taylor Commission or Committee, was mandated by the Minister for Social Development, Dr Zola Skweyiya, by extension through section 97 of the South African Constitution, the then President of South Africa, Thabo Mbeki. Amongst the many purposes of the committee was to contribute to "the provision of affordable, decent and effective health care for all", which had been identified as a specific goal in the area of social policy by Government following the 1994 elections (Taylor, 2002: 09). This was based on the findings of an inter-departmental task team which reported in 1999 that many people could not afford to pay for health care, and there was therefore a need to design a policy that would cover this vulnerable sector of society. In addition, the terms of reference for the Taylor Committee mentioned that the general objectives of analysis included examining the public and private sector environments "with a view toward ensuring universal access to basic health care" (Taylor, 2002: 10). This was based on understanding that inequality between races was striking in the South African context and transformation of the health sector towards a more umbrella cover was ideal in addressing these inequalities.

The committee's report had a whole chapter dedicated to the health sector and it started by saying that, "transformation of the health system has been and remains an urgent priority for the democratic government since 1994" (Taylor, 2002: 85). This was based on the proposed NHI paper in 1995, which showed that NHI was a valid departure point for on-going reforms. This required that SA ultimately move towards the NHI system. Some of the findings, looking at problems identified with the existing strategic framework, were that, "the public sector is faced with an increasing population, both low-income and indigent, while the private sector population is not increasing" (Taylor, 2002: 85). This was brought to the attention of the committee by the fact that public health care had to accommodate those who were more seriously ill and could not afford to pay for private health care. There was also a shift from risk selection and uncontrolled cost increases. Another key issues was financing, "despite an increasing population and disease burden, the public sector health system faces a constant or declining real budget" (Taylor, 2002: 86). The budget cut contributing factors were also the GEAR policy principles which were cutting down on social spending. Meanwhile there was a significant increase in the private sector budget allocation: double the inflation rate on a per capita basis.

Furthermore, the responsibility for the general performance of a country's health system lies with government, which in turn has to consist of all sectors of the public. The Taylor Committee Report further emphasized that, "government has the responsibility for establishing the best and most equitable health system possible with available resources" (Taylor, 2002: 86). This extends to the private sector as well with regards to the oversight and regulative role that government should play and should be high on the policy agenda. Thus the commission outlined the role and scope of government involvement in the health system of South Africa. The committee noted that, "government policy needs to provide a framework that results in oversight for a minimum level of essential benefits irrespective of whether it is provided in the public or private sector" (Taylor, 2002: 86). There has been a contestation around the specifics of a benefit package that NHI is proposing, and this will be detailed when discussing the Green Paper. Even the private sector did not welcome this proposal wholeheartedly, arguing that it had loopholes and was not clear who would be funding what and how. The report further outlined that public sector must remain in charge of the health system, while the private sector can provide an effective environment to achieve high levels of funding over and above tax based funding.

Table 9

Summary of coverage by broad income category

	Phase 1	**Phase 2**	**Phase 3**	**Phase 4**
Poor	○ Public sector: basic amenity (free)	○ Public sector: basic amenity (free)	○ Public sector: basic amenity (free)	○ Public sector: basic amenity (free)
Low-income	○ Public sector: basic amenity (user fee)	○ Public sector: basic amenity (user fee) ○ Medical Scheme (voluntary)	○ Public sector: basic amenity (free) ○ Public sector contributory fund (voluntary) ○ Medical Scheme (voluntary)	○ Public sector: basic amenity (free) ○ Public sector contributory fund via NHI contribution (mandatory) ○ Medical Scheme (voluntary)
Middle-income	○ Public sector: basic amenity (user fee) ○ Medical Scheme (voluntary)	○ Public sector: basic amenity (user fee) ○ Medical Scheme (voluntary)	○ Medical Scheme (mandatory)	○ NHI contribution (mandatory) ○ Medical Scheme (voluntary)
High-income	○ Public sector: basic amenity (user fee) ○ Medical Scheme (voluntary)	○ Public sector: basic amenity (user fee) ○ Medical Scheme (voluntary)	○ Medical Scheme (mandatory)	○ NHI contribution (mandatory) ○ Medical Scheme (voluntary)

(Taylor, 2002: 91).

The coverage of NHI changes over four general phases outlined in Table 9 above with the steadily expansion of the contributory system. The phases are arguable, a guide towards evolution of the comprehensive health system in achieving universal health care. Phase one is basically a development of the enabling environment with recognition that, "the current health system is incompatible with the introduction of, or integration with, contributory environments" (Taylor, 2002: 87). Hence the focus is on improving the public health care facilities such as decentralising public hospital management, consolidating of medical schemes reforms to remove any residual risk, development of effective policy process and implementing basic essential services.

Phase two on the other hand focuses mainly on implementing preparatory health systems reforms. The report emphatically states that, "the phase two reforms serve to enhance the voluntary contributory environments in order to facilitate the establishment of a mandatory environment emphasised in phases three and four" (Taylor, 2002: 88). The numerous reforms included final implementation of the state-sponsored medical scheme along with a mandatory environment for civil servants and risk-adjusted subsidy to medical schemes that begun in phase one. Whereas phase three is to focus on the implementation of the initial mandates, as phase two would have laid the ground work to build on based on the statutory mandates. The two key frameworks to be implemented would be, "the first based on medical schemes (including the state-sponsored medical schemes); and the second a dedicated Public Sector Contributory Fund (PSCF)" (Taylor, 2002: 89). This is based on the understanding that the income distribution in South Africa is skewed, therefore, the higher income category would be, to start with, to fund NHI. Then the final phase would be the implementation of an NHI health system which would be a contributory system, which would use an extent substitute general tax funding as a source of revenue. The final phase essentially envisages, "the establishment of a contributory environment for all groups and individuals assessed to be in a position to contribute towards the health system" (Taylor, 2002: 89).

