South Africa's Universal Health Coverage Reforms in the Post-Apartheid Period

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

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ABSTRACT

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

1. Introduction

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

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

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

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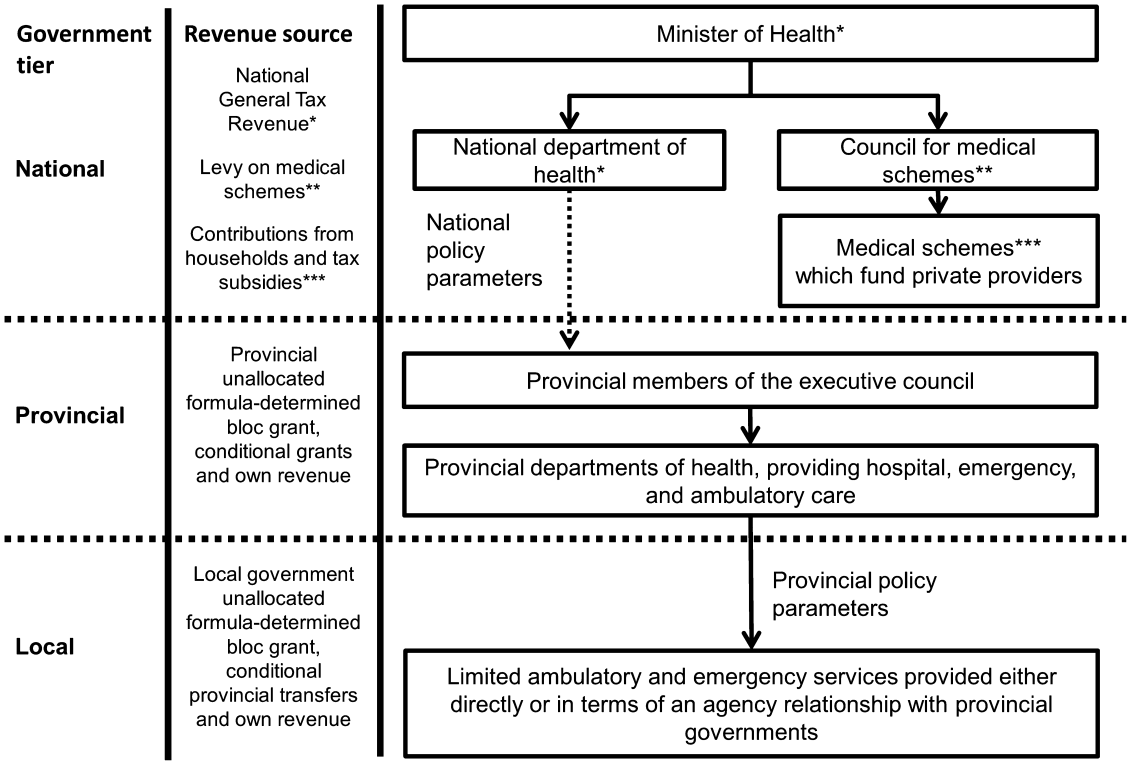

Fig. 1. High-level overview of the South African health system
*Asterisks indicate which revenue source matches a national function.

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

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

2. Method

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

3. The South African health system

3.1. Overview

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

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

3.2. Financing and coverage

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

care from private providers. Overall expenditure through these systems in 2014 amounted to 7.5% of GDP, with 4.1% occurring in the public-sector [12] and 3.4% through medical-schemes [13].

The system of medical-schemes caters for income earners, particularly for families with breadwinners who earn above the tax threshold (tax payers), altogether amounting to 8.8 million beneficiaries (members and dependants) or 16.3% of the total population [13]. The remaining 45.2 million (83.7%) are implicitly covered by free public-sector services. However, a means test for public-hospital services excludes around 5.5 million of the group falling outside medical-schemes, leaving them technically uninsured (extrapolating from a Ministerial Task Team report of 2005 [21]). Primary care is universally free regardless of medical-scheme coverage or income.

