

Article

The politics of universalising health care in South Africa: history, policy, and institutions

Robert van Niekerk¹

r.vanniekerk@ru.ac.za

Abstract

The article locates current South African government proposals for establishing a national health service (referred to as National Health Insurance) in its historical context. The attempt to create a national health service in South Africa is not a new policy idea, having been preceded by two prior unsuccessful attempts, in the 1940s and the 1990s. The institutional and political obstacles to re-distributive health policy achieving its egalitarian outcomes are examined. The article argues that the current ‘third NHI moment’ for health care reform in South Africa will need to resolve key concerns if it is to be successful. These include vested interests in the private sector, severe problems of capacity to deliver on quality health care in the public sector, the problem of drawing the middle class back into public forms of health care provision, availability of fiscal resources to sustain a universal system of provision and the ‘gate-keeping’ function of the Treasury in regards such fiscal resources, and provincial opposition to central government control of health care provision. Not least political support for a universal health care service beyond championing by the Department of Health and its minister of Health will be a vital element in achieving a universal system of health care it is argued.

Introduction

In December 2015 the South African government finally made public the White Paper on National Health Insurance for South Africa (NHI), four years after the initial Green Paper on the NHI was released. The key policy intention consistent in both papers is the establishment of a single government managed health fund that can equitably provide health care to all inhabitants of South Africa through a guaranteed basket of health services at not only primary but also secondary and tertiary levels of care. This milestone health policy reform in South Africa occurs within the context of a global policy

drive to universalise the provision of health care, the essence of which is to provide a comprehensive package of basic health care to all citizens without financial impediment. Since the passing of a United Nations resolution in 2012 endorsing universal health care more than 80 countries have requested technical assistance on universal health care from the World Health Organisation (WHO 2012). In the coalition of Brazil, Russia, India, China and South Africa (BRICS) countries, constituting half the world's population, there is a commitment to universalise health care (WHO 2012). In the United States under the presidency of Barack Obama, the Patient Protection and Affordable Care Act (ACA) was promulgated after a marathon legislative process and major compromises to private health care. The Act has put in place since 2012 a legislative requirement of basic health care for all citizens (except undocumented immigrants). In the United Kingdom, where universal health care on the contrary has been a right since 1948, the promulgation in 2012 of the Health and Social Care Act under the Conservative led government has resulted in the devolution of responsibility for providing health care from the Secretary of State to GP influenced clinical care commissioning groups, also a major access point for private care providers. Thus while there is policy agreement on the aims of universal provision there is no consensus on the strategies to achieve it and the relative influence accorded to the state and private sector in such provision. Unsurprisingly this has led to political contestation on the extent of health care reform and the organisation and financing of new health care arrangements.

The inequitable system of health provision in South Africa has similarly impelled government reform initiatives in the direction of universal provision. Figures on trends in health care spending for 2013/14 indicate that of the total 8.6 per cent of GDP South Africa spent on health 4.1 per cent of GDP (amounting to R148.9 billion) was spent on public health care while 4.5 per cent of GDP was spent on private health care (R155.7 billion) and 0.2 per cent through donors. The inequity in health spending is evidenced in the fact that private sector health spending caters for only 16 per cent of population (amounting to 8.2 million people with financial means). Public health care spending in contrast has to cater for the majority 84 per cent of the population (amounting to 42 million people reliant on public care). This fiscally differentiated system of health care provision has resulted in an unequal two-tier system of health care provision (Republic of South Africa 2015b). The mismatch between the spending in health care and health outcomes is illustrated in figures which indicate that despite South Africa's

comparatively high levels of expenditure on health services it has worse health indicators than countries which spend significantly less on health care (Schellack 2011).

In response to the looming crisis in health care provision the government's Minister of Health has publicly called for the ending of 'rampant commercialism' (Motsoaledi 2011) in private health care. This position is reflected in the principles underpinning the NHI White Paper which argues that '(h)health care shall not be treated like any other commodity of trade, but as a social investment' (Republic of South Africa 2015b). Motsoaledi has championed the development of the NHI proposals and maintained its establishment on the policy agenda despite fierce criticism and opposition from within the private sector to the initial policy proposals reflected in the NHI Green Paper (*Mail & Guardian*, February 7, 2014).

The current NHI proposals directly raise concerns about the role and obligations of the state in providing social services of sufficient quality and quantity to citizens and casts a light on past neo-liberal policy which diminished the role of the state in the delivery of social rights (as illustrated in the privatisation of water).