This concludes the discussion of the Taylor Committee Report, which gives an understanding of the first analysis of this essay. It will be followed by comments from key stakeholders, grouped

into categories such as academics, the private sector, the public sector, political parties and labour unions, and the media.

Response to the Taylor Commission Report

After the release of the Taylor Commission Report, there was a lot of consultation and a public hearing process, whereby the Department of Social Development was engaging with different stakeholders in hearing their opinion about the report. A joint submission was made by COSATU and National Education Health and Allied Workers Union (NEHAWU) which raised points of great concern with the report and recommended what could be done moving forward. The submission started by expressing NEHAWU's views that, "the proposal in the Taylor Committee Report is misleading, what is actually being proposed is a Social Health Insurance (SHI) system not a National Health Insurance (NHI) system" (Parliamentary Monitoring Group [PMG], 2003). They argued that this is a very important distinction between the two because the concept NHI has been mooted in 1995, so the terms are used interchangeably.

The first proposal to the Taylor Committee Report made by COSATU and NEHAWU was that, "the consequences for workers of the Taylor recommendations are huge and we submit such proposals would need the National Economic Development and Labour Council (NEDLAC) to be discussed" (PMG, 2013). This proposal was based on the premise that the proposal to reconfigure tax relief on employee contributions to medical schemes, while demanding all workers of larger corporations and the public service to join medical schemes is problematic as it will result in higher costs for low income workers. Furthermore the union raised critical questions that the report did not address entirely, such as: "access to and staffing clinics, labour relations issues and the brain drain, both from the public to the private sector and overseas and the structure of tertiary care and how that would affect equitable access" (PMG, 2003). The risk was that, if NHI failed the soaring of health costs and human resource drain from the public sector would continue. Also the agreement to create privileged facilities to private users in the public sector institutions did not do justice towards doing away with the two-tier public health system. This was learnt from the two-tier fee-based system in the South African education, and would therefore take the country a step back from achieving equitable access to health care.

In summary, NEHAWU supported the committee's measures to enhance equity and control medical costs. However, the main proposals to achieve the ends were increased funding for public health through increased contributions by the rich, clear definitions of minimum standards of care for both the public and the private sector, and lastly, a mandatory membership in medical schemes for any group, including workers for large employers and the public service.

Most information around stakeholders' engagement with chapter eight of the Taylor Committee Report, which deals with NHI, was not available then and is only referred to in recent media statements. However, it is worth noting that the Inkatha Freedom Party (IFP), since the release of the 1995 NHI paper, and the Taylor Committee Report, have stood by the principles that, "all working individuals should be obliged to purchase health insurance – of their own choice, the options should include insurance with a savings component and pre-funding for retirement, pay-as-you-go schemes, managed care or a national health insurance" (IFP, 2011). They further emphasise that, all health care funds should be controlled to guarantee financial stability, and to provide incentives for effectiveness.

52nd ANC National Conference Resolutions:

The ANC, as the leading majority party in government since the inspection of a democratic government in 1994, has a comparative advantage in influencing policy processes in South Africa. The ANC won the 2004 general elections with 69.69%, followed by the newly formed party the Democratic Alliance (DA) with 12.37% (Independent Election Commission, 2004: 60). The ANC's 52nd conference in Polokwane in 2007 was the platform for the ANC as a political party to reflect on its past performance and decide on strategic points when it came to public policy, amongst many other matters. According to the ANC's 52nd National Conference Resolution Number 52, "education and health should be the two key priorities of the ANC for the next five years" (ANC, 2007). As South Africa has a one party dominant democratic system, the lines get blurred between the party and the government's objectives, because what happens or gets decided at Luthuli House, gets pushed to become a mandate for government institutions. Luthuli House is the headquarters of the ANC's offices located in Johannesburg, South Africa.

Furthermore, Conference Resolutions Numbers 53, 54, 55, 57 and 67 speak exactly to NHI and what the Taylor Committee reported on. Resolution 53 states that the ANC will "reaffirm the

implementation of the National Health Insurance System by further strengthening the public health care system and ensuring adequate provision of funding" (ANC, 2007). The political implications of this Resolution are that, the next elections' agenda would be to ensure that when the new term of government, the ANC would push for NHI implementation. The aim for NHI according to Resolution 54 was to, "develop a reliable single health information system" (ANC, 2007). As prior research about the South African health system has been saying about affordability, the conference paper identified that private health care was expensive. The ANC then took a stand that, "government should intervene in the high cost of health system" (ANC 2007). This meant that government would play a major role in setting the prices for the health sector, which would require support from the private sector.

The paper draws to attention the fact that, the ANC emphasised implementation, rather than engaging on formulating an NHI policy. This therefore suggests that the policy needed to be fast forwarded to ensure a roll out of NHI without hindrances such as those of funding, human resources or opposition stakeholders. The ANC's Polokwane conference concluded on health by stating that, "caution should be exercised when deciding on Public-Private-Partnerships (PPPs) as a solution for the delivery of health services" (ANC, 2007). This was underpinned by the call for government to insource its services more than collaborating with the private sector. The government engages in PPPs to involve the private sector in rendering services on behalf of the government. This argument of insourcing was reaffirmed by Resolution 64, "the ANC should explore the possibility of a state-owned pharmaceutical company that will respond to and intervene in the curbing of medicine prices" (ANC, 2007). However because the ANC considered itself a broad church, there were concerns by other members that it was not fair of government to keep injecting money into state-owned companies, as this was unfair to the private companies.

