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South Africa's Health Care System and its aim to achieve universal coverage

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Summary

The South African government is in process of implementing health financing reforms, through the implementation of a national health insurance. The aim of my thesis is to present the plans outlined within the National Health Insurance Policy. Emphasis is placed on the social, economic and health background of South Africa as well as the history of reforms. How universal coverage is defined as well as the key factors that need to be addressed when attempting to implement universal coverage. The theory of trust is explored. The focus is on what is understood by trust and how trust functions within the context of a health system, particularly how it functions in the process of implementing universal coverage. The thesis also briefly explores experiences of Ghana, Rwanda and Mexico in implementing universal coverage. It presents the guiding principles and the objectives of the National Health Insurance Policy as well as the financing model proposed. This is followed by a discussion on the challenges and essential changes that have to be implemented in order to realise the objectives as set out in the National Health Insurance Policy. The following aspects need to be addressed in order to effectively implement the National Health Insurance Policy, keeping in mind South Africa's current health system structure and financing:

1) The access to health services is very important in extending health insurance, but equally important is ensuring that services are utilised. This includes providing education on benefit packages and continuous communication with communities and considering whether patients will be able to reach health facilities in order to receive services, this is particularly important in rural areas.
2) Continuous monitoring and evaluation is required in the process of implementing health finance reforms.
3) Good governance, stewardship and most importantly accountability are emphasised by different scholars.
4) In order to provide effective financial protection through national health insurance, significant cross-subsidisation has to occur from the rich to the poor and the healthy to the sick. This requires social solidarity which is important particularly in the context of South Africa's high inequality. In addition, in order to develop social solidarity, government has to build on the trust relationship between state, the health system and its citizens.

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1. Introduction

Inequality in health exists in all countries around the world and represents unfair disparities in the health status of many populations. Many of these differences are as a result of social and economic status, gender and ethnicity. Inequality in health can also be explained in the differences of access, how services are used (utilisation) and the quality of health care (Lindstrand, Bergstrom, and Rosling 2006, 61). South Africa is one such country that is faced with glaring inequalities in income distribution, education and quality health care (Statistics South Africa 2012). Moreover (Mayosi et al. 2012, 2037–2038) point out that poverty, unemployment, sexism and social and economic inequity in South Africa are central to deprivation and ill health experienced in the country. Equally the (World Health Organisation 2010, 2) emphasise that improving health is essential to overall human wellbeing and sustained social and economic development. In an attempt to address inequalities in health and improve the quality of health, the South African government is in the process of implementing health financing reforms within the health system, through the implementation of a National Health Insurance (Department of Health, Republic of South Africa 2011, 554:section18).

The aim of my thesis is to present the South African government's plans to extend existing health insurance to cover the entire population. The theoretical perspective of trust is explored in relation to its importance in implementing health financing reforms. The paper will focus on providing a social, economic and health background of South Africa and to some extent the history of health care reforms. Attention will be given to how universal coverage is defined and what has been written on the implementation of universal health coverage, particularly focussing on implementation among developing and middle income countries. In addition the potential constraints or challenges to

implementation and the likely benefits to having universal health coverage in South Africa will be assessed.

1.1 Research Questions and Purpose

The thesis study focuses on the proposed implementation of a national health insurance in South Africa, as outlined in the South African government's policy document (Green Paper) on National Health Insurance released 12 August 2011, it refers to the fact that the implementation of national health insurance is aimed at achieving universal health coverage (Department of Health, Republic of South Africa 2011, 554:section18).

The main research questions I will focus on in my thesis are; how is universal health coverage defined? What are the key issues that need to be considered when implementing universal coverage? What key issues need to be considered by the South African government to aid in successful implementation of health financing reforms? What are the possible benefits of implementing National Health Insurance in South Africa? What are the possible obstacles that may impede the effective implementation of National Health Insurance?

1.2 Background to South Africa: historical, social and economic perspectives.

In order to appreciate the potential impact of the above mentioned reforms planned, it is necessary to look at the current health system, its historical background, the existing health outcomes and some of the key challenges, which have ultimately hindered improving health outcomes and effectively implementing programmes and policies within the country. South Africa is classified as a middle income country, but it should be noted that, the greater part of the population can qualify the country to be classified as a low-income country.

Inequality in South Africa is high and this is for the most part, attributed to a high unemployment rate and a labour force participation rate that is low (Statistics South Africa 2012, 38–39). The Gini index or Gini coefficient measures “the income distribution of a country’s residents where 0 represents perfect equality and an index of 1 represent perfect inequality.” This measurement helps to define the gap between those who are rich and the poor (“Gini Index Definition | Investopedia” 2013). The Gini coefficient of South Africa (including salaries, wages and social grants) was estimated to be 0.73 in 2006 (Statistics South Africa 2012, 25). “The top decile of the population accounts for 58 percent of the country’s income, while the bottom decile accounts for 0.5 percent and the bottom half less than 8 percent”(Mitra et al. 2012, 15–16). The quarterly labour force survey released by Statistics South Africa, revealed the unemployment rate to be an estimated 24,9 percent by the second quarter (April-June) of 2012 (Statistics South Africa 2012a, xvi). As stated by the mid-year population estimates of 2011, South Africa has a population of approximately 50, 59 million people and more than fifty one percent of the population is female. This is an important factor to consider given that, “the proportion of females living below $ 1 (PPP) per day is high compared to that of males, 5, 3% among females and 4, 8% among males (2006)”. In addition the maternal mortality ratio is high , in 2007 it was estimated to be 625 maternal deaths per 100 000 live births, in 2009 HIV prevalence among pregnant women was estimated to be 29, 3% (Statistics South Africa 2012, 28–76).

Additionally Mid-year estimates compiled for 2011, report that approximately one-fifth of women in their reproductive ages are HIV positive (Statistics South Africa 2011, 2–9) A recent report by (Department of Health Republic of South Africa 2012, 7) estimates the maternal mortality ratio to be 310 per 100 000 live births. South Africa also has a comparatively young population, with almost a third (31, 3%) being under 15 years of age, while an estimated 3, 9 million (7, 7%) are aged 60 years and older. Life expectancy at birth, for the year 2011, is estimated at 54, 9 years for males and 59, 1 year for females; the recent increase in life expectancy can be attributed to the roll-out of anti retroviral treatment. Infant mortality is still considered to be high, despite the fact that it has

decreased from an estimated 53 in 2001 to 38 in 2011. Statistics South Africa also estimate that the total number of persons living with HIV in South Africa has increased from an estimated 4,21 million in 2001 to 5,38 million by 2011.

According to (Chopra et al. 2009, 1023), during the 15 years since the first democratic election, South Africa has made insufficient progress towards achieving the Millennium Development Goals and in some cases progress has even been reversed. One of the important challenges preventing progress in achieving the Millennium Development Goals are, among others, the fact that South Africa has what they refer to as, a disproportionately high global burden of disease, in relation to the size of the country's population. South Africa's total disability adjusted life years (DALYS) for high burden diseases is almost equivalent to that of Bangladesh, which has a population three times larger than South Africa and which is much poorer (Chopra et al. 2009, 1023). Moreover, according to the 2010 Millennium Development Goals Country report, South Africa's lack of progress in achieving some of the Millennium Development Goals can be attributed to challenges in providing quality education as well as access to quality health care, since these factors impact on outcomes such as employment, income levels and life expectancy (Statistics South Africa 2012, 3).

Also referred to by (Coovadia et al. 2009, 16) are the challenges associated with implementing the Millennium Development goals, they point out the importance of promoting gender equality, increasing access to all social services and a development policy that concentrates on the redistribution of growth and interventions that address South Africa's current burden of disease as well as violence and crime, as important factors to focus on in order to accomplish the Millennium Development Goals (Coovadia et al. 2009, 16).

This high global burden of disease is also referred to by (Harrison and South Africa Department of Health 2010, 9) in a report that covers South Africa's health and health care system from 1994 to 2010. The report calls attention to four disease priorities, which require effective intervention,

namely HIV/AIDS and Tuberculosis; injuries from road accidents and interpersonal violence; other infectious diseases related to poverty and cardio vascular conditions and chronic diseases of lifestyle (diabetes mellitus, cancer), among others.