The current NHI proposals also re-connect with a universal health care policy agenda (broadly consistent with social democratic values) that goes back to the 1940s with the 1944 National Health Service Commission of Henry Gluckmann (United Party minister for Health), and which was also iterated in a range of ANC policy documents such as African Claims of 1943, the Freedom Charter of 1955, and the RDP 'base document' of 1993.

The article will explore the relationship between actors, institutions and policy in attempts to reform South African health care in more egalitarian directions. The article will argue that the current contestations over health care reform needs to be seen in their historical context. Health care reforms constitute contestations over the content and extent of social rights of citizenship in a democratic South Africa (in this case health). These proposals attempt to drive reforms in the context of political and fiscal institutions which have limited the possibilities for such a health reform agenda being realised. The NHI proposals will need to confront these institutional obstacles if they are to have any possibility of being successfully implemented. The exercise of political citizenship, or the mobilisation around such citizenship, may also be the deciding factor in the realisation of the historical goal of establishing a universal system of health care.

The article is organised in two sections. This first section reviews the history of health care reform in two significant ‘moments’ – the 1940s and the 1990s – and assesses the reasons why these reforms failed. In the second section the NHI reforms are explored, their origins and what they intend to achieve and what the emerging focus of the proposals suggest about South African attempts to universalise health care.

Section One: The ‘war years’, health policy and political contestations over social citizenship

From the evidence available it has been established that the war years in South Africa between 1939 and 1945 were a watershed in South African social policy-making (Bromberger 1982: 172, Seekings 2000, 2005, Dubow 2005, van Niekerk 1997, 2012). The consensus on the global struggle against Nazism allowed for comparatively radical social policy proposals to be developed in the ‘war years’ by various government commissions of the United Party (UP) government. Within the African National Congress (ANC) under the leadership of Dr AB Xuma, there was an unequivocal post-war expectation of the extension of universal citizenship on the basis of which the African political élite supported the ‘war effort’ and social reforms (Robertson 1971: 29-31, Gish 2000).

The dependency on African labour power and political support during the early war years balanced the domination imperative in the policies of Smuts’ United Party. Many of the reformist social policy proposals developed were far-reaching in that they ultimately placed the sustainability of institutions and existing forms of white domination in question, albeit unintentionally.

The work of the National Health Services Commission or ‘Gluckmann Commission’ reveals the breadth and limits of social reformism of the period.

The Gluckmann Commission on a National Health Service

The brief of the 1942-1944 Commission on a National Health Service chaired by Henry Gluckmann (MP) was to investigate how a national health service could be established based on ‘modern conceptions of health’ and which would provide adequate health care ‘for all sections of the people’ (Union of South Africa 1944).

The health service at the time was racially fragmented with control of public health services devolved to four provincial administrations. These absorbed the bulk of public health funding and which were mainly spent on

academic hospitals rather than community based health care. These co-existed alongside a largely unregulated fee for service private health sector with a proliferation of private medical schemes used predominantly by whites (Union of South Africa 1944).

The National Health Service Commission recommended the establishment of a state controlled and directed national health service provided free at the point of delivery which would be delivered to all South African inhabitants without regard to any criteria other than need, funded through a central health tax (Union of South Africa 1944).

The most significant institutional proposal of the 1944 National Health Service Commission was that full control over the public academic hospitals would be taken over by the central government because these provincial academic hospitals absorbed the bulk of health funding at provincial level. They were thus the key obstacle to delivery of a more radical, local level system of primary health care oriented to prevention.

The National Health Service Commission has largely been favourably assessed in the literature (Harrison 1993, Marks 1987, 1997, 2005). Freund (2012) has cautioned however against an overhasty assessment of the Commission as an intrinsically radical innovation. He argues that the National Health Service Commission was the outcome of a process of debate and assessment that remained consistent with the policy of segregation, while the advocacy of rural health centres for intended use by Africans mainly could also be seen as representing a form of inexpensive, racialised health care in the context of segregation.

The National Health Service proposals of the 1940s were however never implemented. Smuts was instrumental in blocking the implementation as he did not wish to challenge the status quo within the provincial governments. The four provinces of the old South Africa mobilised against the loss of provincial revenue and the loss of control over the large academic hospitals which, then as now, represented a substantial proportion of their provincial revenue for health care funding. The proposals thus ran aground on vested institutional interests (Marks 1987: 8). Again this is strikingly invoked in the post-apartheid period of debate on health reform.

The ANC, social citizenship and health policy: from African Claims to the Freedom Charter

The support by the ANC for a national health service in the 1940's was reflected in a document containing proposals for a post-segregation society

called 'African Claims'. The document represented an 'Africanisation' of the anti-Nazi Atlantic Charter of 1941 and its recognition of political citizenship and welfare as a right of all peoples globally (African Claims 1943, quoted in Karis and Carter 1987: 209-10).