Soon after the ANC Polokwane conference and the Resolutions were made there was a lot of consultation, roundtable discussions and debates around NHI and the ANC proposal itself. In 2009 the Helen Suzman Foundation (HSF), hosted a round table discussion attended by representatives from the ANC, Netcare, Independent Health Economist, Mr Alex van den Heever, Discovery, the South African Private Practitioners Forum (SAPF), the South African

Medical Association (SAMA) and Wits School of Public Health, on the topic of *Health Reforms and NHI*. To understand the context, Netcare and Discovery were private sector health care stakeholders, while the ANC was representing the governing political party, Wits and Heever were in attendance as academics and experts in the field of public health and lastly SAMA and SAPF were advocating for the well-being of the health professionals.

The conversation started by acknowledging that the health care reform was at a critical juncture, hence there was a process of engaging all stakeholders in a more beneficial debate on the implementation of NHI. Mr Tebogo Phadu, who represented the ANC, opened by saying that, "this is born of the fact that if we really are to raise high the health-care agenda, leadership is required and will also require cooperation and involvement of all types of stakeholders through social impact" (HSF, 2009: 08). This suggested that the HI was mandatory and required coordination and cooperation amongst stakeholders from academics to private sector. Phadu further reiterated that, "NHI is an ANC proposal, not a government proposal, first we are proposing the creation of a public national health insurance fund which will receive the majority of health care funds" (HSF, 2009: 10). This further emphasised the ANC health plan of 1995 and the resolutions of the ANC in 2007 of creating a universal health care for all South Africans to ensure equitable access.

However, Heever had a different point of entry as he was more concerned by the lack of focus on resource allocation and institutional design in the ANC proposal. He argued that, "resource allocation decisions involve rationing, having earmarked a proportion of funds, they must be appropriately allocated and this requires a distributive mechanism" (HSF, 2009). The distributive mechanism falls within institutional organisation although it is specific to the financing part of it. Similar to NEHAWU, Heever enquired if the ANC proposal was a NHI or a National Health Service (NHS), as fundamentally the two were different. He explained that, "NHI over NHS means that residents will be required to enrol to obtain cover when at present they access the services for free" (HSF, 2009: 14). His argument was based on a premise that NHI is inherently an enrolment-based approach to a universal health system. Which begs the question why would one want to pursue that route if in South Africa people already have access to free primary health care?

Netcare was represented by Hein van Eck who also had concerns about the proposed NHI and its implications to the private health care. The first point he made was, “we have been to previous presentations, where some official from the Department of Health mentioned that you cannot cost NHI because you cannot cost it accurately” (HSF, 2009: 16). The question of cost was very relevant and thus there was a need to know the benefit package that NHI was proposing in order to make projections on finances when it was being implemented. Moreover, not only did he address the issue of finances but also human resources, this after both the ANC policy and Taylor Commission put an emphasis on equal redistribution of health personnel evenly in both sectors.

Eck stated that, “much has been said about inefficiencies in both sectors but I think one thing that few people know is the fact that the databases that get used in this country to count health professionals are hopelessly inaccurate” (HSF, 2009: 16). According to the Health Profession Council, South Africa had 36 000 doctors and 213 000 nurses in 2009 while, “if you look at Persal, the government database, the payroll talks to roughly 10 000 to 11 000 doctors and 105 000 nurses in the public sector” (HSF, 2009: 16). For NHI to be implemented there was a need to have an accurate database of existing health personnel and the database should be able to tell where that personnel was in terms of sector and geography and function. If this information was available, it would be easier for government to speak of fair redistribution, because redistribution was not only by sector from private to public but also by regions and speciality.

His last comment was on the design of NHI, “the NHI plan was all about one funder, a single funder and everybody would be part of it, but Dr Olive Shisana [President and CEO of Human Sciences Research Council] acknowledged that medical schemes will be allowed” (HSF, 2009: 16). The single funder version of NHI means that there would be no medical schemes and this was not welcomed by the private sector. However after serious interaction between the two sectors, NHI plan subsequently included an option to use a medical scheme while contributing to the NHI fund.

In the round table discussion was Joe Veriava from the Wits School of Public Health and his concern was on operations more than technical understating of NHI. He said that, “our hospitals are not coping, make no mistake about it, our hospitals are running at the present moment

virtually at 100% bed occupancy in contrast to 65% in the private sector" (HSF, 2009: 17). This is why South Africa needed NHI and partnership between the private and public sectors to ensure that the remaining 35% was being used for public sector purposes instead of sending patients home early to admit the next one. He furthers adds that, "the issues are clearly around funding, I see the NHI system being able to integrate both public and private systems so that we can provide universal access" (HSF, 2009: 17). His stance was underpinned by section 27 of the South African Constitution, which states that every citizen must have equal access to public health care, but funding is what kept government from fulfilling that basic right, hence the need to partner with private sector.

