HEALTH REFORM

Perspectives and Proposals

November 2021

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PROJECT TEAM

This report has been produced in a partnership between Concentric Alliance and SECTION27.

Concentric Alliance (Pty) Ltd

CA is an Africa-based conflict resolution and development practice. Through facilitating dialogue and resolving conflict, CA strives to build trustful and productive working relationships between the public sector, private sector, and civil society. CA is accustomed to working in highly politicised often-hostile environments. Team members have designed and been party to multi-party negotiations and political processes, from South Africa's own political transition, and other peace processes, to more recently building social compacts between stakeholders in South Africa's contested mining sector.

SECTION27

SECTION27 is a public interest law centre that seeks to achieve substantive equality and social justice in South Africa. Guided by the principles and values in the Constitution, SECTION27 uses law, advocacy, legal literacy, research, and community mobilisation to achieve access to healthcare services and basic education. SECTION27 aims to achieve structural change and accountability to ensure the dignity and equality of everyone.

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EXECUTIVE SUMMARY

Health system reform efforts in South Africa appear to have stagnated. Following over a decade of discussion and debate, stakeholders are weary and do not trust each other's motives and opinions.

This stagnation is fatal. South Africa's health system is under immense strain and its inequities are well known. Some people continue to receive insufficient care while others are over-serviced in the interests of profit. Health care workers are burning out. Uncertainty about changes that may never come is causing jitters in the middle class and impatience among those who cannot imagine a changed system leaving them worse off.

It is within this context that this research has been conducted. SECTION27 and Concentric Alliance (CA) wanted to see what stakeholders in the health system (when they are away from the public eye) agree on, what they disagree on, and whether there is the possibility of bringing them closer together in the interests of fixing a decidedly broken health care system.

We interviewed 33 people from the national and provincial departments of health, health regulators, medical schemes, public and private health care workers, trade unions, private hospital groups, public health academia, health rights-focussed civil society, the pharmaceutical industry and government. We read submissions and statements on health system reform and National Health Insurance (NHI) from many other stakeholders.

This report presents what we found and what we recommend.

We found that while there are some areas of profound disagreement, there are also areas of (sometimes surprising) agreement. All of the people we interviewed agree that the foundation of a health system is the right to access health care services. Everyone agrees that there is a need for health system reform, in part to realise that right. Everyone agrees that there are governance, accountability and management issues that must be attended to urgently. Everyone agreed that there is a need for, and the possibility of, collaboration.

Many respondents agree on the need to try different mechanisms for harnessing private sector capacity to service the public sector and for establishing the systems to support more rational referral processes. Many agree that we need to monitor health outcomes and to orientate the health system to respond to those outcomes. Most respondents agree with the need to better regulate the private sector, including the pharmaceutical industry.

These areas of agreement give us somewhere to start: to take tangible steps towards health system reform on a foundation of consensus. Just starting could build the trust that will be needed to make further inroads.

The areas of disagreement are less surprising: the relegation of medical schemes to cover only complementary care; how to produce and keep sufficient and appropriately qualified human resources for health; how to establish the roles of national and provincial departments of health in relation to each other and to other structures; and how to ensure appropriate governance of funds and facilities. These are the difficult areas of health system reform that may be holding up needed reform in other areas.

Even within these areas of disagreement, however, there are glimmers of consensus, agreement on principles, and recognition of the need for change. Subjecting some of the more wicked problems to a good faith consensus seeking process could help to move the needle.

The recommendations are divided into two paths for the way forward: to take action on areas of agreement; and to go deeper into consensus seeking to guide the way forward on areas of disagreement. Taking action on areas where there is already consensus would need to be a government-led and funded process, in collaboration with stakeholders. A consensus-seeking process could be organised and facilitated by people independent of the health system and funded through the fund-raising efforts of stakeholders.

The report's findings are encouraging! They illustrate hope for health system reform beyond the current impasse. The report findings on the areas of contention and of consensus provide a point of departure for reform of a health system in dire need of change; in the interests of the people of South Africa, in dire need of a system that serves them.

INTRODUCTION

This report is the outcome of nearly a year of research and interviews conducted by Concentric Alliance and SECTION27, bringing together diverse perspectives on health reform from government, private sector, civil society, and academia.