Statistics South Africa estimated the overall HIV prevalence rate in 2011 to be approximately 10, 6%. The total number of people living with HIV is estimated at approximately 5, 38 million, while approximately 16, 6% of the adult population aged 15–49 years is HIV positive. The report also estimates the number of Aids orphans to be 2, 01 million (Statistics South Africa 2011, 5–8). South Africa's poor health outputs and outcomes have moreover persisted despite earlier policy and legislative changes, improvements in health programmes and increases in value and type of Social Grants (Chopra et al. 2009, 1024–1025). The failure of leadership in South Africa to tackle the HIV epidemic is the underlying cause for the poor health outcomes. They highlight the inability to build the capacity to implement policies and programmes introduced and to monitor them, resulting in poor implementation of programmes such as the prevention of mother to child transmission of HIV. Moreover weak central stewardship and no decentralization are mentioned as some of the other challenges contributing to poor health outcomes (Chopra et al. 2009, 1026).

Regarding the failure to decentralise, although the National Health Act of 2004 refers to the establishment of a district health system, only one province has enacted legislation to provide districts with the necessary authority. However it is noted that recruiting and retaining staff at district level has been a challenge, partly as a result of the attraction to provincial, national or private positions (Chopra et al. 2009, 1026). The failure to decentralise responsibilities effectively can be attributed to the fact that the National Health Act of 2004, identified the district health system and primary health care, as the responsibility of provincial government. An equally important factor that contributed to the poor health outcomes for South Africa is the need for effective and efficient management of human resources within the health system (Coovadia et al. 2009, 12).

In their analysis of the changes and challenges which have faced South Africa since 2009, (Mayosi et al. 2012, 2029–2030) refer to importance of good leadership or stewardship, when they point out the noticeable changes after the "disastrous policies" of former Health Minister Mantombazana Tshabalala-Msimang to the leadership shown by current Health Minister Aaron Motsoaledi. Critical actions were taken in relation to spending on antiretroviral drugs (spending increased from R4.5 billion in 2009-10 to R8.4 billion in 2010-11), programmes on prevention of mother-to-child transmission, prevention of HIV transmission and the integration of HIV and tuberculosis treatment were intensified. They argue that despite the policy changes made by the topmost leadership since 2009, adjustments still need to be made in the overall management of the Health system, particularly at health facility level. This includes the need to restructure the civil service into a responsive, caring and enabling service as well as making the necessary adjustments in protocols, regulations and organisation of the current healthy system (Mayosi et al. 2012, 2029–2030).

In respect of the need to improve the responsiveness and quality services of civil servants, particularly nurses, it is important to note that historically medical training in South Africa was racially segregated. Before 2005, the output of doctors was also estimated to be inadequate to supply the needs of the country. In addition to the shortage of medical personnel, after democratic elections, a key challenge has also been to improve the relationship between nurses and patients, since perceptions among communities has often been that nurses are unkind and rude, particularly within reproductive health services (Coovadia et al. 2009, 13).

This is attributed mainly to the complex history of nurses and the relationship that existed between nurses and communities, indicating that black nurses experienced racial discrimination and were not allowed to nurse white patients until 1986. Nurses were also trained and socialised into a certain way of life, as part of a middle class elite. Nurses were seen as having "to moralise and save the sick" and were "taught to see themselves as subordinate to doctors and as authority figures in control of the lives of their patients" (Coovadia et al. 2009, 13). (Harrison and South Africa

Department of Health 2010, 27–32) also draw attention to the shortage of doctors and nurses, particularly in the public sector, as well as low morale among health workers as factors that have contributed to poor health outcomes. What are the historical developments of South Africa's health system that has contributed to some of the challenges mentioned above?

1.2.1 History of reforms within South Africa's health system

Prior to the democratic elections held in 1994, health facilities in South Africa were separated along race and towards the end of apartheid there was a reported 14 different health departments in South Africa, this included the health departments within the "Bantustans" that were created. Non-profit and missionary hospitals were central to the delivery of health services in the then "Bantustans". After 1994 these 14 health administrations were merged into one National Department and nine provincial departments (Coovadia et al. 2009, 9–12). Another noteworthy aspect of South Africa's health system was its fragmentation, within the public sector and between the private and public sector. Voluntary health insurance was first introduced in 1889, with membership largely restricted to white mine workers. The private sector was essentially developed or funded by the mining sector and membership to private health insurance was limited to the white population until 1970 (Coovadia et al. 2009, 9–12).

Reforms within health financing dates back as early as 1928-1935, where proposals were introduced to establish a health insurance scheme that covers all low income formal sector employees, these initiatives were however not taken further. During the period 1942-1944, the National Health Service Commission led by Dr. H. Gluckman, proposed a National Health tax that would ensure the provision of free health services at health centres for all citizens regardless of "race or station in life". Although the recommendations made by the National Health Commission were accepted, only the introduction of community based centres was implemented at the time. In 2002, a proposal was made to move towards universal health coverage through a social health insurance model, but this was not supported. Ultimately a decision was reached in 2007, at the ruling party's conference in

Polokwane to establish a national health insurance (Department of Health, Republic of South Africa 2011, 554:section12–15).

Some of the most effective health programmes and policies are referred to by (Harrison and South Africa Department of Health 2010, 13–15) such as the implementation of free primary health care in 1994 for pregnant women and children under six years. This was extended to all users of primary health care in 2006; the Choice on Termination of Pregnancy act was introduced in 1996 in response to the number of women dying from unsafe abortions; in addition the anti-tobacco legislation initiated in 1993, which included increasing taxation on cigarettes and the prohibition of advertising of tobacco products, proved to have contributed to a decline in smoking. Along with these reforms, after the 1994 general elections, government has also initiated reforms in social and economic policy, one of which has been to improve access to basic services such as water, electricity, particularly the provision of free water and electricity for poor households (Coovadia et al. 2009, 8). The following section will briefly focus on South Africa's current health financing arrangements and key concerns related to these financing arrangements.

1.2.2 Health Care Financing in South Africa

South Africa's total health expenditure is approximately 8,3% of the Gross Domestic Product (GDP) (Mills et al. 2012, 3). Furthermore South Africa's expenditure on health care relative to its GDP, is described by (D. McIntyre et al. 2007, 19) as "relatively high by international standards, exceeding that of many countries with similar level of economic development. Presently, South Africa's health care is financed through voluntary private insurance, which covers mostly formal sector employees, and covers approximately 17,6 % of the population, however large differences exist between races in respect of health insurance coverage or as it is known in South Africa, medical scheme coverage. Medical scheme coverage for the black population in 2010 was estimated to be 10, 3%, for mixed race people 21, 8%, Indian population 46, 8,% and for the white population 70,9% (Mayosi et al. 2012, 2038).

Those not covered by a medical scheme or health insurance depend on public health sector services, which are tax funded (Mills et al. 2012, 3). Why is it important to note that more than eighty percent of South Africa's population is not covered by health insurance? It is critical because it ultimately means that a large percentage of the South African population is exposed to the risk of catastrophic health expenditure and inadequate access to health services.

A review was by (Diane McIntyre et al. 2006) of studies in low and middle income countries, and the economic consequences for households of illness and direct payment for health care use. The review focussed on direct (cost of service, medicine, transport) and indirect (loss of productive time) costs. Overall results show that the amount of health costs as well as the timing has an impact on the degree of catastrophic consequences for households. In many instances health expenditure is unexpected and may occur when household income is at its lowest. Hospitalisation, maternity care and acute illness such as malaria and long term illness such Aids are reported to incur considerable costs for households. Strategies to cope with health expenses include selling assets, borrowing from family and friends and money-lenders, redirecting tasks to other household members and in some cases even removing children from school (Diane McIntyre et al. 2006).

Currently user fees (direct payments charged for various health services delivered) are not charged at primary care facilities; however some form of direct payment is required at public hospitals. Direct payments constitute a small percentage of health care funding (about 13%), of which most are in the form of co-payments by those who have private health insurance (Mills et al. 2012, 3).The 2010/2011 Income and expenditure Survey, estimated that 1, 4% of national household consumption expenditure, is due to health expenditure. This seems like a small percentage, spent on health, but excludes income spent on health insurance. In addition the survey also indicates that all South Africans spent a significant amount of household income on pharmaceutical products, accounting

for almost half (48, 3%) of all household expenditure on health (Statistics South Africa 2012b, 17–18).

According to Health Economic Unit in (Harrison and South Africa Department of Health 2010, 24) there is unequal financing of the private sector, relative to the number of beneficiaries who are covered by private health insurance. Five times as much is spent on each person on a medical scheme for health services in the private sector than on an uninsured person using public sector health services. Financing in the private sector is also regressive, with the poorest 20% of private insurance contributors spending twice as much of their income as the richest 20% who are covered by private health insurance (Harrison and South Africa Department of Health 2010, 24. (Chopra et al. 2009, 2027) further point out the imbalances between these two sectors, when they draw attention to the fact that the amount of doctors and nurses employed in the health sector favours the private sector creating a challenge for the public sector to respond to the health care crisis due to limited human resource capacity.