Together, the two systems achieve a high degree of financial-risk protection reflected by the moderate levels of out-of-pocket (OOP) expenditure at only around 7.1% of overall expenditure (under 1% of GDP) [17]. The bulk of OOP expenditure, around two-thirds, involves medicine as well as pharmacy and practitioner expenses by the beneficiaries of medical-schemes rather than the poor [23]. However, a growing number of people covered by the free public-sector services have opted to use private ambulatory care [19,23].

3.3. Pooling and resource allocation

Whereas fund pooling is regarded as the accumulation of "pre-paid revenues on behalf of a population" [22, p.16], any system of pooling operates along two dimensions: a vertical dimension, which transfers income from high- to low-income households; and a horizontal dimension, which provides resources to individuals in need of protection today financed predominantly by those not in need today [24]. Three strategic pooling weaknesses are identifiable in the South African health system.

First, there is no organised national system of resource allocation within the public-health system, generating spatial inequity [25]. Second, medical-schemes in the private-sector cannot pool at a societal level along both the vertical and the horizontal dimensions, in the absence of government intervention [7,21]. Third, pooling inadequacy is argued to exist between the public and private systems along the vertical dimension, based on crude per-capita expenditure differences–suggesting an inequitable allocation of resources [5,8].

4. National Health Insurance 1–the period from 1994 to 2008

Post the democratic elections in 1994, various official processes reviewed options for health-system reform [10]. The Taylor Committee of Inquiry [7], which completed its work in 2002, provided a strategic reform pathway first enunciated in government policy in 1994 [30] and 1995 [27]. This is referred to here as NHI 1, based on the reform end-point specified as National Health Insurance [7]. The central assumption underlying NHI 1 was that a single monopolistic scheme could not deliver both a universal subsidy, incorporating both the vertical and the horizontal dimensions, and a universal benefit, in the form of a dedicated entitlement to a dedicated provider system, for the foreseeable future [21,30]. Policy emphasis was therefore placed on a pathway to a more integrated and harmonized UHC system, with an end-point, outlining an integrated NHI scheme, sketched out as a long-term goal [7].

4.1. Underlying principles

Underpinning the 1994 to 2008 reform path was an understanding that UHC was only feasible using both the public and the private systems of financing [27,30]. As a result, policy proposals involved two key elements: first, a national health service to restructure the workings of the public-health service [18,27]; and second, a managed market for medical-schemes, referred to as social health insurance in the 1997 White Paper [18], to ensure that those able to contribute toward their own health-care did not become a financial liability of the public-health sector [18,27,30]. The public-health sector was located as the default arrangement for the entire population, with the system of medical-schemes regulated to enable the public-system to optimise its available resources for those without adequate incomes.

4.2. Equity in resource allocation–restructured pooling

Achieving an equitable distribution of health resources required the development of an integrated financing framework capable of harmonizing the allocations derived from general tax revenue with contributions made to medical-schemes.

The complete framework consequently proposed: the introduction of a centrally (nationally) determined formula-based resource-allocation system for the public system; a risk-equalisation mechanism for medical-schemes; the replacement of tax subsidies for medical-scheme members with an explicit portable contribution-subsidy equivalent, on a per-capita basis, to the implicit in-kind subsidy provided to public-sector users; mandatory minimum benefits for medical-scheme beneficiaries; guaranteed access for applicants to medical-schemes; the prohibition of any form of discrimination on the basis of health status in respect of contributions (community rating); and mandatory participation for all families with breadwinners earning in excess of the tax threshold (i.e. required to pay tax). This framework sought to ensure complete life-cycle coverage for income earners within the system of medical schemes [7,21].

Based on this framework, universal coverage would exist across the entire health system, public and private, underpinned by a uniform universal subsidy funded from general taxes, available either in-kind for those not on medical-schemes or as a contribution subsidy for those on medical-schemes. The proposals accepted that the uniform subsidy may not be sufficient to fully finance the mandatory benefits of medical-schemes. However, if families selected medical-schemes that used public-sector services as their main provider, the subsidy would be sufficient to cover average service costs. Alternatively,

medical-schemes would have incentives to compete for private provider efficiencies due to the transparency of the mandatory benefit and the removal of health risk-factors from medical-scheme pricing through risk-equalisation and community-rating. [7,21]

4.3. Efficient purchasing

Three changes were envisaged to address the system of public and private purchasers of health care.