It comes at a time when South Africa has been ravaged by the Novel Coronavirus (COVID-19), which has exposed the great inadequacies of the health system in South Africa, within both the private and public sectors.

The participants universally agree on the urgent need for health reform and while there are many divergent views that have been shared, there has also been a surprising degree of alignment on many issues.

While it has been acknowledged by many that there are real disagreements on the approach to health reform, not least of which is the current National Health Insurance (NHI) Bill, participants have shown an eagerness for real engagement, if that results in meaningful and urgent reform, to address the many challenges in the health system. This report seeks to document the perspectives of stakeholders, their views on health reform, the primary tensions that exist within the health system, the barriers to reform and the opportunities that exist for collaboration on health reform in South Africa.

The purpose of this report is to create an open and safe space for key stakeholders to share their perspectives on the health system and their thinking on health reform. The objectives of this research are to:

+ Identify whether there are a set of core principles that stakeholders within the health system may be able to agree upon.
+ Identify the tensions that exist between stakeholders on health reform, the causes of these and possible areas of convergence.
+ Outline the views of stakeholders in the health system on current proposals for health reform.
+ Identify a possible approach to health reform that navigates the existing tensions and builds a level of consensus on what must be done.

APPROACH AND METHODOLOGY

CA and SECTION27 designed an in-depth interview process, with participant confidentiality guaranteed, that enabled us to get to the personal perspectives of stakeholders in a safe environment. The result is a rich array of novel perspectives that increases the potential for dialogue on health reform.

The approach aimed to circumvent the often acrimonious and frustrating experiences that stakeholders have had in debating health reform in an environment where perceptions are hostile and fixed, where trust is low and where positions must be defended.

The perspectives in this report have been gathered using qualitative methodologies that included primary data analysis of government legislation and reports, including the National Health Insurance Bill, submissions to parliament on the Bill, the Health Market Inquiry report and secondary data analysis of news and journal articles. Following document review, CA and SECTION27 interviewed 33 informants whose selection was based on their prominence in the debate on health reform. CA used a purposive participant selection process, which is a qualitative methodology that aims to produce a sample that well represents the broader population, either because of participants' expert knowledge on the subject, or their representation of a particular stakeholder group.

Participant selection

The participants were selected on the basis of two general sets of criteria: 1) Their representativeness of the health sector, with reference to health system building blocks, as identified by the World Health Organisation (WHO), which are understood to be the key inputs of a health system that need to work for it to have improved health outcomes[1]; 2) their representativeness of stakeholder groups important in public policy making. The sample chosen for the research was diverse and a balanced representation of the different high-level stakeholders needed for public health system reform. Thus, the participants were drawn from institutions and organisations in the health system. These institutions and sectors included public health academia, public health civil society organisations, health professionals, private sector business and funders, health regulators, trade unions; and various government institutions responsible for public health. Respondents participated in their own personal and professional capacity and did not represent their institutions or organisations. See Annexure 1 to review the participant selection methodology.

Interviews

Interviews were conducted by CA and SECTION27 using a semi-structured interview process over a period of several months commencing in November 2020 and being completed in June 2021. Thirty-three interviews were conducted. See Annexure 2 to review the questionnaire used during the interview process. Participants were requested to complete a consent form prior to the interview taking place.

Limitations

The methods selected for this research are qualitative and therefore non-probabilistic. However, it was agreed that our sample would be representative of the large diversity of views within the health sector. While there was considerable effort to reach out to the Departments of Health, national and provincial, we have unfortunately not been able to secure as many interviews from the National and Provincial Department of Health as we would have liked. We also regret that we have not interviewed officials at local government level.

1. World Health Organization, Monitoring the Building Blocks of Health Systems, 7.

THE DISCOURSE ON HEALTH REFORM

The discourse on health reform has been characterised by disagreement, distrust and social distance between many of the stakeholders that play important roles within the health system. These stakeholders include all levels of government, the public and private health sector, academia, civil society, and trade unions, and have diverse perspectives on how health reform can be achieved and implemented.

While there are in fact many shared principles that each hold on health reform, the way the debate has been pursued so far has resulted in worsening relationships, a breakdown of constructive dialogue and a stymying of response to one of South Africa's most important challenges.