In response to the questions and requests for clarity on the NHI policy, Phadu responded to some questions. He started by stating that, "on medical schemes the ANC is very clear that there is a role for the medical aids even under the NHI system, and that even though health care insurance will be compulsory, we will not prohibit voluntary health insurance" (HSF, 2009: 18). The ANC's policy statement was driven by the need to expand the pool of people and resources required to integrate both the distribution of private and public services. The ANC was of the idea that via one single channel from a central pool or central fund, it would be easy to facilitate and coordinate the allocation of resources.

A representative from Discovery Health also referred to the ANC resolution with great concerns. According to Jonathan Broomberg, "the Polokwane Resolution says the ANC will implement the NHI system by strengthening the public health system and raising additional funding" (HSF, 2009: 20). However, the NHI model that the ANC was proposing did not convince that it would actually strengthen the public health system. This was based on the fact that there were no projections for costs of NHI and hence there was little probability that the cabinet would approve such a policy without knowledge of how much it would cost taxpayers. Phadu instantly responded by saying that "the ANC is not saying that there is no need for costing, I think that is very important and lot of work has been done on much more sophisticated costing methods" (HSF, 2009: 21). However, the emphasis was on how the costing was structured and to avoid ending up with a detailed service package which was typical of the scientific calculations.

Chris Archer, a specialist in the private sector, represented the Private Practitioner's Forum of South Africa. He argued that, "my major concern is accepting that the two-tier system currently in place is inequitable and whether the change to a NHI system will make it more equitable" (HSF, 2009: 22). The concern was whether NHI would live to the promise of access of services for all South Africans, and access to what? The questions challenged the notion that implementation of NHI would solve all the problems that were found in the public health system. He further argued that, "one should examine very carefully the assumption that the private sector was attracting away resources from the public sector and that if the private sector was not there those services would flow back to the public sector" (HSF, 2009: 22). This related to the human resource question that health personnel were overflowing in the private sector whereas a significant number of personnel actually migrated overseas for better opportunities. How was the government under the NHI plan to attract health professionals and make sure that they stayed and did not leave the country?

SAMA was represented by Trevor Terblanche, who welcomed the move towards universal access to health care for all South Africans but with reservations. He stated that, "the challenge always lies in the detail of how to achieve that, SAMA is also clear that it says it's not either private or public sector oriented, but watches over both" (HSF, 2009: 23). SAMA's argument was that South Africa had a national health system but it was fractured and not ideal and also fragmented in so many ways. Hence they proposed that, "instead of being grandiose and talking about the mechanism of funding, let's talk about delivery and how we can do things better and make a difference" (HSF, 2009: 23). This argument was based on the premise that health was not a bargain, someone had to pay for it and there was no such thing as free health care because someone was paying, the question was who and why. Hence the emphasis should be on ensuring proper service delivery rather than mechanisms of funding and design of the scheme.

The round table discussion was organised by the Helen Suzman Foundation to engage with the ANC's proposed NHI policy coming from the 52nd ANC National Conference in Polokwane, 2007. Stakeholders such as SAMA focused more on ensuring that services were rendered to the people and that having such discussions was only solving a minor part of the problem. Whereas SAPF, believed that NHI would not magically solve public health care problems and that

perhaps, like the ANC resolution says, public health care should first be strengthened before moving towards a universal coverage. In addition to that, Heever was concerned about the financial feasibility of implementing such a policy without known costs and whether or not South Africa was adopting NHS or NHI.

2009: New Minister of Health Dr Aaron Motsoaledi

The South African political system is a one dominant party system, with the ANC being the dominant political party with an overwhelming majority. The South African political system therefore benefits the ANC in a sense that, whatever they decide in their national conferences, becomes their manifesto for the next elections which later transforms to government policy. Hence in Polokwane the ANC resolved that the NHI would be implemented after the 2009 elections. This was supported by the article by *City Press* in October 2009 which said that, "the ANC will undertake a charm offensive to sell the national health insurance scheme to the public in the face of opposition from the private health sector" (Sidimba, 2009). According to the ANC's NHI proposal, they planned to use platforms such as NEDLAC and the South African National Aids Council. This was aimed at setting the agenda leading to official discussions of implementing NHI, which was why the ANC consulted all major stakeholders through NEDLAC. Furthermore, according to the ANC proposal, "NHI will be effective in collecting revenue, better able to negotiate prices and will offer government a higher degree of control over health expenditure" (Sidimba, 2009). The proposal was that it would be funded through general tax and mandatory contributions which was recommended by the Taylor Committee Report in 2002.

A month after the release of the ANC's NHI proposal document, the Minister of Health, Dr Motsoaledi, appointed a Ministerial Committee on NHI. The committee was mandated to, "advise the Minister on aspects of National Health Insurance Policy, to enrich the process on policy and legislation development and the implementation plan for the NHI system" (Ministry of Health, 2009). This was another sign of positive direction of implementing resolutions of the ANC on health. The committee consisted of members with backgrounds in academia, labour union, insurance financial services, health economics and public policy.

Furthermore, not only was the ANC and the Minister of Health pushing for NHI as a formal agenda for government but also the Finance Ministry. For the first time then Finance Minister, Trevor Manuel, mentioned that, "the development of a national health insurance system is aimed at improving the equity of health care financing and enhancing the quality of health care for all South Africans" (Manuel, 2009: 14). He rationalised his 2009 budget by acknowledging that the complexities of health reforms had led to task teams which had been mandated to conduct research and advise a way forward to implement these reforms, which would be introduced through NHI. For the Finance Minister to highlight NHI in his budget speech meant that NHI was becoming an institutionalised agenda.