First, for the public system, a purchaser-provider split was proposed incorporating autonomous (decentralised) public-hospitals and DHAs [7,18,27]. Provincial authorities would take on the role of purchasers of regional and tertiary hospital care, with DHAs operating as purchasers of primary care [18,27]. Public purchasers would also be free to contract with both public and private providers [7,27].

Second, to address the weak medical scheme incentives to contract efficiently with providers, two interventions were important. First, the improved transparency resulting from a risk-equalised standardised mandatory basic benefit would encourage competition on the cost and quality of essential benefits. Second, a government-sponsored scheme would play the role of a default competitor, encouraging purchasing efficiencies [7].

Third, the removal of the means test for public-hospital services, ensuring that all public services were free at point-of-service, would generate a degree of competition between the medical-schemes system (and associated private providers) and the default public system. Families and individuals would choose either to use the free public-sector, or to exercise their right to a contribution subsidy and purchase coverage through a medical-scheme [7,21].

4.4. Financing

At a macro level, the system would continue to be financed by a combination of general taxes and medical-scheme contributions (which could top-up the contribution subsidy). It was assumed that as the economy grew and employment rates increased, the universal coverage system would adapt accordingly. To enhance the linkage between economic and employment growth and a deepening of UHC, the funding of the universal subsidy (both in-kind and contribution) would be achieved by way of an earmarked tax determined as a fixed percentage of general taxes rather than a regressive payroll tax [7,21].

4.5. Timing

The implementation of the full institutional framework was originally estimated as 15 years [7]. The reforms were never framed in relation to a specified set of benefits or costs. Instead, the proposed institutional framework would allow for continuous adaption to changes in context. For instance, if private-sector costs continued to rise excessively, income earners would gradually shift toward public-sector coverage. Conversely, if the public-sector offered poor care, people with both adequate and inadequate incomes could shift incrementally toward private coverage and more efficiently contracted providers (including public services). In the long-term, it was assumed that employment rates and economic growth would systematically increase the number of families able to contribute toward their own health-care in excess of the universal subsidy. The size of the population able to switch between systems would consequently increase over time. As revenue would move with these choices, both the public and the private systems would be subjected to increased competitive pressures resulting from choice.

4.6. Policies implemented

Over the period 1994 to 2008, only a subset of the NHI 1 policy proposals, centred on the regulation of the private-sector, were implemented, with some proposals withdrawn from implementation in 2008. None of the public-sector reforms involving resource allocation or the purchaser-provider split were implemented. Also, no autonomous hospitals or DHAs were pursued due to vested interest opposition (Table 1).

Several far-reaching reforms of the medical-scheme system were, however, implemented in 1998. These included: the establishment of a special-purpose regulator for medical-schemes, the CMS; mandatory open-enrolment; mandatory minimum benefits; a prohibition on health-related discrimination of any form, including in setting contributions/premiums; governance improvements; and the regulation of intermediaries [28,29].

Reforms set for implementation in 2008 but withdrawn (Table 1) included the establishment of a risk-equalisation system; a revised system of mandatory and supplementary benefits; revised governance frameworks for schemes; and the establishment of a low-income medical-scheme system [26].

5. National Health Insurance 2–the period from 2008

In 2007, a number of political changes brought with them policy changes, with health policy a focus of review. In a departure from previous positions, greater emphasis was given to the specification of a strategic institutional endpoint, also referred to as NHI, referred to here as NHI 2. By contrast with NHI 1, NHI 2 initially sought to integrate both a universal subsidy framework and benefit, in the form of a dedicated provider system, into a single scheme within a short- to medium-term time horizon.