There have been attempts to bring these parties together in dialogue, most recently during the government's Presidential Health Compact in 2019. However, during our interviews many participants argued that while the intent was good, the process was not consensus-based but rather sought the acquiescence of stakeholders to government's position. Many felt that the participants of this process were selected for their compliance and that the process failed to address the fundamental challenges to the health system and excluded many stakeholders. Engagement also failed to be sustained much beyond the process itself.

During the COVID-19 pandemic, government and business attempted to co-ordinate the response to the pandemic using a six-a-side approach including the National Department of Health (NDOH) and Business Unity South Africa (BUSA) members. These meetings have been ongoing throughout the period. While this forum has been lauded by some respondents as a step in the right direction, others have expressed their frustration at the difficulties experienced in working collaboratively, with dialogue frequently being hampered by disagreements over approach, and on perspectives of health reform and the NHI Bill.

Context of the health reform debate

Much of the focus on health reform has been on NHI since 2007, when at the African National Congress' (ANC) national conference, the implementation of NHI was affirmed as party policy. In 2009, then President Jacob Zuma initiated steps to develop proposals for implementation. The NHI as currently proposed expressly aims to promote equity and access to quality healthcare to all in South Africa. It aims to do this by pooling all health resources in the Republic and introducing the state as a single payer for services and as a single purchaser of health products and equipment. The NHI aims to enable access to the closest point of service for the user by accrediting and contracting health service providers from both the public and private sector. The NDOH views this as the best means for creating a universal health system that gives equal access to quality healthcare.

The public debate on health reform and the NHI Bill has become deeply contentious, creating a false dichotomy of those who support NHI and those who do not. In truth, the distinction is not nearly so clear cut, with many supporting the fundamentals of the Bill, while being deeply concerned about how NHI will be implemented. There are also those who may support the intent of the Bill but believe that much more needs to be done to reform healthcare than is presently contemplated within the NHI Bill. The lack of nuance in the public discourse has meant that major stakeholders are speaking past each other, that important and relevant points are being lost in a debate that relies on expertise, and that the level of rhetoric is contributing to uncertainty and a lack of trust in government and other stakeholders by both practitioners and users of the health system.

Barriers to engagement

During our interview process, several respondents offered perspectives on why they felt that the discourse on health reform was so conflictual. These were:

Lack of trust

Eleven of the respondents we spoke to have raised 'a lack of trust' as a reason why health reform has thus far been unsuccessful. Given the many years of often conflictual engagement between the different stakeholders in the health system, it should not be surprising that there is now a deep lack of trust between different stakeholder groups, both on an individual level but also between the institutions they represent. Many of those outside of state institutions, and even those within them, indicated that they do not trust the state to lead health reform. Many believe that the state has neither the capacity nor the integrity to lead reform for the benefit of South Africa. The numerous incidences and allegations of fraud and corruption within NDOH and provincial departments of health, which was cause for the removal of the Minister of Health only recently, are seen as clear examples of why the state cannot be trusted.

The COVID-19 pandemic, while having been the site of some collaboration, has mostly exacerbated the lack of trust between stakeholders. Mismanagement of funds, a slow start to the vaccine roll-out and the ever-shrinking public purse are seen by many as warning signals.

Additionally, there are misgivings between stakeholders about the motives of each other. For instance, one respondent holds the perspective that health reform would have an impact on the profitability of the private sector and that the private sector was, therefore, not a neutral party in health reform. This being the case, this respondent argued that the private sector's approach to reform would be self-serving.

Vested interests in the public and private sectors

Concerns were raised by many participants about the role of special and vested interested in the healthcare reform. Scepticism was expressed amongst public health academics as to whether the government has any real intention to reform the health system, believing that there are too many vested interests involved. Rather, they think that NHI is an easy way to distract the population and create the perception of reform happening. This sentiment was echoed by a respondent from government who stated that NHI has made such little progress over a long period of time that perhaps it is "just simply big talk."

Within the private sector, a respondent said that the concentration of health markets, particularly in facilities and funding, militates against health reform in the private sector, as the current system is very profitable. Also, the respondent believed that many politicians and politically connected individuals have significant interests in the private health sector, creating a conflict of interest on the issue of health reform.