Not only was NHI mentioned by the Minister of Finance in 2009, but also the newly elected President of the Republic of South Africa, Jacob Zuma, gave a way forward for the implementation of NHI. In his State of the Nation address, he stated that, "we will introduce a National Health Insurance scheme in a phased and incremental manner, in order to initiate NHI, the urgent rehabilitation of public hospitals will be undertaken through Public-Private Partnerships" (Zuma, 2009). In addition to the Presidency and Minister of Finance giving the go-ahead for implementation of NHI, newly elected Minister of Health, Dr Aaron Motsoaledi, also emphasized the need to implement NHI and called upon all stakeholders to cooperatively work with government to ensure smooth implementation. He started by explaining that NHI, "is a system of universal healthcare where every citizen is covered by healthcare insurance and the present system of healthcare financing can no longer be allowed to go on, because it is simply unsustainable" (Motsoaledi, 2009). Nonetheless, none of the aforementioned key stakeholders explained how NHI was going to function differently and how it was going to improve the quality of health care and address the current challenges of the public health care. However, after all these key stakeholders in government welcomed the implementation of NHI, this left no room for other stakeholders to delay the implementation but to find solutions and recommend ways of how to go about implementing it.

Not all stakeholders were content with the process that was led by the ANC in-camera and the leading opposition party, the DA opposed the NHI plan proposed by the ANC. In the DA press release statement they stated that, "the DA believes that we must fix the problems of the health

system on the ground, without massive expenditure on more bureaucracy and we will fight to ensure South Africans do not bear the brunt of another ANC spending extravaganza which delivers little" (Waters, 2009). Instead the DA proposed a comprehensive review of the qualifications and experience of hospital managers, a review of the structure which governs hospitals, improved quality of management and a change of attitude towards the private sector, only then one could one table NHI. Though DA proposals were noted they did not hinder the process of implementing NHI.

While the DA was opposed to NHI in principle, The African Christian Democratic Party (ACDP) views were that, "the overall aim is to reduce taxation of companies so that they, together with the employees can contribute towards medical savings schemes" (ACDP, 2009). Also Old Mutual conducted a Healthcare survey, with an attempt to gather employers' perception of NHI and they surveyed 100 employers. According to the survey the general perception was that, "they want to play a part in the process of transformation and in the decisions taken that affect both employer and employees; this finding contrasted sharply with 62% of respondents who said that they did not understand the impact of NHI on the health care industry" (McLeod, 2009: 15). There were many stakeholders who contributed to the NHI policy development with an attempt to shape it in a way that best fit their beliefs and interests.

The consultative period with regards to NHI lead to the release of the long-expected official document by government. During the State of the Nation address of 2010, President Zuma mentioned that, "we will also continue preparations for the establishment of a national health insurance system" (Zuma, 2010). This was further echoed by the Minister of Finance in his budget speech, when he mentioned that, "alongside longer term reforms to the financing of health care, a closer partnership between the public and private health care systems is a prerequisite for the introduction of national health insurance" (Gordhan, 2010: 17). In addition, the Minister of Health during his budget vote speech also emphasized that, "our major objective of pursuing an NHI is to put into place necessary funding and health service delivery mechanisms that will enable the creation of an efficient, equitable and sustainable health system for all South Africans" (Motsoaledi, 2010). The argument was that through NHI the government would make provisions for universal access to quality health care to all South Africans in

collaboration with private sector and other stakeholders. However what was not being addressed by government was how NHI was going to generate income, attract health personnel from migrating to other countries, and increase production of health professionals from South African higher education institutions of learning.

The 2011 State of the Nation address by President Jacob Zuma shed some light about some of the critical questions with regards to challenges faced by the public health care system in South Africa. He emphasised appointing well qualified management in hospitals and clinics and announced the plan to revitalise 105 nursing colleges and the plan to open a medical faculty at the Limpopo Academic Hospital to train more doctors that were needed to ensure the smooth implementation of NHI. He further reaffirmed the commitment to implementation when he said, "work has continued to develop NHI policy and implementation plan and government will soon be releasing a policy document for public engagement" (Zuma, 2011). This was a positive shift from NHI being informal dialogue by stakeholders but now moving towards putting it on a formal agenda for government as promised in the ANC manifesto and Polokwane resolutions.

Not only did President Zuma have a radical shift by advocating for NHI, so was the Minister of Finance, Pravin Gordhan, in his budget speech. The budget increased from R63 billion in 2007/8 to R113 billion projected for 2012. In his speech he also reaffirmed the commitment to NHI implementation by announcing that "R8 billion is added to specific health service interventions, laying foundation for NHI, these includes, new Office of Standards Compliance to inspect and certify hospitals, funding for institutional and management reforms, improve quality in health facilities and hospital systems" (Gordhan, 2011: 19). His budget was motivated by the phasing in on NHI that would need significant reforms to address imbalances across the public and private sectors and investing on professional training.

This essay also notes the change in Dr Motsoaledi's budget speech, for the first time in his speech he had a section dedicated to NHI, which by implication means that, NHI was getting more attention as it is a priority for the Department. He started by asking the stakeholders who did not want to see NHI being successfully implemented to be patient because health was not just about releasing a policy but required a lot of preparation. He said, "in this case, the reengineering of the health care system is very vital, under the present health care system

whether public or private, no NHI can ever survive" (Motsoaledi, 2011). This echoed Minister Gordhan's earmarked allocation of funds to ensure that NHI was being implemented on a better health system than the current which was assessed negatively as being unsustainable, very destructive, extremely costly and very hospicentric or curative in nature.