The section on a Bill of Rights in African Claims set out the unambiguous expectation of Africans for full, unqualified rights to political citizenship as an outcome of support for the war against Nazism (African Claims 1943, contained in Karis and Carter 1987: 217). It advocated for social rights to income maintenance, free and compulsory education, and for health, the latter was explicitly articulated as the '*establishment of free medical and health services for all sections of the population*' (African Claims 1943, quoted in Karis and Carter 1987: 217-22, my emphasis).

As was the fate with the proposals of the Gluckmann Commission, African Claims was rejected by Smuts and the UP who sought to appease the white electorate and who favoured a post-war order based on racial segregation for black people rather than the formulations of African Claims based on inclusive social and political citizenship.

With the election of the explicitly racially motivated National Party (NP) and the right-wing drift of the white electorate political opposition emerged to financial support for black welfare. The limited reformism in social policy in the 'war years' was abandoned and the ANC undertook a change in political direction in favour of increasingly militant civil disobedience campaigns for civil and political rights, such as the Defiance Campaign against Unjust Laws of 1952. This new direction was given expression in the Freedom Charter, following a 'Congress of the People' at Kliptown in 1955 (Lodge 1983). The Freedom Charter, framed by the primary citizenship demand that the 'People shall govern', contained demands for social rights, including rights related to income maintenance, state-provided education which would be free and universal, rights to housing and rights to free, state-provided medical care. Demands on health were framed as follows: 'A preventive health scheme shall be run by the state; Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children' (Freedom Charter 1955, in Karis and Carter 1987: 205-8). There was thus a continuity with the proposals of the 1940s of the need to establish a national health service run by the state up until the period of the banning of the ANC in 1961. Between 1961 and 1990 the debate on social policy was subsumed to the political struggle to create a democratic state.

The second moment for universalising health care: constitutional negotiations and the re-emergence of debate on health policy in the 1990s

On the February 2, 1990, president FW de Klerk unbanned the ANC and entered into negotiations on a new post-apartheid constitutional order. As in the period of the 1940s a combination of external geo-political changes (collapse of the Soviet Union) and a willingness to negotiate internally between the major political forces led to a convergence on the need for political reform.

This development was critical to shaping the social policy debate. The language of negotiation, accommodation, compromise and fiscal feasibility displaced the polarised discourses of state-led intervention as opposed to a primary role for the free market. This became apparent in the new debates about social policy including health policy, in a post-apartheid South Africa.

Initially, the dominant social transformation current in the ANC was a more far-reaching re-distributive growth strategy consistent with a social democratic approach. This approach was reflected in the policy proposals of the ANC commissioned Macro-Economic Research Group (MERG) and the Reconstruction and Development Programme (RDP) 'base document'. In these proposals the state was accorded an interventionist role with substantially increased expenditure in the social sectors to meet equity imperatives. These social-democratic currents were displaced however by other, moderating, influences, including that of the World Bank, which reinforced the politics of pragmatic, cautionary social change in the ANC as it considered its role as a future government. It should be recalled that the dominant ideological influence on the ANC and its ally the South African Communist Party was the collapsed Stalinist derived model of socialism of the ex-USSR. The ideological vacuum left by this collapse, coupled with the ascendancy of the World Bank, led to an aggressive positing that there was no alternative to neo-liberal orthodoxies (Marais 2011). The RDP of 1993, a 'base document' developed with its allies in the anti-apartheid trade union and civil society movement, contained the most authoritative statement on the ANC's post-election economic and social policies. The RDP set out its key policy programme in health in the following terms: one of the first priorities is 'to draw all the different role players and services into the NHS [National Health Service] ... Reconstruction in the health sector will involve the complete transformation of the entire delivery system ... The whole NHS must be driven by the Primary Health Care (PHC) approach. This emphasises community participation and empowerment, inter sectoral collaboration and

cost-effective care ...' (African National Congress 1994: 51). The mechanism for achieving the transformation in health care is described in the following fiscally redistributive terms:

The RDP must significantly shift the budget allocation from curative hospital services towards Primary Health Care to address the needs of the majority of the people. This must be done mainly by re-allocating staff and budgets to district health services ... within a period of five years a whole range of services must be available free to the aged, the disabled, the unemployed. (African National Congress 1994: 51)

The *cumulatively* social-democratic and re-distributive ethos of the RDP and MERG was displaced by the neo-liberal Growth, Employment and Redistribution Strategy (GEAR) in 1996. The specific strategy enunciated in GEAR was to maintain internal fiscal restraint to rapidly eliminate the high, inherited government deficit while, simultaneously, re-structuring and re-prioritising the existing national budget to meet social needs (Republic of South Africa, Department of Finance 1996).