The stated rationale for NHI 2 centred on the achievement of UHC, based on the premise that South Africa falls short of this goal. The problem-statement located the central concern as a pooling issue, where the existence of a two-tier health system is argued to undermine efficient and fair coverage. The two tiers refer to the dual financing mechanisms of the public-health system and the privately owned and privately operated non-profit medical-schemes. The private health system is seen as costly and systematically increasing in cost over time.

Table 1
Summary comparison of NHI 1 and NHI 2 proposals.

Function	NHI 1	NHI 2
Pooling	National pooling is external to the public and private funders. Universal vertical transfers occur via the allocation of a formula-based risk-adjusted subsidy to public health authorities and medical schemes in respect of the entire population. Medical schemes pool horizontally by way of a risk-equalisation scheme. Where public sector coverage is chosen by an income earner, the subsidy will be implicit and in-kind through access to a free service funded by general taxes. Where coverage is selected through a medical scheme, the contribution payable would be government subsidised by an explicit subsidy, in the form of a risk-adjusted transfer, allocated to the relevant medical scheme via the risk-equalisation scheme. No net increase in health expenditure, as a percentage of GDP, is required for implementation.	National pooling is achieved by consolidation into a single monopoly public funder. Universal vertical and horizontal transfers are achieved through the establishment of a single national scheme (the NHIA) that consolidates existing coverage. Achieving this consolidation requires: a) that additional funds are raised to cover the cost within the NHIA of families presently covered through medical schemes; and b) that they transfer their coverage to the NHIA. An expenditure increase of approximately 2.1% of GDP, funded by way of an earmarked tax, is proposed to achieve this consolidation. On the assumption that coverage substitutes completely from medical schemes to the NHIA, no net increase in national health expenditure is envisaged. [1]
	Implementation considerations Initial reforms along the lines of NHI 1 were withdrawn in 2008 as implementation was underway. Although certain constituencies promoting the proposals argued that the reforms would be incompatible with the NHI 2 reform pathway, no technical reasons were advanced based on their viability [32]. In the period 2007 to 2009, it was also presumed that an NHI 2 pathway could be rapidly implemented [9] and therefore the NHI 1 and NHI 2 approaches were seen as competing options.	
Purchasing	Purchaser/provider split for provincial public health authorities. Introducing a purchaser-provider split into provincial health authorities would enable purchasing to involve both public and private providers. A decentralised district health authority system is proposed, falling within the jurisdiction of provincial authorities. These would be purchasers of primary care and district hospital services–to be universally available. Medical schemes would be able to purchase services from both the public and private sectors.	Purchaser/provider split is envisaged with the NHIA as the purchaser. The implementation of a purchaser-provider split would enable the NHIA to purchase services from both provincial public health authorities and the private sector. A district health authority system, forming part of the NHIA, will purchase primary care services–to be universally available. It is proposed that medical schemes would only purchase services not covered by the NHIA, i.e. there would be no parallel coverage [3].
	Implementation considerations Although no formal rationale was enunciated for the failure to implement the NHI 1 district and public hospital reforms, they would have curtailed the system of political patronage emerging in the 2000s by removing appointment and procurement powers from centrally located political office-bearers. The NHI 2 purchaser-provider split proposals were tested from 2012 through eleven pilot projects. General practitioner contracting, a key element of the purchaser-provider split, was the focus. Very few contracts were ever allocated, and the pilots to date are judged as failures [14,15]. The pilots did not investigate institutional options, accountability frameworks or governance designs. Although the NHI 1 and NHI 2 district health authority frameworks appear similar, vested interests within the provincial political structures remain a risk to both NHI 1 and NHI 2 designs.	
Private system of financing	Enhanced regulatory regime for medical schemes. Medical schemes would be regulated to ensure life-cycle coverage for members, through the removal of discrimination on the basis of health risk status, without compromising the financial sustainability of medical schemes or, arguably, the viability of the NHI 2 reform pathway.	Medical scheme system deregulated–permitting for-profit risk-rated health insurance. Removing life-cycle protection for all income earners and permitting risk-related discrimination by private funders, is implicitly motivated on the basis that medical schemes are either irrelevant or possibly even harmful to the NHI 2 reform pathway. This deregulation has not been explicitly proposed, but is implied by the over-riding framework outlined in the White Paper.
	Implementation considerations Although aspects of the NHI1 regulatory framework are in place through reforms implemented in 1998, structural weaknesses remain which can only be addressed through a complete NHI 1 framework. Although the NHI 2 framework reduces reliance on regulated private health insurance to deepen UHC, even at maturity this option will most probably require strong government stewardship over private financing and provision.	
Timing	Sustainable universal coverage is argued to be attainable in the short- medium-term.	Sustainable universal coverage is possibly attainable in approximately 25 years. [1,3,4]