On the contrary, COSATU and South African Non-Governmental Organisation Coalition (SANGOCO) under the coalition called Peoples Budget Coalition (PBC) had different views than those of the Minister of Finance but also supported some aspects of the budget. For example they stated that, "they welcome the fact that the budget makes available an additional R8 billion to take the first step in establishing NHI" (PBC, 2011: 12). This was acceptable because the funds were made available to benefit the people of South Africa in terms of enhancing the health system in ensuring that NHI was implemented without hindrances. However, they had different views on some matters with regards to the budget speech, for instance, "we do not support any consideration of a general increase in the value added tax (VAT) rate as a mechanism to close the gap of the shortfall in terms of the current estimates of the financing mechanism of the NHI" (PBC, 2011: 12). They based this stance on the basis that VAT affects the poor severely. They held that instead the rich should be taxed more, as taxing the poor defeats the ends of equity. They further suggested an alternative that, "there are various options available such as an earmarked levy on luxury imported items, an imposition of a tax on producers of extreme health hazards such as tobacco, alcohol and other industrial polluters" (PBC, 2011: 12). This suggestion was considered in line with redistribution of income from the rich to the poor according to the coalition.

Chapter Four

Analysis of the NHI Development (August 2011- August 2013)

Introduction

In August 2011 the official policy paper document was released by the Department of Health and this prompted a huge debate from NGOs, the private sector, civil society, academics and political parties. Debate was prompted mainly by the lack of information and engagement on the NHI process which left a lot of stakeholders outside the policy discussion realm. The main aim of this chapter will be to identify the reaction to the policy paper document and whether or not the interests had changed from primary ones.

National Health Insurance in South Africa Policy Paper (Green Paper)

The publication of the NHI policy paper was a relief to many stakeholders, as most of them felt left out of the policy discussion, after the ANC National Conference in 2007. Prior the conference there was communication but for reasons ranging from the secret ANC NHI plan which was later leaked, to Minister Motsoaledi being criticised of being selective of whom he consulted about NHI made some of the stakeholders feel excluded. This section aims at giving a brief overview of the policy paper and later on will critically discuss stakeholders' views to the policy paper.

The paper starts by acknowledging the problems within the South African health system. The paper states that, "prior to the 1994 democratic breakthrough, South Africa had a fragmented health system designed along racial lines, one system was highly resourced and benefitted the white minority and the other was systematically under-resourced for the black majority" (DoH, 2011: 05). The post-1994 attempts to transform the health care system through health financing reforms failed dismally as they created a two-tier system. This led to government seeking alternatives, and NHI is that alternative.

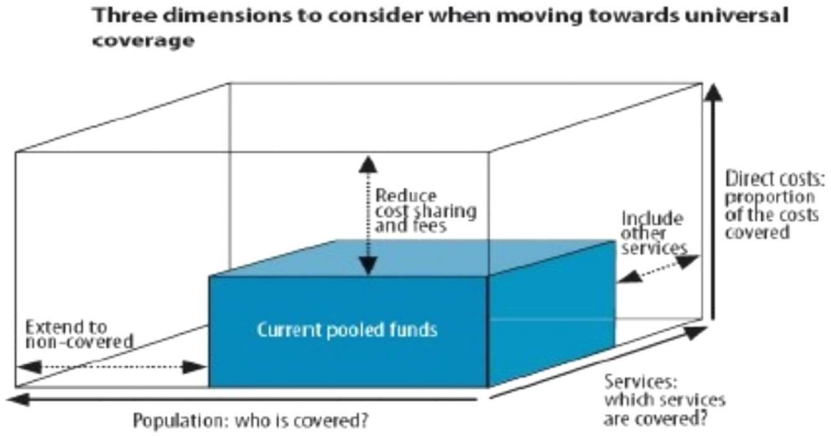
Furthermore, the majority of South Africans cannot afford health care, while on the other hand the country suffers from multiple diseases. Therefore, "the introduction of NHI, should take into account the burden of diseases the country is experiencing, diseases include HIV/AIDS and TB, injury and violence, non-communicable diseases and maternal, infant and child mortality" (DoH, 2011: 07). The majority of people who are suffering from these diseases are black South Africans who cannot afford better health care from the private sector, due to the nature of the private health care arrangement which is prepaid or based on medical schemes, and to an extent some public hospitals. Moreover, one of the challenges that have been raised by many stakeholders is insufficient human and financial resources in the public sector. The paper states that, "the recent estimates show that the ratio of patients to health professionals is lower in the private sector than in the public sector: (DoH, 2011: 10). Hence the Department is working on a strategy to address this challenge through consulting with relevant stakeholders such as labour unions and medical schools.

Likewise, the key problem that NHI is trying to tackle across the globe is to do away with out–of-pocket payments and co-payments. The paper cites that, "payment of health care, particularly for those who cannot afford and who pay out of pocket cannot be planned in advance and this lack of predictability is what exposes households to financial hardships" (DoH, 2011: 12). The vulnerable that become prey to this conundrum are the majority of this country who were systematically disadvantaged under the apartheid system.

NHI is driven by seven principles: the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency. Hence the objectives of the NHI are, "to provide improved access to quality health services for South Africans, to pool risks and funds so that equity and social solidarity will be achieved and to strengthen the under resourced and strained public sector so as to improve health systems performance" (DoH, 2011: 18). The establishment of the Office of Health Standards Compliance is aimed at ensuring that all hospitals are achieving these objectives, hence the budget allocated to it by Minister of Finance.