The specific commitments for fiscal restraint was the reduction of the fiscal deficit to 3 per cent of Gross Domestic Product from double figures by the year 2000, entailing a significant reduction in government expenditure. This fiscally austere approach to social policy characterized by GEAR was to have profound implications for attempts to reform the health care system.

Fiscal federalism and the undermining of health equity in post-apartheid South Africa

The period following the inauguration of the democratic government in 1994 saw a significant transformation in health care from the era of apartheid. The health care system was de-racialised and integrated into a comprehensive national system of provision with a clinic infrastructure programme which built 1,345 new clinics and upgraded 236, extending the availability of public health care at a local level. The democratic government also introduced a policy of free health care to pregnant and lactating women and to children under the age of six. Essential drug supply was improved in public health facilities and mass immunisation campaigns against measles and poliomyelitis embarked on (Coovadia et al 2009). After a tenacious struggle to secure anti-retroviral treatment for people with an HIV condition, a campaign led by the activist Treatment Action Campaign (see Friedman in this volume), treatment was introduced to a scale where South Africa currently has the largest number of individuals on anti-retroviral therapy at 2.6 million (UNAIDS 2014: 18).

These significant gains have been offset however by the impact of governance and fiscal institutions which established a ‘path dependency’ which continues to impact negatively on health policy and has arguably been a significant cause of health service delivery failure.

The most significant fiscal legislation in this regard was the Intergovernmental Fiscal Relations Act introduced in 1998, which led to a fiscal budgetary system which aimed to determine what the appropriate share of revenue should be between the national, provincial and local levels of government. The intention was to establish mechanisms to make provinces more accountable for their expenditure by providing them with greater autonomy over their prioritization and allocation of functions at provincial level. This system of fiscal accountability was consistent with the shift in government economic policy from the neo-Keynesian RDP to the market-friendly GEAR economic strategy and an emphasis on ‘fiscal discipline’. The major threat represented in the restructuring and introduction of these fiscal arrangements was that it no longer entrenched health funds at provincial level. The nine new provinces were in effect allocated a cumulative bloc grant from the national Department of Finance (now National Treasury), including health and welfare services, determined using a formula aimed at achieving inter-provincial equity. Once they ‘received’ this grant from the national government, provinces were then entitled to allocate it according to their own provincially determined priorities, alongside the nationally agreed upon norms and standards. A report by McIntyre et al (1998) drew out the implications of these fiscal federalist arrangements for achieving inter-provincial equity in healthcare financing:

Since the introduction of fiscal federalism in 1997, different sectors have had to compete with each other at the provincial level for a share of the resources allocated from the national level or generated within the province. The respective provincial treasuries are the main arbitrators in this resource competition ... through awarding the final ... departmental allocations.... (McIntyre et al 1998: 35)

The problems associated with fiscal federalism have been acutely felt in the post-apartheid era in the ex-bantustan provinces such as the Eastern Cape. In a bid to contain ‘over-spending’, the provincial Treasury of the Eastern Cape ordered the Health Department to cut its 2011/12 budget by R205 million and ordered the Health Department to stop the appointment of 400 new doctors for the province (*The Herald* January 25, 2012).

Fiscal federalism has had real implications for service delivery and health outcomes, which are demonstrated in the consistent under-performance of the Eastern Cape compared to national figures. Figures for 2015 reported on healthcare in the Eastern Cape indicated an under five mortality death rate (death of children under five years old per 1000 births) of 59.6 per cent compared to a South African average of 44.8 per cent (Day and Gray in 2015: 254). The wider concern emerging from the evidence of the difficulty in achieving equity in funding and spending on healthcare between provinces was that the failures suggested a re-fragmentation of the state, not based on race but due to the new provincial boundaries. This served to reinforce the bantustan legacy and departed from the ideal of a unitary state. The implication of this was a differential citizenship – for those living in better-resourced provinces the ideal of social rights such as adequate health care enshrined in the constitution had greater possibility of realisation, while the chances diminished for those in provinces with bantustan legacies.

Section 2: The National Health Insurance (NHI) proposal: a third moment for achieving a national health service?

Initially announced as a key priority by the ANC in its 2009 Election Manifesto, and subsequently confirmed by president Jacob Zuma in his 2010 State of the Nation Address, the NHI proposals were eventually released in the form of a Green Paper for Public Consultation in August 2011 (Republic of South Africa 2011). The launch of the final White Paper, initially scheduled for late 2012, has been delayed and was finally released in December 2015. The ‘insurance’ aspect of the NHI is a misnomer – it is properly understood as a national health service as it is a public system of health care with fiscal resources primarily derived from general tax. The roll-out of the NHI are occurring in 11 designated pilot sites.