The authors also point out that, expenditure by government on health care in the public sector, for those individuals who are not privately insured, has been stagnant until the past six years, while costs among private medical schemes has escalated (Chopra et al. 2009, 2027). According to (Mills et al. 2012, 8) eliminating such fragmentation of health care financing within a population can be complicated. (D. McIntyre et al. 2007) also indicate that financial risk protection in South Africa's current health financing environment is problematic, due to the limited potential for cross-subsidies within the overall health system. This includes cross-subsidies within respective medical schemes and cross-subsidies between the private and public sector.

Having looked at South Africa's social and economic background and the history of and the current health system in South Africa, hopefully the context within which the current health financing reforms are taking place is more apparent. Therefore the question I wish to explore is; how is universal health coverage defined? What processes do the South African government need to follow

to implement such health financing reforms successfully? What are the benefits of implementing National Health Insurance in South Africa? The next section will outline the methodology and theory that relates to this thesis.

2. Methods, data and theory

The methodology used for this thesis is that of a literature review. The topic of my thesis focuses on of universal coverage and the implementation thereof, since South Africa is currently in the process of implementing a National Health Insurance Policy. A literature review of studies, scholarly articles, government reports, documents was conducted, examining how universal coverage is defined, trends in implementation of universal coverage in developing countries as well as existing discussions around the proposed implementation of Universal Health Insurance in South Africa. According to Mouton (2001, 179–180) a literature review, provides an overview of scholarship in a particular discipline, by analysing trends and debates. It can provide an understanding of the various issues, debates, definitions and concerns in a specific area.

2.1 Data

Information for thesis was sourced from secondary data such Journal articles, government reports and books. A systematic search was conducted on online data archives and Libraries such as; BIBSYS, Google Scholar, Academic search premier via EBSCOHOST. A systematic search was also conducted on websites of International organisations such as United Nations Population Fund (UNFPA), the World Health Organisation (WHO) and the International Labour Organisation (ILO). In addition journal articles were sourced from the online peer reviewed medical journals the Lancet and the Journal of Public Health Policy. Grey literature in the form of government policy documents and reports were sourced from the official government website of the Department of Health, while official statistics were sourced from the Statistics South Africa government website. Newspaper

articles were also examined in order to gain understanding into the different viewpoints from various stakeholders and public.

The following key terms were used during search for relevant literature; “universal health coverage”,” universal health coverage Africa/South Africa”, “financing health care”, “social health insurance” , “implementing universal health coverage”, “South Africa health system”, “social health protection” and various other combinations. Information was processed systematically starting from the most recent work published in 2012, until work published in 1995. The abstract or summaries of all journal articles, reports or books where perused in order to assess relevance of articles or reports. The referencing system Zotero was used to manage references, therefore all literature used as well as literature searched has been archived electronically.

2.2 Limitations

Due to the fact the health care reforms proposed by South Africa is very recent (policy on the National Health Insurance was released on April 2012) and is in the process of implementation, there is a limited amount of literature on the subject of extending universal coverage in South Africa. In addition, a literature review merely summarises existing academic articles and research, therefore new ideas or insights cannot be created (Mouton 2001, 180). Throughout the search for literature and while writing the thesis, I had to be particularly aware of my opinions and possible bias that may exist in relation to the topic. As a South Africa I am very aware of the existing dynamics within the South African health system and its affect on South Africans. As a result I had to try to be as objective as possible in my analysis. The literature review merely presents discussions on the process of implementing universal coverage as it is documented and the challenges and benefits associated with its proposed implementation in South Africa through initiating a National Health Insurance.

2.3 Theory

In my discussions on my thesis with my supervisor Bennedichte Olsen, I mentioned issues around poor service delivery within South African public health services and the differences that exist between public and private health care, the issue of trust arose from our discussions. The perception that South Africans are critical of public health service delivery prompted the question why are people critical, what is the connection between trust and the health financing reforms and service delivery changes planned. Most of the literature I have analysed covering universal health insurance, do not specifically focus on the issue of trust, but focus on the importance of Social solidarity, particularly in the form of cross-subsidising in health insurance. As a result of reflecting on how people (example of Grace and her family) would respond to the proposed changes in South Africa's health system, the theoretical perspective of trust is considered in this thesis. The background on South Africa's Health system provides insight into the complex history that has shaped the existing health system and the resulting relationships between health care providers and patients, as well as the dynamics within the health system. How has this impacted on "trust", in fact, how important is trust in ensuring effective implementation of universal health insurance. I will attempt to answer this by exploring the issue of trust.

(Elster 2007) asserts that, trust is "the lubricant of society". He further defines trust as "lowering your guard, to refrain from taking precautions against an interaction partner", despite the fact that there is a possibility that your partner could act in a manner that justifies taking precautions. Trust is therefore based on the decision to cooperate or act together, as well as the decision not to watch or scrutinise the partner you are interacting with. In addition the object of trust can be viewed according to the other person's ability or motivation.

The above definition however does not completely correspond to trust in relation to institutions, due to the fact that there are no or limited precautions citizens can take against an institution, apart from "refusing to deal with" that institution (Elster 2007, 351). McLeod (2011), however argues that in

order to have institutional trust, the elements of “interpersonal trust” has to exist. The question of, when trust is “warranted” or justified is raised. In answering this question McLeod considers the various features of trust namely; the nature of trust and trustworthiness, the epistemology of trust, the value of trust and the mental attitude of trust. Furthermore some of the important elements of trust highlighted are that trust requires people’s confidence in another’s capability or skills, as well as a belief that the person you trust, is committed to do what they are entrusted to do (McLeod 2011).

(Kramer 1999, 572) further view trust as “choice behaviour” , in this perspective , decisions in respect of trust are seen as comparable to “other forms of risky choice”, people are considered as being motivated to make “rational, efficient choices”, in other words “maximise gains and minimise losses”. How can trust be restored once lost? (Schoorman, Mayer, and Davis 2007, 349) in their analysis of trust, maintain that in order to “repair trust” it is crucial to first understand how the trust was damaged. They argue that there are various ways in which trust can be damaged and therefore will require different responses to repair the damaged trust. They suggest that an important factor to consider is which “trustworthiness factor was damaged and how it was damaged, as this will determine how repairable the damage is and how effective the repair strategies will be.

McLeod (2011) emphasises that building trust takes time and that it has to be “cultivated”. In addition it is also stressed that in order to cultivate trust, certain factors have to be present to indicate that trust would be justified. Trust is therefore possible when; 1) “the conditions required for trust exist; 2) if the trustee is trustworthy, making the nature of trustworthiness important to judge when trust is warranted; 3) if some value come to light or if there is value in trust itself; 4) when it is possible to develop trust given the circumstances and the mental attitude of trust (McLeod 2011). (Gilson 2003) points out that trust is equally important in health systems and that health systems consist of complex relationships which are influenced by the relevant institutions involved and trust. Benington,1998; Giddens,1990 and Taylor-Gooby,1999 in (Gilson 2003, 1463) point out that in

order for the state to build legitimacy in any policy or programme implementation, it is important to build trust in the state and it institutions.

Why is trust, specifically, interpersonal trust, important in any health system? It is important because, as mentioned before, health systems deal with complex relationships. Relationships exist between doctor and patient, institutions and doctors, managers and medical staff and the effective delivery of health care depends on the acceptance and use of services by communities (Gilson 2003, 1459).

In a chapter titled “Low hanging fruit for better (global) health”, (Banerjee and Duflo 2011, 59) allude to the dynamics of trust when discussing people’s “health seeking behaviour”. They emphasise that much of the “belief and theory” people have about various issues, contribute to trust, despite there being no or little obvious evidence for those beliefs or theories. In instances where “trust is eroded” you witness resistance to practises that have previously been accepted. An example of this is cases in the United States and the United Kingdom, where parents refuse to have their children immunised against measles because they believe it to cause autism, despite there being no evidence to support their beliefs. Funding arrangements within health systems are also seen as having an effect on trust between doctor and patient. These funding arrangements can also reveal certain norms or values such as solidarity, which can encourage trust in the health system, Brockner & Siegel, 1996; Levi, 1998; Offe, 1999 and Rothstein, 1998 in (Gilson 2003, 1459).