Additionally, the Green Paper also proposes three dimensions of universal health care coverage and social solidarity. The three dimensions are population coverage, service coverage and financial risk protections and these were advised by the WHO. To expand on the dimensions,

"population coverage refers to the proportion of the population that has access to needed health services, while service coverage refers to the extent to which a range of services necessary to address health needs to the entire population are covered and; financial risk protection refers to the extent to which the population is protected from catastrophic health expenditure" (DoH, 2011: 21). The following diagram simplifies the explanations provided above:



(DoH, 2011: 22).

The length of the cube refers to the population coverage under the universal coverage where the whole cube is covered and not just a portion of it. Whereas the breadth of the cube refers to services covered, "the present system wrongly confuses healthcare with treatment of diseases, a comprehensive healthcare package includes: prevention of diseases, promotion of health, treatment of diseases where prevention has failed, and rehabilitative services" (DoH, 2011: 22). As previously mentioned, households exposed to financial risks because of illnesses are sometimes forced in to poverty because they cannot afford the health care services. Hence the height of the cube refers to, "the extent to which individual households are protected from exposure to financial risks associated with health" (DoH, 2011: 22). However, the policy paper does not specify where the revenue is going to be sourced, aside from general tax, which has been spotted as a shortfall of the paper by many.

Unlike the original plan of having a single tier health care system the, "membership to the NHI will be mandatory for all South Africans but it will be up to the general public to continue voluntarily private medical scheme membership" (DoH, 2013: 43). This is a summary of NHI policy paper presented by the Department of Health for the public to engage with the policy

paper. There have been minor changes from original plan which this essay will discuss in the next chapter.

Responses to the NHI Policy Paper

Adjunct Professor Heever, who is a health economist, was one of the first respondents to the policy paper released by the Department for discussion. His first criticisms are that the paper was not explicit on:

> "clear evidence of institutional failures within the public and private sectors and their causes and feasible options that could address the institutional failures in the short, medium and long term and an depth analysis of the preferred option, including an economic, financial evaluations and risk analysis" (Heever, 2011: viii).

These qualify as the minimum requirements for a policy to be seen as rationally formulated, regardless of its scale. This criticism was based on the fact that no complete situation analysis was tabled that separated institutional failures within the current structural design of the health system. He further recommends the interventions that are required but upon which the policy paper is silent. Those required reforms include but are not limited to: prescribed minimum benefits framework needs to be made watertight and a clear distinction between medical savings account and risk-pooled benefits needs to be clarified (Heever, 2011: xiv). From this response, this paper concludes that government needs to consider an introduction of a new policy paper that holistically responds to the known and prevalent challenges in the health system.

The DA also responded harshly to the policy paper to an extent that they proposed an alternative to NHI, as they believe NHI is irrelevant to South Africans. The DA's argument is that the private sector is not responsible for the low quality outcomes of the public health sector. The DA says, "The Minister of Health blames private the private health care system for poor health outcomes of the public system that he is in charge of, yet there is no relationship between private healthcare's higher quality and the public system's lower quality" (Waters, 2011). The argument is that they are isolated sectors that supplement each other, but do not control each other's outcome.

Additionally, another objection to NHI policy paper is that the true cost for NHI is not clarified by the policy paper. According to the DA response, "one of the most problematic aspects of the NHI proposal is that the Health Ministry has not conducted a proper costing of it and does not list the basket of services that it will offer patients" (Waters, 2011). This criticism is in relation to the lack of a benefit package and formula to calculates costs for the implementation of NHI and the pronunciation of R225 billion to be spent by 2025 for NHI which is not accounted, how the Department came up with cost. The DA proposes that, "firstly, the national Department of Health must create an enabling environment for quality health care; secondly, provincial Departments of Health must be strengthened for better delivery; thirdly, the autonomy of health providers must be supported and health care standards need to be monitored by independent bodies" (Waters, 2011). The proposal is in line with the DA's belief that there is a much cheaper, practical and proven strategy for improving health outcomes.

The South African Private Practitioner Forum (SAPPF) was also one of stakeholders who made submissions on the Green Paper on NHI. The SAPPF is a voluntary association of private specialists working in the South African private health sector of about 2 500 members. The first of objection to NHI was a lack of detailing on important areas of the policy. For example, "the continuing role of the private health care system, with specific detail pertaining to the role of private medical schemes and the nature, function, operation and models of the intended public-private partnerships" (HSF, 2011: 03). The need for detail in many issues contained in the policy paper is only presented at a theoretical level, with little detail and financial modelling provided. Additionally some of the concerns raised by the SAPPF are that, "to simply criticize the private sector distracts attention from the most pressing concern facing the health sector: the dire state of public health" (HSF, 2011: 03). This was in response to the perception that the failures of the public health care is because of private health care system, while there is no evidence to prove this perception. The SAPPF further recommends that health care reforms should be transparent, consultative, researched, qualified, contextual, flexible and accountable and most of these criteria were not taking into account when formulating the Green Paper (HSF, 2011: 13). The SAPPF says that any system of health care reform that seeks to marginalise or threaten the continuity of private health is unreasonable and unjustified; hence they will not support it.