5.1. Reform elements

Three broad strategic elements characterise the NHI 2 recommendations.

First, the public-health system is to be restructured by centralising all financing and purchasing at the national level of government within a National Health Insurance Authority (NHIA).

Second, to address purchasing weakness in both the public and the private-sectors, the implementation of a purchaser-provider split in the public-sector is proposed, whereby health care providers, both public and private, would become arm's-length contractors to the purchasing authority (the NHIA).

Third, a substantial funding increase for the public-sector is proposed, equivalent to around 2.1% of GDP, which forms part of the enhanced pooling objective [1,3].

5.2. Resource allocation and pooling

The centralised funding of health care, envisaged in the NHI 2 proposals, would seek to allow for a ring-fenced health-specific allocation for a specified package for the entire population. The envisaged centralisation of this function moves beyond resource allocation and includes the organisation and contracting (purchasing) of health services. The spatial organisation of health services for the entire population would consequently become a national function operationalized through the NHIA.

5.3. Restructured purchasing

In addition to managing resource allocations, the NHIA would purchase services through a district health system (DHS) which would contract with both public and private health-service providers. The DHS would be made up of DHAs forming part of the NHIA. No detail on the institutional framework, governance design, powers, degrees of autonomy, or financing arrangements has, however, been proposed or made available. The approach described in the consultation documents [1,3], although unclear, does not appear to suggest a system of autonomous DHAs as understood in the 1997 White Paper.

Both provincial and local-government health services would contract with the DHAs, as would accredited private providers. Consequently, the spatial planning and distribution of services would cease to be a provincial function and devolve to the purchaser (the NHIA). A similar situation would apply to the limited range of ambulatory-care services provided by some local governments (mainly major metropolitan local authorities).

Governance of the NHIA, an authority with the proposed functional responsibility to procure services to the value of 6.2% of GDP, requires that the CEO be appointed (and presumably) removed by the MoH. There would therefore be no independent board. No change is consequently envisaged to the governance models already applicable to the administratively centralised and poorly performing public-health services [11,31].

5.4. Consolidated pooling

The substantially expanded funding, taking the public budget to 6.2% of GDP, is intended to, inter alia, extend the coverage of the public system to incorporate those presently financing their own health care on a contributory basis through medical-schemes. Importantly, therefore, the objective is *not* to expand coverage to an uninsured or uncovered group, but instead to extend it to the already covered 8.8 million beneficiaries of medical-schemes.

The financial proposal is argued to be affordable on the basis that a direct substitution of coverage would occur from medical-schemes to the NHIA, with the increased taxation offset by reduced medical-scheme contributions [1,16]. An indicative 15-year phasing-in of the increased expenditure required is spelled out in the Green Paper and in the subsequent White Paper of 2015.

5.5. Timing

Timing for the NHI 2 initially adopted a "big bang" approach, with full implementation to occur in 12 months [20]. This was subsequently increased to 5 years, then 15 years [9]. In 2011, a period of 25 years was proposed in the National Development Plan [4]. In 2015, the White Paper on NHI proposes 15 years from 2015–which implicitly acknowledges no implementation progress from 2012 to 2015 [3].

5.6. Implemented to date

Eleven pilot projects were implemented in 2012, the indicated start date of the NHI 2 reforms [1], to assess DHA options. Instead of testing institutional designs (governance, powers, jurisdiction, and financing), they experimented with general-practitioner contracting, which was unsuccessful. No progress on the development of a DHS has therefore been made over the period 2012 to 2015, with the pilots generally assessed as a failure [2,14,15].