In a study conducted among civil servants in the education and health sectors, during 2008, (Harris et al. 2011) did an analysis on two social solidarity measures, the first measure examined willingness to cross-subsidise other citizens financially in respect of health insurance, while the other measure examined was the “relative progressivity of financial contributions”. Results from the study showed that 28, 6% of the respondents were prepared to “contribute financially to health care that benefits a wider group of people”. In addition almost two thirds of respondents said they trusted

the state to administer a National Health Insurance, while more than a third preferred that a private organisation administer a National Health Insurance. To conclude (Harris et al. 2011, 179–181) emphasise that an important factor in developing equitable solidarity, is building trust in the state among civil servants and the broader public, through accountability. In their discussion on health service utilisation in South Africa, (D. McIntyre et al. 2007, 58–59) the “dichotomy” of South Africa’s health sector is reflected. Analysis indicates that services by the private sector are “preferred” by those who are wealthier, presumably due to quality that the private sector offers.

(Mayosi et al. 2012, 2030) allude to these complex relationships that exist within a health system and the importance of trust. They highlight the importance of good leadership in implementing health care reforms in South Africa. Central to this leadership is the degree of engagement between the state, its agencies and the citizens of South Africa. Several service delivery protests and disappointments with government performance have weakened the relationship between government and the citizens in South Africa. They assert that a long term strategy is required to “renew trust through community involvement and effective governance” (Mayosi et al. 2012, 2030).

3. Universal Health Coverage and the process of implementation

Earlier it was mentioned that health systems have to contend with complex relationships, those between government and health providers, those among doctor and patient and even the relationship between citizens and government. It is therefore it is important to remember the citizens of South Africa, for whom these policy changes have been created and who will ultimately benefit or not from its successful implementation. Through the years my experience as a public servant within the Research and Development Chief-Directorate, has afforded me the opportunity to meet many families and individuals who are vulnerable and at risk, those who are considered poor. During research projects, I have often been involved in conducting interviews with families and individuals or focus groups, covering a broad range of development issues, such as HIV/AIDS, unemployment,

service delivery etc. Poverty, poor health and the inability to adequately protect themselves from health risks is a reality for many of the families who I have met during the course of my work. I was also frequently amazed at how resilient and creative people are in the face of adversity, but I have also observed a sense of despair and anger and frustration at poor service delivery.

[1]Imagine for a moment, a family such as that of Grace aged 46, a widow, who lives with her two children and her 70-year-old mother Lerato. Her two daughters are Mpho (18) and Naledi (12). Mpho has completed school and is looking for work. Naledi is attending the local primary school, but her mother is constantly arguing with her to stay in school. A social worker Mrs Wilson comes to the local school twice a month to provide family counselling and other support to community. Mrs. Wilson is also trying to convince Naledi to stay in school.

Grace is unemployed and receives a Child Support grant (R260) for her one daughter Naledi. In addition, the family also depends on Lerato's old age pension of R1140 to survive. They live in a small village in the North West Province, 220 km away from the nearest town, Mothibistad. Basic services such as water and electricity are available to the community. The village has a health clinic and Police station. The health clinic has two nurses attending patients and a doctor that visits the clinic twice a month. Serious health cases have to be treated in the bigger town, Mothibistad. Grace receives treatment for Hypertension at the clinic, while Grace's mother, Lerato receives treatment for her heart condition, from a private doctor in Mothibistad.

Although all the staff members at the clinic are helpful, services are affected by the fact that there is always a shortage of medicine and proper equipment is lacking. Grace often has to get her medicine for her blood pressure in Mothibistad, where her mother is also receiving treatment for her heart condition.

[1] The family and characters portrayed in this story are fictional and do not represent actual individuals or situations, but represent a collection of experiences from working and interacting with communities, while being employed in the Department of Social Development.

On days when Grace's mother has to go to Mothibistad for her routine examination and to collect her medication, they have to take a taxi to Mothibistad. During one such ride to Mothibistad, the taxi driver asks Grace and Lerato why they are going to Mothibistad. Lerato explains that she is going to her private doctor to have a routine check-up for her heart condition. Lerato further explains that she prefers to go to a private doctor, because she wants to avoid waiting in a queue for hours at the public hospital. There is also a shortage of doctors at the hospital and services are not as good as they should be. The taxi driver mentions that it is must be very expensive to go to a private doctor each time and asks if they have health insurance.

Grace explains that they do not have enough income to afford health insurance. One of the passengers in the taxi, who was following the discussion, mentions that it was announced on the radio that the government was planning to introduce a national health insurance. The insurance proposes to cover basic health costs for all citizens. Grace's mother Lerato asks their fellow passenger how the national health insurance will benefit her family and who will pay for it. Lerato is not sure if the National health insurance will actually work. Grace listens to the debate that ensues and silently wonders what it means to have a national health insurance; will she be able to get medicine at the clinic when she needs it?

Paying for the doctor's consultation fee and medication is expensive and makes it harder for the family to manage their expenses each month. Will she and her mother still have to pay directly for services provided by doctors? Will it result in better quality services at hospitals? She hopes that these new government plans will reduce the amount of money she and her mother has to spend on medication and doctor visits. In the 2010 World Health Report, emphasis is placed on the importance of timely access to services, the provision of promotion, prevention, treatment and rehabilitation; this can only be achieved for the majority of a population through a well functioning health financing system. Having an effective and efficient health financing systems determines whether people can afford health services when needed and whether the service needed exists

(World Health Organisation 2010, ix). The sections that follow will explore the concept of universal coverage and examine what is reflected in literature regarding its implementation in countries, specifically the growing trend among middle and low income countries to move towards universal coverage. In addition South Africa's plan to implement a national health insurance scheme will also be presented.

3.1 Universal Coverage: Defined.

Universal coverage is referred to by (Moreno-Serra and Smith 2012, 917) as "providing people with access to needed health services of sufficient quality to be effective, " without a negative impact on a families' financial well-being. (Knaul et al. 2012, 1260) further describe universal coverage as being equivalent to "universal social protection of health", which consists of an all-inclusive package of health services ranging from promotion, prevention, treatment and rehabilitation.(Ensor 2009, 213–214) describes universal coverage as "attainment of complete insurance coverage of a population for the costs of a specified package of priority health care". In this definition emphasis is placed on levels of care.

Additionally two dimensions are considered as described by Kutzin (1998) in (Ensor 2009), namely that of breadth of coverage and depth of coverage. Breadth refers to the proportion of the population covered by an insurance scheme and depth refers to the type of service. The term universal health coverage came to light in the 20th century to describe countries like Sweden, Germany, UK and France, after expanding access to a set of basic health services. All citizens were recognised as having the right to access health care and governments were responsible for raising funds through taxes and mandatory contributions to health insurance. Despite the fact that the concept began its origins in Western Europe, universal health coverage has emerged in the health systems of many countries throughout the world (Savedoff et al. 2012, 925–926). The authors also point out the differences that exist in implementation of universal coverage, but a common feature is that of the dependence on pooled financing. Pooled financing has the benefits of reallocating funds from

healthy to sick individuals and subsidises health care of the poor with funds contributed by the wealthier population and can significantly increase utilisation, equity, productivity and effectiveness (Savedoff et al. 2012, 925–926). The World Health Report released in 2010, further identify two key elements to universal coverage. These are financial access to crucial health services for all citizens and the degree to which the system is able to provide financial risk protection to people who use health services. This is an important aspect to consider in addressing poverty, since Global health trends indicate that an estimated 150 million people suffer hardships and a 100 million are impoverished due to direct payments for health services (World Health Organisation 2010, 9).

3.1.1 Universal coverage: Important factors to consider when implementing.

Lindstrand, Bergstrom, and Rosling (2006, 89–90) point out that as one of the seven health determinants, the provision of health services is central in the pursuit of good health for any population. In fact it may not be possible to separate the impact of health services from that of other health determinants in determining good health. They also stress that, it is not only important to take into account the access to health services, but to also consider " utilisation of available services", which is essentially dependant on the price of those services, the quality, people's faith in modern medicine, how they are expected to pay for health services and their perceptions on past treatment (Lindstrand, Bergstrom, and Rosling 2006, 89–90).

Weitz (2011, 207–211) emphasise the following important measures that need to be present in a health care system. These measures are among others: 1) the portability of benefits, referring to the ability of individuals to remain ensured despite losing their jobs or experiencing any other changes in their circumstances; 2) affordability of health services requires health care to be affordable in terms of insurance premiums, co-payments, and long term care and prescription drugs. It also means that the cost of health care must be proportionate to the income of individuals; 3) the third measure is consumer choice, are citizens provide with a reasonable amount of choice in where they can purchase health care? ; 4) Geographic accessibility is also important, and refers to the issue of

equitable distribution of doctors, nurses and health facilities in all areas, whether rural or urban; 5) in any health system, comprehensive benefits are important since citizens need to receive all the essential services they need, the difficulty however lies in deciding which benefits are to be excluded and which are essential; 6) the sixth measure, financial efficiency is concerned with the financial efficiency of a health system.