The National Department of Health hosted a conference on NHI, titled *Lessons for South Africa*, this platform served as part of the consultative process in refining the policy paper to drafting the White Paper on NHI. Dr Rudiger Krech [Director of Ethics, Equity, Trade and Human Rights] from the WHO was the first speaker under the theme "Universal Coverage" and he said, "in this endeavour, innovative approaches must be emphasised as they have been shown to lead to positive outcomes in other contexts, the introduction of NHI can serve as social transformation" (DoH, 2011: 12). This supports the argument that no single instrument by itself can work and there is no magic bullet, hence solutions need to be home-grown

The following speaker was Dr Theodore Kutzin from the WHO, and was addressing the conference on the global perspective on health financing. According to Dr Kutzin, "it is of paramount importance that any country's health financing mechanisms must provide access to needed health service for everyone and limit exposure to financial burden for the poor" (DoH, 2011: 12). His comments were based on understanding the social context that huge sums of money are spent on private health care. He further recommended that, "mandatory insurance must be the path which South Africa adopts, risk pooling must be employed to avoid fragmentation, single payer systems are preferred to multi payer systems and there must be widespread stakeholder participation in the policy processes so as to improve global governance" (DoH, 2011: 13). These are regarded as strategic action areas that South Africa must pay attention to as it develops in the direction of attaining universal health coverage through implementing the proposed NHI.

Professor Di McIntyre from the Health Economics Unit at the University of Cape Town addressed the conference on financing options for South Africa. She stated that, "there are three alternative sources from which finances to fund Universal Coverage in health can be mobilised, these are voluntary prepayments, mandatory prepayments or out-of-pocket payments" (DoH, 2011: 42). The current system in South Africa shows that the country has high levels of voluntary prepayments and out-of-pocket payments and to achieve UC, the health system must limit relying on the two financing options and move towards mandatory prepayments.

Similarly, Professor Charles Hongoro of the Ministerial Advisory Committee on NHI shed some light on service provisions. He start by mentioning that, "the package of health services that

South Africa offers to the population under NHI must be comprehensive, it must cover spectrum of primary, secondary and tertiary services including emergency services" (DoH, 2011: 42). In doing so, other capacity aspects need to be attended to such as strategic purchasing for engaging private sector resources especially in underserved areas. Also if the cover is not comprehensive, it will defeat the ends of universal cover which is equity and access to quality health care.

This paper finds it peculiar that at the most critical time of the NHI policy development; President Zuma did not mention anything about NHI in his 2012 State of the Nation address. On the other hand, the Minister of Finance allocated funds for NHI-related projects so to pave the way for NHI implementation. He announced that, "the health sector is allocated an additional R12.3 billion over the next three years, R1 billion is allocated for NHI pilot projects and increasing primary health care visits" (Gordhan, 2012: 21). This was aimed at improving infrastructure, upgrade nursing colleges and rebuilding five major tertiary hospitals. In addition, the Minister of Health gave clarity on NHI and around terminology confusion, during his budget vote speech. He said, "there are people who wrongly believe that the concept of healthcare financing, as envisaged in NHI, is a pipe dream concocted by ANC" (Motsoaledi, 2012). The WHO is advocating for this concept and call Universal Health Coverage (UHC), as a system that does not discriminate against any citizen of a county, therefore it cannot be associated with ANC. Additionally the Minister also reminded the House of Parliament that in March 2012 he announced pilot districts.

There are various perspectives about the NHI Green Paper, the Department of Health both national and provincial aims to prevent diseases and promote health care through promoting curative, preventive, curative, promotive and rehabilitative health services. In summary, government views NHI as means to improve healthcare financing system and introduce affordable and quality health care to citizens. While the DA stands by the view that the private sector is not responsible for the dire state of the public health sector and is concerned about the true cost of NHI and the belief that money is the solution to the healthcare problems of the current system. COSATU on the other hand has embraced NHI and aired their concerns over cost of private health care schemes, hence they demand the exclusion of healthcare from Competition Act and health care be removed from the market and become a social need.

Additionally, Mediclinic believes that details must be provided on the following issues: cost implications of NHI, personnel definition and features of the benefit package, and the role of private schemes in the future. Whereas Discovery Health is in full support of healthcare reforms that are aimed at making high quality healthcare for South Africans, but an open and rigorous public engagement is mandatory and there is a need to focus on improving the public health care system and recognise private health care system as a national asset which should be part of finding solutions rather than being perceived as a problem. Furthermore, SAPPF does not accept the Green Paper premise that the two-tier health care system is to be blamed for poor standard of service delivery. Last SAPPF, does not support accrediting an individual doctor as doctors hold profession and have a council to that.

Conclusion

Almost all stakeholders agree that the two-tier health system is not working, hence the need to introduce a more comprehensive approach which NHI south to introduce. There are two kinds of stakeholders, those who are for and against NHI. Mostly private sector stakeholders such as Discovery Health are willing to partner with government and explore the implementation of NHI. However one also found sceptics such as the SAAPF and DA who is against NHI on the basis that the failures of public health care system is not to be blamed and made a responsibility. On the other hand there is ANC; they are not bothered by how one term NHI as long as the policy does not change it fine.

The shortage of human and financial resources in South Africa, has sought to delay the process of implementing NHI, hence Dr Motsoaledi has called on DHET to increase outputs in South African medical schools. COSATU and NEHAWU are more vocal on trying to secure interests of the workers, through ensuring that the poor do not get taxed, instead the rich must.

Everyone is currently waiting in anticipation for the release of the White Paper on National Health Insurance, which has been recently announced to be released soon. Hence this paper cannot make conclusive ground breaking arguments about how NHI has changed. Release of the White Paper will then show if there has been any changes from Green to White paper.

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