The policy objective of the NHI is to put into place the necessary funding and service delivery mechanisms to enable the creation of an efficient, equitable and sustainable health care system in South Africa. In order to address the imbalances in access, utilisation of services and health care outcomes amongst the different socioeconomic groups, the NHI proposals intend a fundamental transformation of the system. Following the release of the White Paper in December 2015 the minister of Health re-affirmed that the new health reform proposals ‘envisages a society based on values, justice, fairness and social solidarity. Health care is a social investment, therefore it should not be subject to the normal market forces and treated as a normal

commodity' (*Mercury* January 22, 2016).

In the White Paper policy proposals the new NHI system will be underpinned by an NHI Fund which will provide finance for health care and will enter into contracts with public and private hospital specialists, and public and private GP practices, to deliver health services free of charge to every citizen and resident of South Africa.

The NHI will be based on the following principles and features: universal provision; the right to access health care as enshrined in the constitution; social solidarity (based on financial risk pooling to cross subsidise from young to old, rich to poor and healthy to sick); equity in provision (ensured by a 'fair and just health system'); health care approached as a 'public good' and 'social investment' and not a 'commodity of trade'; affordability (involving reasonable procurement costs); as well as a system informed by efficiency, effectiveness and appropriateness.

Of these, the principles of universality and social solidarity are possibly the most pivotal since they assert that all citizens, regardless of their socioeconomic (or any other) status, will be able to access the same essential health care services on the basis of need regardless of their financial means. The significance of this policy intention, and its retention cannot be understated in the four years of increasing polarisation in the health policy debate between the release of the Green Paper and White Paper. It is the first unequivocal statement and defence in a post-apartheid government policy document of universal health care provision based on social solidarity as an explicit government objective. It is also a re-connection with an agenda of health policy reform aimed at establishing a modern national health service, originally articulated in 'African Claims' in 1943 and the National Health Services Commission of 1944 chaired by Henry Gluckmann, as well as the Freedom Charter of 1955 and the RDP 'base document' of 1993. These documents redefined health care as a public good rather than a market commodity with entitlement as a social right. In current global policy discourses South Africa would also thus join the majority of OECD NHS and Social Insurance health systems which encompass five key income cross subsidies between population groups: from rich to poor; healthy to sick; young to old; individuals to families; and men to women. South Africa is also signatory to the United Nations General Assembly agreement passed in 2012 which unanimously endorsed universal health care, urging governments 'to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services'

(United Nations 2012:1).

The achievement of universal health care in South Africa will need however to confront a number of challenges. These are discussed below.

Funding the new system of universal public health care

The Green Paper proposed that the new health system will be funded through (mainly) general tax sources and a new mandatory employment insurance contribution. Significantly the White Paper does not provide any specific details on the proposed mechanism for financing the NHI. Instead it suggests four potential sources of revenue for financing the NHI: direct taxation (derived from individual income); indirect taxation (taxes levied on transactions or goods and services such as value added tax); payroll taxation (derived from those in formal employment); and finally premiums (based on collection of membership contributions). The Cabinet had requested in 2015 from the Department of Health and the Treasury that a single policy document be prepared, containing both the financing and health system proposals. The absence from the White Paper however of specific proposals on how the new system is to be funded coupled with the fact that the Treasury has not yet released an anticipated Discussion Document, that was originally prepared in 2013 on funding of the NHI, suggests there are still serious unresolved concerns and tensions within government over the fiscal implications of the scheme. The director-general in Treasury indicated that the only financing options under consideration are a payroll tax, corporate income tax and VAT (*Business Day* October 22, 2015). The minister of Health admitted after the release of the White Paper that there was a conflict based on the fiscal implications of the new health care proposals, '(i)t's quite clear in our document that NHI presents a substantial policy shift and a massive reorganisation of the current health-care system. We argued very much with the Treasury. But whether GDP grows or not, health expenditure is still growing now in the country' (*Mercury* January 22, 2016). This does not bode well for the implementation of the scheme and has been seized upon by detractors of the NHI such as the Free Market Foundation, a neo-liberal think tank who are ideologically opposed to the introduction of universal health care and who assert that its introduction will lead to an 'unmitigated disaster' (Free Market Foundation 2016).