In the case of the United States of America, there is a large number of private and public insurers which escalates administrative costs of the health system and lastly 7) universal coverage is another measure which is said to be important in a health system, ensuring health care to all citizens (Weitz 2011, 207–211). (Van Ginneken 2005, 70) in his review of trends and policy issues related to the extension of social security, draws attention to the fact that "more than half of the world's population is excluded from any type of statutory social security protection". These unprotected individuals are often part of the "informal economy" and are not protected from health costs or old age through social security. Furthermore it is emphasised that when people do not hold the capacity to "contribute to society and their own well-being", it requires investment from government and financing in health, education services, the provision food and housing ((Van Ginneken 2005, 12).

The need for governments to provide financial risk protection for people using health services, is further supported by (Holzmann and Jørgensen 2001, 541–545), who emphasise that government is a central role player in social risk management. This risk management role essentially includes; implementing strategies that prevent or reduce risks, provide the necessary legal environment and other resources for risk prevention and the "social safety nets for risk coping. This also includes risk mitigation (reducing impact of risk) in the form of "formal insurance mechanisms" which involves risk pooling or sharing risk, such as in the case of insurance. The resolution adopted at the World Health Assembly, to improve health financing systems highlights how important it is for governments to protect individuals from risks and hardship, particularly when they do not have the ability to do so themselves. In recent years there has been a growing trend among countries to

progress towards universal coverage, with the aim to achieve equal access to health services for all citizens based on equity and solidarity (Mills et al. 2012, 1). During the World Health Assembly in 2005, attended by member states, a commitment was made by countries to improve their health financing systems in a manner that will provide all people with access to health services and prevent financial hardship through direct payment for health services at time of need (World Health Organisation 2010, ix).

Resolution 58.33 adopted at the World Health Assembly in 2005, recommends that; countries adopt prepayment as a method of financing in order to share risk among populations, avoid disastrous health care spending, to distribute good quality health care equally; and to plan the transition to universal health coverage in a way that meets the health care needs of all citizens, to improve the quality of health care and reduce poverty. Moreover it was emphasised that the transition to universal coverage will vary among countries, and should be developed in the context of each country's economic, social and political context (World Health Organization 2005).

The World Health Report on Health Systems financing further draws attention to three important issues to consider when countries move towards Universal Coverage; firstly universal systems are complex and therefore relationships between various elements in the system are not predictable and can behave in unexpected ways. Secondly they point out that it is important for countries to assess their current situations, particularly to establish if commitment and social solidarity exists to support such a system and, thirdly countries should consider which proportion of the costs will come from pooled funds and how to balance available resources according to population needs. Equally important is the continuous monitoring and evaluation required by any system of health financing, especially for countries who have progressed significantly in achieving universal coverage (World Health Organisation 2010, 13–14). Carrin et al. (2008, 860–861) give emphasis to the subject of social solidarity, when they argue that in order to provide effective financial protection a

considerable amount of cross-subsidization, from rich to poor and from those with low risk of illness to those with a higher risk of illness has to take place. They also point out that if the degree of income inequality is more significant (such as in the case of South Africa), then the cross-subsidization needs to be greater. In addition they also point out that health financing reform will require monitoring by government, but stress that the process of monitoring will result in related costs and necessitate enforcement of legislation.

(Savedoff et al. 2012, 925) further describe universal health coverage as “a system in which everyone in a society can get the healthcare services they need without incurring financial hardship”. They however firstly stress a rights based approach to achieving universal health coverage, focussing on commitment to; access to health services and establishing guaranteed rights to health services. It is also made clear that some countries legally establish rights to health, but fail to put in place the necessary policies or resources required to ensure that people receive health care without experiencing financial hardship.

A second measure suggested is to determine the proportion of the population financially protected through their enrolment in health insurance schemes, related to this is determining the number of people who are impoverished by health expenditure. Lastly it is recommended that health care utilisation be considered as it is directly related to the aim of providing access, although it has limitations in that it can overestimate coverage and does not fully attend to the concern of financial protection (Savedoff et al. 2012, 925).

(Lagomarsino et al. 2012, 940), moreover, caution against simply assessing enrolment data, as this does not automatically indicate that health care has been received. Additionally they stress that the provision of financial protection becomes futile if populations do not have a good understanding or awareness of the benefits they are receiving. Concerns regarding the aforementioned have been raised on the subject of India’s national insurance programme; Rashtriya Swasthya Bima Yojna,

with studies indicating that the use of services within the scheme in certain regions is lower than enrolment rates (Lagomarsino et al. 2012, 940).

3.2 South Africa and developing countries: In pursuit of universal coverage.

This section highlights progress and developments among developing countries in implementing universal coverage. In addition the section will introduce specific details outlined in South Africa's National Health Insurance Policy, as part of its plans to extend achieve universal health coverage, through the implementation of a National Health Insurance that will cover health care costs of all South Africans. A number of African nations have been shifting towards universal health coverage and national health insurance plans. Thus far only two countries in Africa have made the most progress towards achieving some form of universal health coverage, namely Rwanda and Ghana, Rwanda particularly has been praised for providing comprehensive health insurance (Appiah 2012, 125). Both countries have created national coverage systems, through building on existing community- based health insurance schemes, particularly those schemes with a history of premium collection (Lagomarsino et al. 2012, 936).

Rwanda is reported to have three main health insurance schemes, namely, the Rwandaise assurance maladie, a compulsory social health insurance, which is open to the private sector on a voluntary basis. Secondly they have a military insurance scheme and thirdly they have a cluster of what is called Assurances maladies communautaires (mutual insurance schemes) whose members mainly live in rural areas and work in the informal sector. Unfortunately these insurance schemes do not adequately cover the health costs of individuals, given that households still have to pay for pay part of their health costs out of pocket. Some of the challenges faced by the Rwandan government have been to ensure more affordable insurance contributions for the poor; to increase the scope of services offered within the schemes as well as the proportion of costs covered. The mutual insurance schemes have however expanded over the last ten years and reportedly cover 80% of the population

in Rwanda. Currently work is being done to improve and bring in line the various existing funding mechanisms (World Health Organisation 2010, 7).

Ghana, another country which is presently developing their health system to achieve universal health coverage, have a total health care expenditure of 7, 8% of Gross Domestic Product (Mills et al. 2012, 3). A National Health Insurance Scheme (NHIS) was introduced in 2004. The National Health Insurance act requires all citizens of Ghana to join the National Health Insurance Scheme. The NHIS covers persons in the formal and informal sector for a specific range of services. Coverage by NHIS was estimated at 60% by 2009, though this is subject to debate. Membership in the informal sector is mostly voluntary as payment of contributions is largely voluntary and cannot be enforced.

The government of Ghana is currently considering means to develop the system further to increase coverage (Mills et al. 2012, 3). According to (Lagomarsino et al. 2012, 937) the National Insurance Scheme experienced funding challenges in 2010 when expenditure exceeded revenue, due to an increase in use of scheme and costs. Consequently a capitation pilot to manage costs was introduced in 2011; challenges have been experienced, partly due to small providers not being able to provide the full "capitated package of benefits" and also due to providers fearing reduced earnings and patients becoming confused about benefits. Improvements are being implemented and there are plans to extend the capitation pilot across the country (Lagomarsino et al. 2012, 937).

Mexico has also progressed considerably in their quest to achieve universal coverage. As reported by (Knaul et al. 2012) during 2003, health care reforms resulted in the legislation of the System of Social Protection in health (SSPH) and the subsequent national health insurance program called Seguro Popular, which after nine years of implementation is reported to have reached 52,6 million previously uninsured Mexicans as of April 2012. The formal private sector receives care from the Mexican Institute for Social Security (IMSS) , while "federal public workers" receive care from the

Institute for Social security and Services for Civil Servants (ISSSTE) (Knaul et al. 2012, 1259–1261). It is also reported that the disparity that existed between the private and public health sector expenditure is starting to narrow. In 2000 public spending as a percentage of total health expenditure was 46, 6% and increased to 48, 9% in 2010.