The same respondent from the private sector argued that within government, there are also many who would resist attempts to reform the health system. The principle of fiscal federalism gives provinces control of significant resources and gives them substantial power to distribute those resources, which combined with weak oversight, has created substantial networks of patronage and enrichment. One respondent from government argued that health reform would not be in the interests of many within the governing party.

Ideology

Concern has been raised by respondents from government, the private sector, academia and civil society that the debate on health reform has become unnecessarily ideological in its content, thus intensifying conflict between stakeholders. Several respondents from different sectors stated that this is especially true of the NDOH. The issue of ideology is best illustrated by the contest over Section 33 of the NHI Bill, which has been described as a "totally unnecessary fight with the private sector that could hold this thing back" and, "unnecessary radicalism" by one respondent in government.

Another respondent, a public health academic, argued that there has been an attempt by the NDOH and others to create a false dichotomy of those supporting the NHI, as being supporters of the right to health and those critiquing NHI, as rejecting the right to health or universal health coverage. The view is that the NDOH is taking a populist stance to avoid dealing with the real problems with the NHI Bill (and the health system), whilst still being able to maintain the perception that something is being done to support health reform.

While some felt an ideological debate was creating a barrier to reform, two respondents in the NDOH believe the department is taking a principled view that health markets should not exist. One respondent from the NDOH expressly stated that "it is perverse to discuss health systems as markets" and that the concept of health markets is incompatible with health as a right. While some agree with this in principle, in practical terms there is broad acknowledgement of a need for a properly regulated private sector, particularly in relation to profitmaking and pricing in the health system.

Lack of leadership

Six respondents from all sectors have argued that there has been a failure of leadership within all sectors of the health system and throughout the debate on health reform. One respondent felt that the people who should be providing direction, signalling to other parties, and building trust are failing to do so. For some, South Africa has the technical capacity to implement health reform, however, this is not being sufficiently utilised and there is little effort to marshal this expertise. An academic argued that when health reform was a priority of the Ramaphosa presidency, there was real progress, but other crises have since overtaken it. Another academic made the point that: "I think the COVID crisis provided a golden opportunity for the National Department to assume central leadership and they've missed that opportunity." Particularly, there is the feeling that there has been a failure to bring other stakeholders into the health reform discussion.

CONTENTION IN HEALTH REFORM

During our interviews, it became obvious that there are areas of great contention within the debate on health reform which cannot be easily navigated. The issues of greatest contention arise from conflicting interests, of which there are many. Some of these conflicting interests are transparent and easily identifiable, while others seem to be more hidden, or are perceptions of respondents. These certainly are the issues that contribute to making health reform the complex problem that it is.

The role of the medical schemes in the NHI

The role of the private sector has perhaps been one of the most contentious aspects of health reform in South Africa, particularly medical schemes. As stated previously, for some, health markets are anathema to the concept of health as a right – particularly for those within the NDOH. However, the private health sector contributes significantly to the South African economy, is a large employer and many respondents in both the public and the private sector believe could be an important role player in health reform, having significant excess capacity and resources available.

Section 33 of the NHI Bill states that medical schemes may only provide "cover that constitutes complementary or top up cover and that does not overlap with the personal health care service benefits purchased by the National Health Insurance Fund on behalf of users". Essentially, private medical schemes that are not gap cover, will cease to operate, with members covered by those schemes being required to use the NHI. This has caused significant disagreement between the private sector and the NDOH. For many respondents, across all sectors, this a non-starter and an unnecessary fight to have. Unsurprisingly, all respondents from the private sector have argued that even in countries with the most developed and extensive public health services there still exist private healthcare funders. Additionally, an academic argued that it would better to incentivise people into abandoning private funders by establishing a reliable and well-functioning public funder, rather than threatening to remove a functioning service.

One concern raised by participants in the private sector was that Section 33 will constrain competition and limit the efficiency of the NHI. They argued that competition is necessary to ensure that the NHI Fund functions well. A private sector respondent also noted that the NHI should be able to compete with /private funders to promote efficiency.

Submissions on the Bill have also raised concerns about the lack of detail on the implementation of Section 33 and the transition to NHI. They are concerned that without careful forethought this section will result in many additional users moving into an already overburdened public sector, without the necessary strengthening of the public sector. Without the appropriate steps, it is argued, this section could worsen rather than improve access to quality healthcare.