6. Discussion

While both NHI 1 and NHI 2 seek to address weaknesses in pooling and purchasing, the diagnoses and consequent recommendations differ in content, scale, and implementation risk. Three issues stand out.

First, there is the question of which pooling problem needs to be addressed and how. The stated rationale for NHI 2 is tied to a pooling problem along the vertical dimension, while NHI 1 sees the pooling weaknesses as principally horizontal–but with a need to harmonise and improve delivery efficiencies (of the subsidies) along the vertical dimension. The NHI 2, however, motivates for a 2.1% of GDP tax increase, consistent with the idea of addressing a shortfall along the vertical dimension, but argues that this is needed to absorb the population covered by medical-schemes (eliminating the two tiers) into public-sector coverage (via the NHIA). This group, however, already pays 3.4% of GDP for its own coverage. The scale of the proposed NHI 2 restructuring is therefore thinly

supported with reference to pooling problems along the vertical dimension and unlikely to be implemented with this purpose in mind.

Second, there is the question of whether vertical inequity is principally a question of additional taxation or institutional design. Although both NHI 1 and NHI 2 address pooling problems along the vertical dimension, the former identifies portability gaps (where subsidies cannot follow coverage choices), while the latter argues that too little is spent on the population dependent on the public-sector (per-capita expenditure differentials are emphasized). Assuming an identical vertical subsidy in both NHI 1 and NHI 2, society would theoretically be indifferent between the two options. In practice however subsidy mechanisms can influence the incentives and performance of purchasers. Subsidies could be available via a number of purchasers or systems (NHI 1), or exclusively offered via a single purchaser or system (NHI 2). The grounds for choosing between NHI 1 and NHI 2 cannot therefore be based on the quality of pooling, but rather on the consequential effects on the purchasing platforms.

Third, purchasing failures could be addressed either through the identified source of the failure or by a wholesale replacement of the platform. While purchasing problems are recognised by both NHI 1 and NHI 2, the policy prescriptions exhibit some similarities, but also fundamental differences. While NHI 1 proposes a combination of measures without replacing the purchasing agents, NHI 2 proposes their complete substitution, in both the public and the private-sectors. The latter is, however, silent on how efficiencies are to be achieved–apart from very general arguments based on monopsonistic purchasing opportunities [1,3].

An important feature of NHI 1 involves the incorporation of choice at three levels of the system: first, a choice between public or private financing systems (enabled by the portability of subsidies); second, a choice of purchasers; and third, a choice of services (enabled by choosing different arrangements within financing systems). This is consistent with the idea of structural pluralism espoused in Latin American reforms [33,34]. The NHI 2 in contrast restricts choice to a single financing system and designated regional purchasers (the DHAs). Within these constraints, it is possible to select providers–but only those forming part of the NHIA network.

Therefore, whereas NHI 2 implicitly argues that a single monopoly public agent is best placed institutionally to reflect the public interest as a purchaser, NHI 1 relies on a degree of competition (supplemented by governance and accountability reforms) to ensure that purchasers are incentivised to respond to the interests of the served population.

Another question involves the centrality of governance-related measures as a means to enhance system performance. Governance considerations, a central NHI 1 purchasing concern, are not raised as part of NHI 2. Whereas NHI 1 proposes that public services (such as hospitals) and public purchasers (such as DHAs) be depoliticised, incorporate local representation and have powers to appoint and remove key executives, NHI 2 recommends that the NHIA be headed by a political appointee with no independent oversight board. As all appointments and procurement decisions can be influenced by the CEO, the risk of corruption with this option, already a feature of the public-health service [31], is considerable. Although NHI 2 could be implemented with strong governance arrangements, their absence in policy proposals suggests that this is not recognised as a reform priority.

Overall, therefore, whereas NHI 1 builds off existing systems, connecting them through subsidies, resource-allocation mechanisms and social guarantees, NHI 2 replaces all existing pooling and purchasing mechanisms and places them within an entirely new scheme. If it is assumed that the same degree of pooling is adopted, the two options would be distinguishable only on two features: implementation risk; and delivery efficiencies.