Overall health expenditure grew from 4, 4% of Gross Domestic Product (GDP) in 1990 to 6, 3% of Gross Domestic Product (GDP) in 2010. The objective of Seguro Popular is to reach all "non-salaried workers" who are unable to access social security because they do not have an employer. Some of the challenges highlighted during the process of reaching universal coverage (implementing Seguro Popular) were: continued direct payment for health services rendered persisted due to issues of access and quality; problems with access continued as a result of a shortage in human resources (specialist doctors and nurses) and reaching remote rural areas remains problematic (Knaul et al. 2012, 1266–1272). What prompted these reforms in health financing? Mexico's health system was characterised by inequality and fragmentation, comparable to South Africa's current health financing structure. The insured received care from well resourced or financed institutions, while the uninsured relied on state institutions that were not sufficiently financed. In addition, those who were insured and the uninsured were also confronted with having to pay for a portion of their health cost directly at the point of service or as in the case of many who were uninsured, having to pay directly for basic services and medicine (Knaul et al. 2012, 1261).

Analysis of nine African and Asian health insurance reforms conducted by (Lagomarsino et al. 2012) reveal similarities in the use of tax revenues to subsidise targeted populations, a shift towards larger risk pools and a focus on purchasing services through demand side funding mechanisms(payments are made when patients seek care or enrol at facility). All nine countries assessed are adopting combinations of the social health insurance model (Bismarck) and tax financed (Beveridge), implementing according to each country's unique social, economic and political circumstances. Countries such as Mali, Ghana, Nigeria, Kenya, the Philippines and

Rwanda, continue with collection of voluntary private insurance from the informal sector. Challenges experienced in reaching universal coverage are: collection of household premiums are proving difficult and administratively costly, continuous enrolment of community members on an annual basis is challenging as well as identifying poor populations to exempt from paying insurance premiums. The authors lastly point out, that they are encouraged by the fact that developing countries are moving ahead with implementation of universal coverage despite challenges promising (Lagomarsino et al. 2012).

South Africa, as mentioned in the introduction is currently undergoing health care financing reforms, through the implementation of National Health Insurance (NHI). The following section will present these plans as outlined in the national policy. A National Health Insurance Policy was released in August 2011, the aim is to ensure that everyone has access to “appropriate, efficient and quality health services”. Implementation of the National Health Insurance (NHI) will be phased in over a period of 14 years. An important aspect of these reforms is to address existing challenges within health service provision. Therefore reforms proposed in the health sector is primarily aimed at improving the quality of services in the public health system in South Africa (Department of Health, Republic of South Africa 2011, 554:section4–9).

3.2.1 National Health Insurance Policy: Proposed reforms in services and health financing.

The policy outlines existing challenges experienced with poor quality services in public health sector facilities, and how people in South Africa, prefer to utilise services in the private sector. Health services in the private sector are largely funded through private health insurance and from direct (out of pocket) payments, as mentioned earlier in the background. The aim of implementing the National Health Insurance (NHI) is to ensure access to quality healthcare and to provide financial risk protection.

According to the policy, national health insurance will provide a means to develop cross-subsidization in the overall health system. It is also anticipated that, proposed funding contributions will be associated with a person's ability to pay and the benefits from health services will be connected to the individual's need for care. Healthcare services will be contracted through public and private providers who are accredited and contracted. The policy mentions the fact that direct payments and co-payments for health services, accounts for a sizeable portion of the country's total health expenditure. Co-payments are a challenge, for individuals covered by private health insurance, while those not covered by health insurance have to mainly deal with direct payments, which can have devastating consequences financially (Department of Health, Republic of South Africa 2011, 554:section11–16).

The guiding principles upon which South Africa's National Health Insurance (NHI) is based are; the right to access, social solidarity, effectiveness, appropriateness, equity, efficiency and affordability. The objectives outlined for the National Health Insurance are to: 1) provide improved access to quality health services to all South Africans 2) pool risks and funds in order to achieve equity and social solidarity 3) to procure services on behalf of the entire population and manage resources in an efficient manner 4) strengthen the under-resourced and strained public sector to improve health system performance (Department of Health, Republic of South Africa 2011, 554:section16–18).Who will be covered? The policy outlines the aim to ensure that all South Africans and legal permanent residents are covered by health insurance. Refugees and asylum seekers will be covered in accordance with the Refugees Act (1998) and International Human Rights laws.

In extending coverage those in greatest need should be identified. What services are proposed? Overall the strengthening of the health system of South Africa will include the transformation of Primary health care services. The focus will be on health promotion, preventative care and the provision of quality curative and rehabilitative care. Primary health care will be provided "in three streams"; namely district-based clinical specialist support teams, school-based Primary Health Care

services and Municipal Ward-based Primary Health Care agents (Department of Health, Republic of South Africa 2011, 554:section23–26). Furthermore, benefits under the National Health Insurance will be defined by the type of services that are achievable with the resources available. Services at Primary health care level will be provided by accredited and contracted private providers within each district. Health services will be expected to be available at convenient and sufficient hours. An Office of Health standards Compliance will be established to set norms and standards and inspect all health facilities. Health facilities (those public and private), which wish to be considered for providing health services to the South African population will have to meet set standards of quality. Other criteria for accreditation include; performance standards, coverage, service elements and management systems. Accreditation standards will also detail the minimum range of services that will be required at various levels (Department of Health, Republic of South Africa 2011, 554:section27–32).

3.2.2 Financing mechanism proposed

In terms of the National Health Insurance Policy, universal coverage is best accomplished through a "prepayment health financing mechanism". Therefore funds will have to be pooled, this entails payment for health care in advance, before the illness occurs, these payments are "pooled" and used to fund the health services of the population. The funds can either be from the employer, the individual or the fiscus. Co-payments will only be enforced under certain conditions; such as with services that have not followed treatment protocols and guidelines; health care benefits not covered under NHI benefit package (such as expensive spectacle frames); non-adherence to referral system; in cases where services are not rendered by an accredited provider and in cases where services are utilised by an uninsured person (tourist).

The costing model of the International Labour office (ILO), namely: Total expenditure= user population x service utilization rates x unit costs was utilized to do preliminary costing. Improvements in resourcing of NHI will be gradually implemented over a seven year period. This

costing model also makes provision for large increases in utilisation when “financial barriers” to health services are removed. Estimated costing under this model indicates increases in resource requirements from R125 billion in 2012 to R214 billion in 2020 and R255 billion in 2025 if implemented over a 14 year period. According to the policy, current spending on health for 2010/2011 amounts to R101 billion (excludes health spending by Department of Correctional services and Department of Defence), contributions for private health insurance in 2009 amounts to R92 billion, representing an overall R227 billion being spent on health services in South Africa. A national health insurance card will also be issued to all population members registered and will facilitate easier access to patient information and enable for the portability of health services (Department of Health, Republic of South Africa 2011, 554:section35–43).

Also highlighted is the need to address the current challenges within the system such as “high cost, curative hospi-centric approach and excessive medical charges” should be addressed first to ensure sustainable financing of NHI. Critical to the success of NHI is also the strengthening of the public health system and health service delivery. Revenue will be collected by the South African Revenue Services (SARS), this includes the mandatory contributions. A National Health Insurance fund which is owned by government and publically administered will be established and will be a single payer entity, a multi-payer system will also be explored Private health insurance or medical schemes will continue. National Health Insurance will be mandatory, but South Africans will have the option to continue using voluntary private health insurance (Department of Health, Republic of South Africa 2011, 554:section35–41).

3.2.3 Implementation plan

How does the policy present plans to Implement National Health Insurance? According to the policy implementation will take place in phases at both National and provincial levels. Three phases will be

implemented over a 14 year period. [2]Some of the initial reforms that have to be implemented are: to develop a strategy to strength district health structures to support service delivery within NHI; re-engineering the primary health care system by establishing "municipal ward –based family health teams, district-based specialist teams and establishment of school-based health programs; developing a plan for quality improvement and compliance for all providers supported by the office of Health Standards Compliance; a long term plan to address human resource shortages within the health system; conducting pilots in targeted districts (10 districts), focusing on management capacity, type of service package, and the ability of contracted and accredited providers to deliver services.

Health infrastructure will be assessed with the aim to improve its capacity and effectiveness in supporting health service delivery within the National Health Insurance (NHI). Hospital management reforms will also be initiated. This includes reforms in governance, financial management and decentralization of authority within hospital management. The first five years of implementation will also include establishment of a National Health Insurance fund (Department of Health, Republic of South Africa 2011, 554:section44–52).

(Mayosi et al. 2012 2036) call attention to the fact that more "operational and implementation" research will be required considering the "complexity and scale" of the transformation that will be needed to establish National Health Insurance. Since the release of the policy, the piloting of 10 selected districts has begun, activities include: developing of specific norms and standards through an Office of Health Standards Compliance to enhance quality of care; it is reported that more than 75% of public health facilities have been audited, though few have complied with existing norms and standards (ibid).