For many participants, Section 33 of the NHI Bill has become something of a hill to die on. During the six-a-side engagements between BUSA and the NDOH, urgent discussions on NHI were nearly derailed by demands that Section 33 be re-opened for discussion and one respondent in the NDOH stated that the Bill was now before parliament and these issues would be addressed during public consultations. This respondent stated that they would rather see this point litigated, than back down. The current approach to this draft provision has the potential to undermine the implementation of the NHI and delay urgent reform to the health system.

Misalignment in the health system

One of the critical concerns among many participants is a misalignment between the various levels of the health system. Several respondents noted poor integration between the NDOH and provincial departments. For many this was due in part to the system of fiscal federalism that exists, which sees capita-based block grants allocated to provincial departments, without sufficient oversight by the NDOH. A government official believes that budgets are being allocated without sufficient consultation between provincial departments and the NDOH, which sees the provinces selecting their own priorities. One government official agreed that provinces are unaccountable to the NDOH. Current officials from the NDOH agree that there is a need to reform fiscal federalism to be able implement the NHI.

A government official expressed concerned about how the NHI Bill would be implemented in the current administrative and constitutional framework. The Bill would essentially see the NDOH distributing resources to district health departments, where they would then be allocated to health priorities. Currently, functions of distribution and allocation sit with the provincial departments. A government respondent believes that an attempt to remove these responsibilities will result in conflict between the NDOH and provinces, particularly between the Western Cape and national department, because the Western Cape is led by the opposition Democratic Alliance.

For 10 respondents from all sectors, these roles and responsibilities should have been clarified within the Bill and consideration should have been given to other legislation that regulates the relationship between provinces and national departments.

Governance, management and accountability

Thirteen respondents, representing all sectors, including officials from the NDOH have stated that governance, accountability, and management systems of the public health sector are an area of great concern, and in need of urgent reform. Several respondents raised concerns about the delegation of power and the responsibilities of different departments within the health system. There is also great concern that the public health sector has fallen prey to political patronage and corruption, illustrated most recently by the investigation into the irregular tendering of services from Digital Vibes by the Special Investigations Unit (SIU), the subsequent resignation of the Health Minister, Dr Zweli Mkhize and suspension of the Director General, Dr Sandile Buthelezi. For many respondents, the history of corruption and state capture, and the fact that, notwithstanding the post Zuma leadership's expressed commitment to good governance, state corruption continues unabated in the NDOH; creates significant governance risks for a National Health Insurance model and the delivery of health services in the future.

All respondents have raised concern about the systems of governance within the public sector, which they believe undermines both accountability and effective service provision to the public. Two respondents noted that the limited transparency within the public sector at all levels, along with concentrations of authority within senior management creates opportunities for corruption. One academic went as far as to argue that this was an intentional design flaw that creates space for systems of patronage to flourish and would act as a blockage to reform within the public sector.

Nine respondents, including government officials, have stated that one of, the most severe outcomes of poor accountability in the public sector, is corruption and escalating costs resulting in significant misallocation of resources out of the public sector. Four participants, all of whom have worked at various levels of the public sector and government have identified weak procurement systems being the cause of the PPE procurement scandals that have taken place during COVID-19, where middlemen and close associates of politicians have sold PPE to government at significantly inflated prices. A respondent from government also added that weak accountability and the existence of embedded patronage networks is a system that benefits regional offices of the governing party. Weak accounting and oversight structures, such as hospital boards, clinic committees and untransparent systems are also present in hospitals and clinics, if they exist at all.

Concern has been raised about how existing governance systems will interplay with the proposed governance systems in the NHI Bill. Seven participants, representing civil society and regulators, argue that the current Bill concentrates too much power in the hands of the Minister of Health without providing the necessary oversight over the planned massive resources of the NHI. One participant from a regulator has stated categorically that "the fund will be plundered". Several organisations in their submissions to parliament have recommended that larger numbers of independent and civil society representatives participate in the governance of the system and cite state capture as an illustration of the consequences of the concentration of power. There has been acknowledgement of this risk by the NDOH with one respondent saying that there is a need to build accountability measures that include the participation of the public. The respondent stated that the NDOH has been working with the SIU to protect the NHI fund. All trade union representatives interviewed argued strongly that every effort must be made to protect the NHI Fund.