The projected costs of the new system are on a prohibitive scale. According to the 2011 Green Paper it was anticipated that the NHI will require

R145 billion additional funding over the next 14 years. The proposed NHI funding model in the White Paper predicts that fiscal resource requirements will increase from R134.3 billion in 2014/15 to R185.3 billion in 2020/21 to R255.8 billion in 2025/26 (in 2010 prices). The projections would increase public health spending from 4 per cent of GDP to 6.2 per cent of GDP based on an average growth rate of 3.5 per cent (Republic of South Africa 2015b: 45). With current estimations of economic growth projected at less than 1 per cent for 2016 the base line projections may require significant revision.

These figures must be compared to current spending on health (2014/15 figures), which was R144.6 billion, increasing to R157.3 billion in 2016/17 (Republic of South Africa 2015c:1).

The availability of funding may however not prove to be the most significant constraint to implementing the new health care system. Figures for spending on the 11 NHI pilots reveal that of the budgeted R367 million for 2014/15 only R64 million had been actually spent, 15 months into the roll-out of the NHI pilots. Supply chain management and restrictive administration were cited by provinces as key reasons for poor spending. The major proportion of the budgeting however had been for recruitment of contracted General Practitioners into the NHI pilots (Republic of South Africa 2015a). The Eastern Cape demonstrated the most significant case of underspending, with only 20 per cent of its allocation spent, while Limpopo demonstrated the highest at 93 per cent. These figures on under-spending suggest significant constraints across the provinces and call into question whether equitable health care can be provided across the nine provinces when they demonstrate highly uneven capacities to implement the new health care policies.

The new organisational arrangements for public health care

A complete reconfiguration of the institutions and organisation's involved in the funding, pooling, purchasing and provision of health care is planned. Key proposals but as yet unconfirmed involve the creation of an NHI Fund to collectively pool and distribute funds, a purchaser-provider split and a devolved funding and management to District Authorities as the new purchasers. It is anticipated that these internal checks and balances will provide the necessary framework to ensure both efficiency and effectiveness. In place of 'historic budgets' where public sector health institutions are allocated fixed budgets based primarily on past expenditure patterns, a process of 'active purchasing' is anticipated.

The gate keeping role of primary care clinicians and the referral system

will be reinforced and patients will be required to follow the referral protocols. In addition to the strengthening of the gate keeping role of primary care GPs, there will be a focus on Primary Health Care (PHC) re-engineering more broadly.

The role of the private sector

Private health insurance will be allowed to continue though it is envisaged that tax subsidies for premiums will be removed and will play only a complementary role. The goal is that ultimately the majority of the population, including the middle classes will come to actively choose to use the new improved tax funded public system without additional complementary private insurance.

Though there are as yet very few specific details about the role of private providers within the new NHI structure, the current reality of significant staff shortages and capacity means that there will be a need to include private GPs in the reformed system. Despite initial public acrimonious debates between the government and private sector providers following the release of the Green Paper (*Mail & Guardian* February 7, 2014), the government has recently toned down its statements and acknowledged that private-sector doctors (initially at least) are an essential factor in implementing a successful NHI. Reflecting this view, the minister of Health said '(i)t's not a competition between us and private. If there's something good in private, if there's a service we need to use, money must not be a barrier'. The minister re-affirmed the view however that engagement with the private sector would be on the basis of acceptance of 'financial risk protection of all citizens based on a 'mandatory prepayment' system which would 'change the exclusive system of the rich' (*Mercury* January 22, 2016). The exact organisational or provider payment arrangements are still being determined but the preferred arrangement is the 'contracting-in' of private GPs through sessional periods in public facilities. The current evidence on enrollment of private GPs in the NHI pilots suggest however that recruitment into the new system is a serious concern. Of a targeted number of 900 contracted GPs only 175 had been recruited by March 2015 into ten NHI pilot sites, and four years into the implementation of the pilots. (*Business Day* March 16, 2015). While the Department of Health suggests that current levels of recruitment reflect availability of private medical doctors to work in the designated pilots, according to the South African Medical Association the doctors who have been recruited are not from the private sector but public sector doctors who resigned to enroll on

the NHI pilots. A key issue for private sector doctors are levels of remuneration in the public sector and the location of sessions in public health facilities with no option currently for private GPs to provide services in their private consulting rooms. Enlisting the support of private GPs into the system is thus proving difficult. This is consistent with research findings of a study of the views of private GPs in the Eastern Cape on the NHI, which suggested the government will face very significant challenges in eliciting the support of private GPs for the new proposed health care system (Surender et al 2014, 2015). The key concerns of the private GPs in relation to the NHI related to remuneration, state control, increased workload, clinical autonomy and diminished quality of care and working conditions. These concerns it would seem are reflected in the slow recruitment of private GPs into the pilot NHI which suggests a fundamental concern of private GPs' willingness to work in the NHI that will need to be addressed directly by the government.