NHI 2 fares worse with respect to implementation risk as the social guarantees are available only when the NHIA is operational, purchasing efficiently and has universal participation. Given that the purchasing platform is entirely replaced, this can therefore only be regarded as a long-term reform. NHI 1, by way of contrast, is able to progressively deepen the coverage without placing existing coverage at risk. NHI 1 is consequently more scalable than NHI 2, can be implemented without a substantial tax increase, and will face less institutional resistance at implementation.

The absence of any detail on the purchasing approach of NHI 2 renders any comparative assessment of delivery efficiencies with NHI 1 impossible. However, given the likely timeline to complete implementation, interim measures to achieve delivery efficiencies will inevitably need to draw on existing purchasers as proposed by NHI 1. The NHI 1 approach, which does have a degree of elaboration, therefore offers the potential to improve health outcomes on quality and cost in the medium- to long-term, relative to the status quo, without removing any long-term options consistent with NHI 2.

7. Options for an integrated reform path

Both strategic reform frameworks (NHI 1 and NHI 2) considered from 1994 address weaknesses with pooling and purchasing in the South African health system. Both involve system-wide pooling and a purchaser-provider split within the public system. However, whereas NHI 1 connects the public and private systems through the subsidy framework and restructured purchasing, NHI 2 consolidates the subsidy and purchasing framework into a single authority, the NHIA.

The NHI 1 approach is consequently: simpler to implement (as it leverages off the existing institutional arrangements); more adaptable; and more likely to deliver on UHC objectives over the medium- to long-term. The NHI 2 framework, although a viable long-term goal, is fiscally and institutionally ambitious, with an extended implementation path before any outcomes are likely to emerge [1,3,4]. Although NHI 2 was originally considered as a medium-term option, it is now acknowledged as the long-term goal of an extended reform process. Two options are therefore possible.

The first is to invest exclusively in the NHI 2 single-payer agency as the sole funder and provider of UHC in South

Africa, irrespective of the time of delivery. Here the private system of regulatory protection would degrade despite the likely non-availability of a capable public purchasing platform. Coverage in the private-sector would regress as market failures cause the exclusion of high-health-risk individuals and groups together with systemic cost increases. As the NHI 2 pooling objective is explicitly targeted at the group presently covered by medical-schemes, rather than at any uncovered group without adequate incomes, this reform trajectory could harm the coverage of a historically covered group for an extended period before the complete system is achieved.

The second option is to invest in the NHI 2 public platform together with the effective regulation of the private system, as envisaged in NHI 1, thereby preventing any UHC reversals in the interim. Here the private system would supplement the public system until such time that a sensible choice can be made regarding a system end-point. This option manages the implementation risk of NHI 2 by optimising coverage at all points in time for the groups covered by both the public and private systems. Even with the final implementation of NHI 2, there is no reason why both substitutive and supplementary coverage in the private system should not form part of the formal UHC approach – provided pooling, both vertical and horizontal, are maintained at a societal level.

8. Conclusions

Despite technically complying with UHC, South Africa has a poorly functioning health system characterised by systemic failures in both the public and the private systems. An intensely political process in 2007/8 generated ambitious but technically vulnerable reform proposals, referred to in this paper as NHI 2. Revealed complications with the designs and their medium-term feasibility have, however, stalled not only these proposals but also other possible UHC reforms – in particular those falling within the NHI 1 design.

This review suggests that risks inherent in the NHI 2 reform proposals are less important when it is considered as a reform end-point. Possible conflicts between NHI 1 and NHI 2 are minimised when the former defines the pathway and the latter the ultimate goal. Important to the NHI 1 framework, however, is an investment in the development of a subsidy framework, a strong public health system, and health coverage protection guarantees that can be applied across multiple systems and purchasers, both public and private, as a means to optimise UHC at all points in time rather than only at some end point far in the future.

Competing interests

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Authors' contributions

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