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Health legislation currently provides for councils and consultative fora at various levels, including hospital boards and clinic committees. However, the role and function of many of these structures vary considerably. Five respondents, including one from the NDOH, have stated that the oversight structures throughout all levels of the public sector are weak. For example, hospital boards rarely exercise sufficient oversight of audit processes, giving hospital managers outsized control over expenditure. For them, there must be a significant strengthening of public accountability prior to the implementation of the NHI otherwise procurement and other frauds will remain a fundamental problem in the public health sector.

However, it should also be noted that one tertiary hospital manager argued that proposals of devolving decision making down to the local level is important. It was argued that the current system creates relatively small thresholds for procurement before needing approval from a higher level of government. This frequently means that procurement of materials and maintenance work could be delayed by provincial departments not approving procurement. The respondent felt that greater devolution, with adequate accountability structures, could greatly enhance the responsiveness of health facilities.

Five respondents from the public sector, or working closely with it, have acknowledged that there are severe constraints within the NDOH, with one respondent stating that their experience of working with the department illustrates dysfunctionality. They argued that in many cases there are insufficient people with the necessary skills to fulfil the role of the national department successfully. This was exacerbated by the loss of experienced deputy directors general during the onset of the second wave of COVID-19. Additionally, respondents expressed that there is also a lack of collaboration within the department that undermines the role of the NDOH, illustrated by the failure to include the former DG, Precious Matsoso, in the formulation of the NHI Bill during the tenure of Minister Aaron Motsoaledi.

A respondent from government has stated that the NDOH has not significantly built its capacity to implement NHI in nearly seven years. It was the respondent's view that this could have been resolved, as there was budget allocated to strengthening the capacity of the department. However, this budget was incompletely used.

It was further elaborated that despite the prioritisation of NHI for the last decade, the existing NDOH staff were unable to make progress on the implementation of the NHI and it required the hiring of a consultant, Dr Nicholas Crisp, to commence implementation. Dr Crisp has since been appointed as Acting Director General. One academic noted that the fact that the department had become dependent on consultants to fulfil important implementing functions highlighted institutional weaknesses. The respondent further suggested that political appointees were having an outsize influence on the NDOH's policy making agenda. The lack of capacity in the NDOH has meant that many priority projects, including the Strategy for Human Resources for Health and NHI, have been severely delayed by the response to COVID-19.

Thirteen respondents from all sectors have noted that, at all levels of the public sector, there is a lack of necessary management skills within health departments and health facilities, which is concerning given the proposed massive expansion of services and needs under the NHI. Respondents have pointed to a significant gap in logistics, purchasing and HR skills, not to mention the shortage of health workers. One respondent noted that corruption in procurement could be greatly reduced by ensuring adequate skills in purchasing. The lack of necessary skills and capacity was undermining public health institutions. One respondent stated: "The public sector lacks innovation and is lethargic". Another respondent felt it was critical that innovation and learning should be taking place within public health, but that this could not happen in the current context.

During the interview process eight respondents, from both the private and public sector, suggested that there is a great opportunity for partnership between business and government to facilitate the necessary skills transfer to support the NHI. However, many felt that these opportunities had been missed due to a lack of mutual trust. Many civil society respondents suggested that an opportunity has also been missed to strengthen the governance and accountability structure of the NHI through adequate public consultation and that important lessons from the State Capture inquiry had not been incorporated into the NHI Bill. Given the arguments made that the existing beneficiaries of weak accountability in the health system also have the power to undermine the NHI's purpose, there could be important linkages that could be made to support an accountable and transparent public health system and support the NHI Bill.

Regulation of the medical schemes, services and facilities

Seven respondents, including a government official, private sector respondents and academics, share a view that the NHI Bill has been a distraction from other pressing health reforms and is being seen as a panacea for all that ails the health system. Many respondents have stated that there is an urgent need to amend the National Health Act (No. 61 of 2003) and the Medical Schemes Act (No. 131 of 1998), which they argue are outdated and need to reflect the needs of the current health system. One respondent from the NDOH, on the other hand, argued that it made little sense to prioritise reform of the Medical Schemes Act given the intention of the NHI Bill, stating further that their priority was on fixing the public sector, rather than reforming the private sector. From the private sector, a respondent stated that they believed the lack of reform in the private sector was intentional and aimed at destabilising the private sector.