[2] See attached appendix for detailed outline of phases of implementation.

4. Discussion: Reflecting on essential aspects that will facilitate effective health financing reforms in South Africa (implementation of NHI).

The Policy on National Health Insurance proposes reforms in health financing through the establishment of a national health insurance, but also outline plans to restructure the health system in terms of human resources, infrastructure, overall management of health facilities, and quality of health care and "re-engineering" of primary health care services. Given what has been presented thus far, how important is it for South Africa to implement these health reforms? (Harrison and South Africa Department of Health 2010, 33) caution against viewing the National Health Insurance (NHI) "as the panacea for both financing shortfalls and health service deficiencies", they emphasise that the National Health Insurance is essentially a financing mechanism which will enable implementation of policies and programmes that are intended to address health priorities.

Critical to ensuring improvements or benefit for people in the country is to ensure the efficient and effective management of human and financial resources. (Coovadia et al. 2009); (Chopra et al. 2009) and (Mayosi et al. 2012) call attention to how essential good leadership, stewardship and effective and efficient management of human and financial resources is to ensure success in implementing policies and programmes. (Coovadia et al. 2009, 16) further stress the need to change the national thinking with regard to accountability, failure to do this will result in a country that is unable to address its health problems or prepare for the future. The public sector, particularly the health system, has to become more focused on accountability and delivering effective services. (Lewis and Musgrove 2009, 206) refer to the importance of accountability in good governance.

Ultimately accountability ensures that employees who do not perform or behave in an erratic manner are disciplined accordingly. Reward and discipline become important to ensure that public employees are held accountable. In (Daniels et al. 2000) accountability is used as a "benchmark" to

analyse overall fairness in health care reform, particularly in developing countries. In this context accountability includes factors such as “transparency; fair appeal processes and adequate privacy protection “among others. (Cassels 1995, 337) however caution that accountability is a complex issue in reality, often having conflicting dimensions. A succession of role players are involved; “public servants may be accountable to bureaucratic superiors, audit authorities, the legal system and other more powerful patrons”. Moore,1993b in (Cassels 1995, 337) further point out that systems designed attain accountability are only effective when connected to systems that can sanction or adjust behaviour.

As pointed out by (Savedoff et al. 2012, 925) earlier, achieving universal health coverage, requires commitment to; access to health services and not only establishing guaranteed rights to health services, but also putting in place the necessary policies or resources required to ensure that people receive health care without experiencing financial hardship.

In the case of South Africa, I would add that, ensuring the right of all South Africans to access health care requires not only putting in place the necessary policy or legislation, but also ensuring the effective and efficient management of human and financial resources needed to make universal access to health care possible. The policy on National Health insurance draws attention to the changes that need to take place within the current health system, when referring to among others: improving the capacity of the current health infrastructure to deliver health services within the National Health Insurance (NHI); ensuring reforms in hospital management including reforms in governance, financial management and decentralization of authority within hospital management (Department of Health, Republic of South Africa 2011, 554:section44–52).

A recently published article in the Mail and Guardian, titled “Low potential for NHI success in rural health”, points out current inefficiencies experienced in the administration and management of health care facilities in rural areas, particularly in the Eastern Cape Province. Concerns are raised

about the capacity of the current health system to effectively implement a National Health Insurance given the current challenges experienced. According to the article, just as with other provinces the Eastern Cape Province is experiencing a shortage of doctors and nurses. In addition there a serious delays in appointing doctors needed (Malan 2012).

Another important factor that needs to be considered when implementing National Health Insurance in rural areas is the cost of transport to get to health services, patients need to be able to get to a hospital or clinic. In the article, Marije Versteeg from the Rural Health Advocacy Project points out that "one in five poor households live more than an hour from the closest hospital and about one in six families stay at least an hour away from the nearest clinic", with travel costs forming a significant percentage of overall health expenditure for poor families (Malan 2012). Mexico's experience with extending social health protection also shows continued challenges with human resource capacity, particularly shortages of specialist doctors and nurses as well as challenges in reaching "remote and hard to reach" rural areas (Knaul et al. 2012, 1271–1272).

(Ruff et al. 2011) further emphasise the above factors raised when they argue that funding is not the central problem of South Africa's public health system, but the huge inefficiencies in management and low productivity. In the private sector resources are not distributed efficiently to assure demand for services, and do not focus on "clinical necessity or cost-effectiveness of services". They further maintain that in comparison to some African countries, South Africa has sufficient funding available for health, the problem they argue is inadequate value from funding allocated. This is due to what they refer to as "inadequate management of the supply side and demand side of the health system and mechanisms by which funds are deployed". Supply side denotes the supply of "human, physical and other resources" needed to deliver health services, while demand side for health care services signify the "pattern of usage and demand from population and subsequent clinical load" They maintain that health financing reforms should focus on improving existing tax-based public financing instead of implementing a new insurance based system (Ruff et al. 2011, 185–191).

Bearing in mind the key concerns raised regarding the implementation of a national health insurance, let us once again reflect on one of the key objectives of the National Health Insurance, that of, providing improved access to quality health services to all South Africans and pooling risks and funds in order to achieve equity (Department of Health, Republic of South Africa 2011, 554:section18). (D. McIntyre et al. 2007) in their analysis of South Africa's current health financing environment indicated that financial risk protection is problematic, given the limited potential for cross-subsidies within the overall health system. This includes cross-subsidies within respective medical schemes and cross-subsidies between the private and public sector. The 2010 World Health Report released in 2010 stress two key elements to implementing universal health coverage, namely; financial access to crucial health services for all citizens and the degree to which the system is able to provide financial risk protection to people who use health services, an important aspect in addressing poverty (World Health Organisation 2010, 9).

It is in the interest of South Africans, (people such as Grace and her mother Lerato) that the South African government succeeds in providing equal access to health care and financial risk protection. This includes, reducing the amount of funds spent by South Africans on direct payments for health services, particularly for the poor. Based on the experiences from developing countries in implementing universal coverage, there is no clear model that must be used to reach the goal of universal coverage. Results from a review conducted by (Moreno-Serra and Smith 2012) reveal that expansion in " coverage measured by higher levels of pooled health spending" usually lead to better population outcomes (they also emphasise that much more research is needed to understand the effects of universal coverage). How effective pooled health spending is, however, depends (once again) on the quality of governance and institutions. Where governance and institutions are ineffectual, improvements need to be made in "public sector administration and provider accountability" (Moreno-Serra and Smith 2012, 920).

As part of the South African government's aim to initiate broader consultation on the Green Paper on National Health Insurance released in August 2011, a National Health Insurance conference was held on 7 to 8 December 2011, in an effort to consult as many stakeholders as possible on the implementation of national health insurance, delegates present at the conference, included representatives from countries who have achieved or are in the process of reaching universal coverage. The following key lessons and or recommendations can be drawn from the experience and knowledge of the various stakeholders and representatives present, namely: that a single payer insurance system is advisable, coupled with "active purchasing" in order to control "hospital prices and volumes"; there is also a need for a strong monitoring and evaluation system; involvement and continued communication with civil society and the broader community is essential, involvement in community organisations will create a "civic movement" that may assist in implementation of the National Health Insurance ; strengthening governance and finding innovative ways to mobilise additional funding for National Health Insurance, such as a levy on currency transactions; increasing sin taxes for alcohol and tobacco; excise taxes on unhealthy foods and a special levy on large profitable companies among others (Department of Health Republic of South Africa 2011).

4.1 National Health Insurance, outlining the Road ahead.

Health care policy reforms in South Africa has a long history, starting with health financing reforms as far back as 1928 with the introduction of health insurance schemes for low income formal sector employees to the reforms that were initiated since the 1994 democratic elections in South Africa. The questions the thesis attempts to answer are; how is universal health coverage defined? What are the key issues outlined for successful implementation of universal coverage what processes do the South African government need to follow to implement such health financing reforms successfully? What are the potential benefits and constraints of implementing National Health Insurance in South Africa?

Different definitions of universal coverage are presented, but essentially universal coverage refers to two key elements namely; financial access to crucial health services for all citizens and the providing financial risk protection to people who use health services (World Health Organisation 2010, 9). The key factors which need to form part of South Africa's implementation of National Health Insurance, in attempt to reach universal coverage are; Access to health services as well as "utilisation of available services", which is essentially dependant on the price of those services, the quality, people's faith in modern medicine, how they are expected to pay for health services and their perceptions on past treatment (Lindstrand, Bergstrom, and Rosling 2006) . Savedoff et al. (2012, 925) emphasise the importance of utilisation when they refer to it as being related to the aim of providing access.

