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

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ABSTRACT

In 2011, the South African government published a Green Paper outlining proposals for a single-payer National Health Insurance arrangement as a means to achieve universal health coverage (UHC), followed by a White Paper in 2015. This follows over two decades of health reform proposals and reforms aimed at deepening UHC. The most recent reform departure aims to address pooling and purchasing weaknesses in the health system by internalising both functions within a single scheme. This contrasts with the post-apartheid period from 1994 to 2008 where pooling weaknesses were to be addressed using pooling schemes, in the form of government subsidies and risk-equalisation arrangements, external to the public and private purchasers. This article reviews both reform paths and attempts to reconcile what may appear to be very different approaches. The scale of the more recent set of proposals requires a very long reform path because in the mid-term (the next 25 years) no single scheme will be able to raise sufficient revenue to provide a universal package for the entire population. In the interim, reforms that maintain and improve existing forms of coverage are required. The earlier reform framework (1994–2008) largely addressed this concern while leaving open the final form of the system. Both reform approaches are therefore compatible: the earlier reforms addressed medium- to long-term coverage concerns, while the more recent define the long-term institutional goal.

1. Introduction

Based on positions emerging in 2007, in August 2011, in an apparent departure from earlier health reform initiatives in the post-apartheid period (from 1994), the South African government released a discussion paper proposing fundamental changes to the health system, involving, principally, the replacement of the existing "two tier" with a "single tier" health system [1,3].

While South Africa technically complies with the objective of UHC, various pooling and purchasing weaknesses remain which may only be addressed through institutional reform. The question for South Africa, and countries roughly at the same level of development, is whether it is feasible to resolve these weaknesses by resorting to a single scheme that combines both pooling and purchasing functions, or whether they are better addressed, at least for the medium- to long-term (roughly the next 25 years in this article), through mechanisms that pool across multiple purchasers.

This paper compares the recent recommendations, referred to here as National Health Insurance version 2 (NHI 2), to earlier reforms that defined the period from 1994 to 2008, referred to here as National Health Insurance version 1 (NHI 1). Account is taken of recent government

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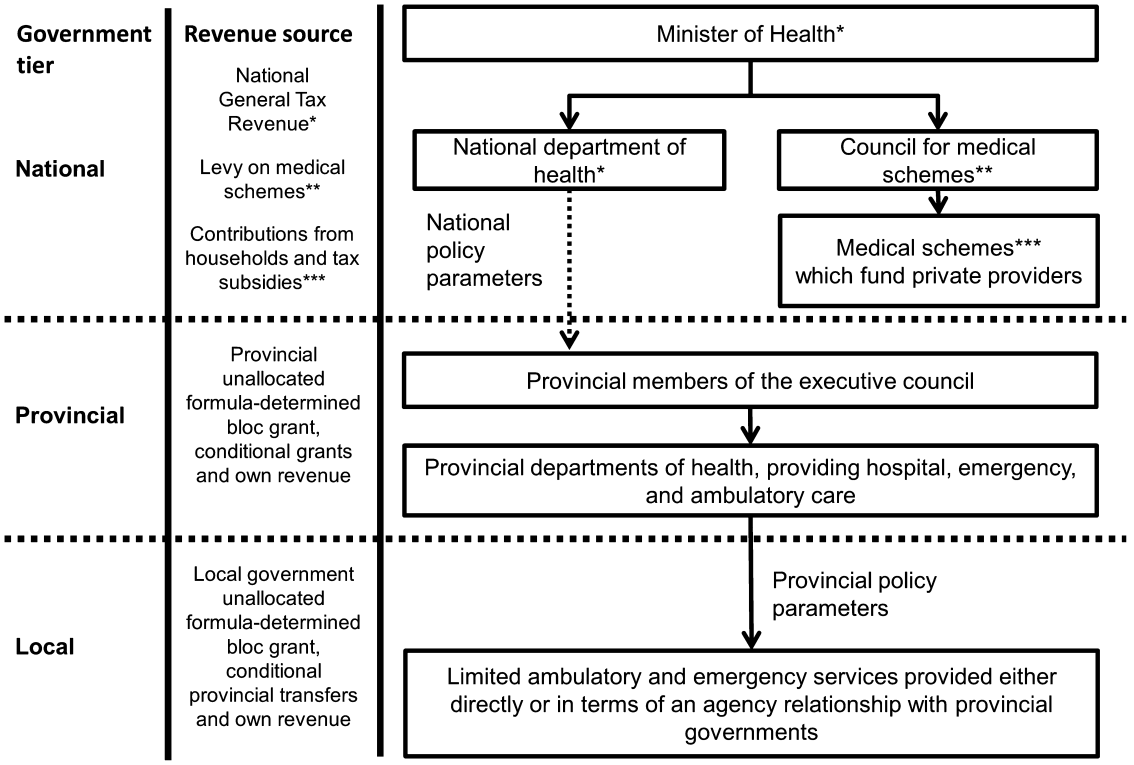

Fig. 1. High-level overview of the South African health system
*Asterisks indicate which revenue source matches a national function.

positions that acknowledge that, whereas NHI 2 originally sought to fast-track the implementation of a single-payer system, the achievement of this approach will take in excess of 25 years [4]. NHI 1, by contrast, focused on optimising existing coverage mechanisms through subsidy schemes and guarantees that could be applied across multiple schemes operating within both the public and the private-sectors–with a long-term trajectory involving more consolidation.

As the stated institutional end-points of both NHI 1 and NHI 2 are very far in the future, the short- to medium-term reform options potentially converge, suggesting that existing forms of coverage, both public and private, should be optimised, as proposed in NHI 1, as the pathway to the fully integrated scheme envisaged in NHI 2 or some variant thereof.

2. Method

This paper reviews strategic health reform proposals in the post-apartheid period in three steps: first, a contextual overview identifies health system weaknesses using an adapted version of the Kutzin framework [22]; second, the strategic health reforms proposed in the two periods, from 1994 to 2008 (NHI 1) and from 2008 onward (NHI 2), are outlined, compared and discussed; and third, the way forward is broached. The approach is necessarily discursive and relies on available published and grey literature to draw insights and conclusions for strategic health-policy recommendations.

3. The South African health system

3.1. Overview

Responsibility for overall health policy lies with a national Minister of Health (MoH) who has the powers to set national policy parameters in national legislation and to ensure compliance at all levels of the system. Policy coordination occurs through a National Health Council (NHC) which is made up of provincial Members of the Executive Council (provincial ministers) with responsibility for health and of relevant departmental heads. Nine provinces and local governments (eight metropolitan, 44 district, and 226 local municipalities) are devolved tiers of government with their own powers to make legislation, raise funds, and execute programmes (Fig. 1).

Medical schemes, making up a substantial part of the health system, are regulated by the Council for Medical Schemes (CMS), a statutory body notionally independent of government but which reports to the MoH. It is also responsible for the prudential regulation of schemes as well as their general conduct. There are presently 87 medical-schemes [13]

3.2. Financing and coverage

South Africa's health system is divided into a publicly delivered part, principally financed and delivered through the country's nine provinces, and a regulated system of non-profit medical-schemes that finance health