The importance of ideas in establishing a new system of universal provision

Despite receiving strong support from organisations such as the World Health Organisation, the idea of a publicly funded and delivered universal health care system is still a contentious one. It provokes resistance, opposition and concern across political, academic and private sector groups (Van Den Heever 2011, *Mail & Guardian* May 3, 2013, Free Market Foundation 2016). At the heart of the debate is the question of whether health care is a 'public good' rather than a market one and the connected issue of the extent to which the state should assume a responsibility for its provision. Similarly, disagreements about the extent to which NHI should utilise private providers in delivering a public service are normative as much as technical in nature.

In this context it is evident that the government has not yet definitively won the battle of ideas. Opposition from political parties, academic and other analysts as well as the private sector health businesses (that arguably have the most to lose) has been vocal in its hostility to the reforms. Arguments range from traditional public sector critiques (the state will always be less efficient, innovative and consumer oriented than the market) to attacks on the specific mismanagement and capacity of the South African system. Opponents have been successful in galvanising media sources and the national debate and have raised concerns, especially among middle class tax payers and medical scheme members about the future viability and sustainability of the health care system.

Tensions about policy design are reflected in internal divisions within

government itself. In particular, the Treasury has a conservative view of the fiscal implications of the NHI and is concerned not to alienate private sector health care providers. It has voiced public criticism of the lack of a detailed strategy for reforming public health services and argued that more attention needs to be directed towards drawing in private providers to district level health service provision (*Star* February 24, 2012).

Conflict between national and provincial level health prioritization

The relationship between national and provincial government in the implementation of the NHI is becoming an increasingly tense one. As indicated in the previous section separation of national level policymaking from provincial level implementation, accompanied by federalist budgeting arrangements means that the central government has little leverage to ensure national policy priorities are uniformly implemented at provincial level. Government concern about failure of provinces to implement policy has resulted in attempts to assert greater control over provincial health services. Controversially the ruling ANC passed a resolution at its Mangaung Elective Conference in 2011 that ten major hospitals, mainly teaching hospitals, should come under the control of the national Ministry of Health due to service delivery failure. This included not only institutions in traditionally weak provinces such as the Eastern Cape but also those in better resourced and managed provinces such as Gauteng and the Western Cape. This has led to accusations that attempts to impose national government control is politically driven (*Business Day* December 28, 2012) and has further complicated the institutional challenges of health care delivery. The White Paper (Republic of South Africa 2015b: 2) proposes that central hospitals will be 'directly funded' and become 'a competence of the national sphere of government which will require new governance structures' and will be 'semi-autonomous to improve management and governance'. The ruling Democratic Alliance in the Western Cape province meanwhile criticised the overall NHI proposals, arguing that it '(c)entralises decision-making power in structures and individuals who are remote from the day-to-day practical delivery of health services' (Democratic Alliance 2015).

It may be recalled that the 1944 Gluckmann Commission on a National Health Service similarly faced opposition to provincial health care functions being taken over by the national government. Tensions then also surfaced over the procurement of medicines following the government's decision to make it a national function following weak regulatory compliance and

corruption in the award of tenders at provincial level. In 2011 a Central Procurement Agency was established under the national Department of Health, and emerging evidence suggests that it is dealing with the inefficiencies in the tender process previously managed through the Treasury (Pharasi et al 2013).

The key institutional challenge however, given the inequalities between provinces, is the creation of a nationally uniform high quality service, so that patients can expect the same quality of care irrespective of their geographical location across provincial boundaries. It would seem that many provinces do not possess the capability to spend even their current health budgets, a pre-requisite for the implementation of a universal system of provision. The national Department of Health revealed the scale of under-spending in 2012 thus: the Eastern Cape underspent on its public health budget by R191 million (52 per cent underspend), the Free State by R134 million (35 per cent), Limpopo by R89 million (27 per cent) and the Northern Cape by R158 million (37 per cent) (Bateman 2012). In this context the drive to take over control of failing provincial health services becomes understandable. The minister of Health recently identified the current funding model for public health care as providing too much discretion to provinces. Aware of the tensions with perceived government interference in provincial implementation of health care he commented that ‘People say we want centralising. No, we want strong decentralising to districts’ (*Business Day* August 24, 2015). It is unclear however how the national government will manage the additional responsibilities of a nationalised health care services if it was to take over the delivery of provincial health care services.