The experience of Mexico shows continued challenges with human resource capacity, particularly shortages of specialist doctors and nurses as well as challenges in reaching "remote and hard to reach" rural areas (Knaul et al. 2012, 1271–1272). It reflects the importance of considering utilisation and access in implementing universal coverage. In the South African context this is of particular importance given the fact that provinces in South Africa are experiencing shortages of doctors and nurses and delays in appointing doctors needed (Malan 2012). The cost of transport to get to health services, in rural areas is equally important since patients can't utilise services if they can't reach health facilities. Connected to this is the importance of communication and education of South African citizens on the benefit package and functioning of the overall health insurance scheme, (Lagomarsino et al. 2012, 940), point out that the provision of financial protection becomes futile if populations do not have a good understanding or awareness of the benefits they are receiving.

Equally important for South Africa to consider is continuous monitoring and evaluation that is required in any health system financing reforms. Most importantly good governance, stewardship and accountability are crucial to ensuring effective implementation of National Health Insurance in

South Africa. The National Health Insurance (NHI) is essentially a financing mechanism which will enable implementation of policies and programmes that are intended to address health priorities. Accountability and delivering effective services also has to become a priority for South Africa's public sector, as stressed by (Lewis and Musgrove 2009) accountability is crucial to ensuring good governance.

The issue of social solidarity is also important to consider, as pointed out by (Carrin et al.2008). In order to provide effective financial protection, significant cross-subsidisation has to occur. In cases where income inequality is large, such as with South Africa, greater cross-subsidisation is required. An important factor in developing solidarity in South Africa , is for government to build on trust in the state among civil servants and the broader public through accountability (Harris et al. 2011, 179–181).

4.2. Conclusion

Effectively implementing the National Health Insurance in South Africa, means that people such as Grace and her mother Lerato will be protected from financial hardship or poverty that could occur because of catastrophic health spending and equally important is providing access to quality health services at a time when it is needed. Given the existing challenges experienced in South Africa's health systems and the poor health outcomes discussed in the background, reforms in health financing is not an option but a necessity. The method used to achieve universal coverage can be debated, but ultimately achieving it should be a goal that is sought by government, civil society and all citizens. Achieving universal coverage will certainly be a challenge, but should not be considered an unreachable goal. Success requires political support, good leadership effective management and overall commitment to good governance.

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Appendix A

Table 1: Phasing-In of National Health Insurance – The First 5 years

Key features	Time-frames
1. NHI White Paper and Legislative Process • Release of White Paper for Public Consultation • Launch of Final NHI Policy Document • Commencement of NHI Legislative process	 10 August 2011 December 2011 January 2012
2. Management reforms and Designation of Hospitals • Publication of Regulations on Designation of Hospitals • Policy on the management of hospitals • Advertisement and appointment of health facility managers	 August 2011 August 2011 October 2011
3. Hospital Reimbursement reform • Regulations published for comment on Hospital Revenue Retention • Development of a Coding Scheme	April 2011 January 2012
4. Establishment Office of Health Standards Compliance (OHSC) • Parliamentary process on the OHSC Bill • Appointment of staff (10 inspectors appointed)	 August 2011 January 2012

5. Public Health Facility Audit, Quality Improvement and Certification
• Audit of all public health facilities
  • 21 % already audited (876 facilities)
  • 64% completed (2927 facilities)
  • 94% completed (3962 facilities)
• Selection of teams to support the development and support of quality improvement plans and health systems performance
• Initiate inspections by OHSC in audited and improved facilities
• Initiation of certification of public health facilities
	
	End July 2011
	by end of December 2011
	by end March 2012
	
	October 2011
	February 2012
	March 2012

6. Appointment of District Clinical Specialists* Support • Identification of posts and adverts • Appointment of specialists • Contract with academic institutions on a rotational scheme	 August 2011 December 2011 February 2012
7. Municipal Ward-based Primary Health Care (PHC) Agents • Training of first 5000 PHC Agents • Appointment of first 5000 PHC Agents • Appointment of PHC teams	 December 2011 March 2012 April 2012
8. School - based PHC services • Establish data base of school health nurses including retired nurses • Identification of the first Quintile 1 and or Quintile 2 schools • Appointment of school-based teams led by a nurse	 August 2011 October 2011 November 2011
9. Public Hospital Infrastructure and Equipment • **Refurbishment and equipping of 122 nursing colleges** First 72 nursing colleges by end of financial year 2011-2012	 March 2012

• **Building of 6 Flagship hospitals and medical faculties through PPP's** • King Edward VIII Academic (KZN) • Dr George Mukhari Academic (Gauteng) • Nelson Mandela Academic (E. Cape) • Chris Hani Baragwanath Academic (Gauteng) • Polokwane Academic (Limpopo) • Nelspruit Tertiary (Mpumalanga) • Refurbishment of public sector facilities	**Commence 2012** Ongoing
10. Human Resources for Health (HR) • Launch of HR Strategy • Short to medium term increase in supply of medical doctors and specialist • Increase in production of nurses • Increase in production of pharmacists • Increase in production of allied health professionals	 September 2011 2012 – 2014 2012 – 2014 2012 – 2014 2012 – 2014
11. Information Management and Systems Support • Establishment of a **National Health Information Repository and Data Warehousing** (NHIRD) • Provincial and District roll-out of the NHIRD • Appointment of Information Officers and Data Capturers	 July 2011 November 2011 November 2011
12. Build capacity to manage NHI through the strengthening of District Health Authority • Creation of NHI district management and governance structures • Selection of Pilot Sites (First 10 districts) • Development and test the service package to be offered under NHI in pilot sites • Extension of Pilots from 10 districts to 20 districts	 **April 2012** June 2013
13. NHI Conditional Grant to support piloting of initial work in 10 districts • Piloting of the service package in selected health districts • Piloting fund administration	 **April 2012**
14. Costing model • Refinement of the costing model • Revised estimates	 2012 2013
15. Population registration • Partnership between Departments of Science and Technology, Health and Home Affairs on: ▪ Population identification ▪ Population registration mechanisms	 **Commences April 2012**
16. ICT • Scoping exercise with Department of Science and Technology and CSIR ▪ Design of ICT architectural requirements for NHI	 **April 2012**
17. Establishment of NHI Fund • Appointment of CEO and Staff • Establishment of governance structures • Establishment of administrative systems	 **2014**
18. Accreditation and contracting of private providers by NHI Fund • Establishment of criteria for accreditation • Accreditation of first group of private providers	 2013 2014

Appendix B

Table 3: Phasing-In of National Health Insurance – Second Phase (2016-2020)

Phase	2016 – 2020
Key features	**Further real-life demonstration and further contracting independent providers**
1. NHI Act	
2. Build capacity to manage NHI	√
3. NHI Conditional Grant (to support creation of Fund and piloting of initial work)	
4. Establishment of NHI Fund	Provincial branches of Fund
5. Alignment of Funds: NHI, RAF + COID + ODIMWA + CCOD	NHI progressively takes over admin for Health functions
6. Family Health Teams	7 000
7. Accreditation and contracting of General Practitioners and networks	3 000
8. Public Hospitals QI and accreditation	**QI and Accreditation**
9. Public hospital Infrastructure	√
10. Private Hospitals accreditation	Contracting model Pilot selected Priority areas
11. Management reforms	√
12. Health Workforce	Increase production
13. Office for Standards Compliance	**Certification and licensing**
14. Hospital Reimbursement reform	Implementation of Coding Schema and DRGs
15. Population registration	Population registration
16. NHI Card	Simple
17. Population-based capitation payments	Capitation to all PHC providers

Table 3: Phasing-In of National Health Insurance – Third Phase (2021-2025)

Phase	2021 - 2025
Key features	Maturing
1. NHI Act	
2. Build capacity to manage NHI	√
3. NHI Conditional Grant (to support creation of Fund and piloting of initial work)	
4. Establishment of NHI Fund	
5. Alignment of Funds: NHI, RAF + COID + ODIMWA + CCOD	
6. Family Health Teams	10 000
7. Accreditation and contracting of General Practitioners and networks	6 000
8. Public Hospitals QI and accreditation	QI and Accreditation
9. Public hospital Infrastructure	√
10. Private Hospitals accreditation	Selected accreditation and contracting
11. Management reforms	√
12. Health Workforce	Increase production
13. Office for Standards Compliance	Certification and licensing
14. Hospital Reimbursement reform	
15. Population registration	Population registration
16. NHI Card	Further improvements
17. Population-based capitation payments	Capitation to all PHC providers

Source: (Department of Health, Republic of South Africa 2011, 554:section48–51)