The limits, challenges and possibilities of universalising South African health care: some key considerations by way of conclusion

Whilst there has been a retreat from open confrontation, the NHI reforms suggest an increasingly ideologically and politically driven and polarised engagement. While the government initially pointed to the unrestrained commercialism and disproportionate power of the private sector as a major contributor to the current systems problems, others point to government failure to run social programmes as the fundamental problem (ie corruption, bloated bureaucracies and lack of managerial and technical capacity). For these critics, rather than ‘build a new system on poor foundations’ (Amado et al 2012), what is needed is for the existing public system to be overhauled and better administered. Equally, while the architects of the proposals, the

Department of Health and the minister of Health have emphasised a discourse of social rights and distributive justice and sought to justify NHI in terms of ethical considerations, other sectors of government, in particular the Treasury, have taken a more 'instrumental' approach, emphasising the efficiency and developmental benefits of a healthier workforce. This divergence in problem definition and aspiration has to some extent become translated into disagreements on the strategies and mechanisms that should be used – in particular the extent the private sector should be both accommodated and relied upon in the new NHI system.

Though the Department of Health appears to be seeking greater accommodation with the private sector and has publically toned down its previous confrontational rhetoric, a political stalemate seems to be looming on the reform of private health care. It is revealing however that despite a continued commitment to implementing the NHI by the ANC at its 2015 National General Council mid-term policy review there has not yet been a major, unambiguous statement by the central government in support of the Department of Health and minister Motsoaledi in their pursuit of reducing private health care costs. Instead the central government has focused on the pragmatic task of improving the public health care system on the 11 NHI pilot sites and the capacity to deliver the new public health care system under the NHI.

It may well be that the limits have been reached on the central government's willingness to aggressively challenge the private sector, which is mainly utilised by the middle class, and which was a pivotal site of electoral contest in the 2016 local government elections. Here there are echoes with the 1944 Gluckmann Commission, which similarly found little support on the part of the Smuts government for the health care reform proposals due to electoral and institutional concerns. The significant difference with the 1940s though is that the ruling party is also under electoral pressure from its poor and working class constituencies to deliver on good quality public health care. Thus the NHI remains a muted but formal policy goal of the party as reflected in the ANC's election manifesto for the 2014 elections (African National Congress 2014).

The South African case demonstrates that the determination of individual policy champions and pioneers (in this case the minister of Health, dr Aaron Motsaedi) to achieve universal health care reforms is not sufficient. Again comparisons are apposite with that of Henry Gluckmann, the policy champion of the National Health Service Commission of the 1940s. Rather, achieving

consensus with key stakeholders and crucially, the support of the wider central government are crucial if the momentum for far reaching health reforms are to be maintained. The South African case also demonstrates that political citizenship is a necessary, but not a sufficient condition for achieving the goals of inclusive social policy such as universal health care. Extra-parliamentary mobilisation tacitly aligning with sympathetic government figures would seem an additional and crucial factor, as demonstrated by the TAC's successful campaign to extend the roll-out of anti-retroviral therapy despite the opposition of the Mbeki government.

Given the likely reliance on the private sector to meet healthcare needs at least in the immediate term, SA policy-makers will thus need to identify strategies to meaningfully engage and incentivise them to achieve the desired outcomes. Given the entrenched and deep-rooted market culture which presently exists, a key challenge will be to achieve a shift in culture and norms, in particular to instill a more cooperative model of care with patient centred values.

The proposals for universal health care is arguably also the first post-apartheid social policy which is reliant on the middle class for its long-term success. The ability to reverse the vast inequities in public/private health spending will rely heavily on the middle class returning to the public sector and choosing to use public health care services and directing their spending to public health care instead of the increasingly commodified system of private health care. Incentivising and institutionalising middle class support for public health care, such as the UK NHS, will be a major challenge however. There is a crisis in quality public health care provision due to ailing infrastructure, inadequate human resources in quantity and quality and corruption in procurement and administration of health care. There is also little research on the middle class and their propensity to support an NHI arrangement. The social differentiation associated with the high levels of poverty and inequality puts into question the sustainability of a system of universal health care provision based on a consensual system of reciprocity and social solidarity. The poor quality of care in public health care compared to the commodified system of private health care also acts as a major disincentive to the middle class to enroll into a universal system of public health. In the light of these considerations it is understandable that the government has focused its policy attention on improving public health care services, identifying 11 NHI pilot sites across the country where it hopes to demonstrate a 'turn around' in public health care. The improvement of public

health care should create a basis for a social compact between the poor, working people and the middle class all of whom are interested in affordable, good quality health care, including health care provided by the state. Such improvement may be dependent however on establishing a movement across class which can mobilize strategically around the historical demand for a universal, National Health Service.

Note

1. The contribution of professor Rebecca Surrender to the second section of the paper is very gratefully acknowledged. Section 1 draws on previously published research.

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