Eight respondents, including civil society, practitioner representatives, government and the private sector

believe that the basis for reforms of the private sector should be the findings of the Health Market Inquiry (HMI), which found that costs of medical schemes, treatment and facilities are increasing at often above inflation rates. The HMI found that health funders are competing within an incomplete regulatory framework that sees the creation of schemes that pool risk, without a risk adjustment mechanism. In addition to this, two respondents, one from the public sector and one from the private sector, argued that the cost of administration has increased the overall price of premiums. The HMI also found that the regulatory framework for private practitioners had led to a "price vacuum" due to a lack of space for collective price-setting and regulation on anti-competitive behaviour that prevented practitioners from discussing pricing. This had led to practitioners setting prices at levels that their clients could bear or settling for medical scheme rates where they could not.

The HMI made several recommendations, including reforms to diversify the risk of medical schemes, increasing the information available to consumers and increasing competition within medical schemes as a means of reducing the costs of medical schemes. However, this suggestion has been rejected by a respondent in the NDOH, who felt there is already too great a proliferation of medical schemes and rather the focus needs to be on reducing the number of medical schemes, encouraging greater transparency and cross-subsidisation of risk in medical schemes. This suggestion is seemingly supported by respondents from government who have suggested that the creation of a standardised offering across all medical schemes could be the basis of the benefits provided by the NHI.

Additionally, two respondents, an academic and a respondent from a regulator, stated that if there is a genuine desire to deal with price escalation in the private sector then the regulation of medical scheme administrators needs to be prioritised.

Four respondents, two representing practitioners, have criticised the fee-for-service model of pricing in the private health sector, where patients pay for each service provided, rather than for an overall consultation. A respondent in the private sector argued that the current model incentivises overservicing and that there are frequently coding errors, either intentional or accidental. They were of the view that there is an urgent need to create a more systematic and predictable system for tariff setting where price reflects the actual value of services. Echoing this, a respondent working in private hospitals noted that it is not currently possible for private hospitals to employ doctors, which is leading to overservicing, because they are paid per procedure, rather than by the hour.

An academic has argued that perhaps the most significant reason for escalating costs in private healthcare provision and medicines is due to the way health markets are structured in South Africa. They argued that in all cases the major actors in health markets are dominant in both the supply and demand sides of those markets. They gave the example of Discovery and Mediclinic both being substantially owned by REMGRO. The oligopolistic form of market structure enables companies to pass on their costs to the customer and for them to make substantial profits. The HMI found that there is a significant concentration of the facilities market, that is private hospitals, both at the national and local level, being dominated by three major players. The HMI noted that this makes the facilities market susceptible to collusion and makes it difficult for contractors to negotiate pricing effectively. This has enabled the facilities market to both secure significant profits and to make market entrance extremely difficult for new players.

For respondents representing private practitioners, the private sector and civil society the failure to implement or even to explore options proposed by the HMI has been a critical failing of government, and a lost opportunity. It has been expressed that the recommendations of the HMI are both intrinsically valuable and could substantially reduce medical costs but are also important for the NHI given that it will be contracting with both private and public providers. However, this is an area where many feel there is neither the will nor the capacity to reform the health system, despite the opportunities that exist.

Human Resources for Health

During our interview process, it was clear that there is concern about how human resources for health (HRH) were being prioritised, regulated, and managed to support the health system in South Africa. There are many challenges facing the health system in this regard, with many perspectives on what should be done. Additionally, there is great mutual scepticism about the motives of many of the stakeholders in this discussion. It seems clear that respondents from all sectors agree that there is an urgent need to plan for the training and expansion of the numbers of health professionals. Less clear is how to train these health professionals and what should be expected of health professionals in the health system.

The NDOH has submitted the Strategy for Human Resources for Health to the National Health Council for approval. As its departure, the strategy acknowledges

It seems clear that respondents from all sectors agree that there is an urgent need to plan for the training and expansion of the numbers of health professionals. Less clear is how to train these health professionals and what should be expected of health professionals in the health system.

It was noted by several health professionals that South Africa's approach to training is resource intensive and largely focused on producing practitioners who can operate within the tertiary health sector, whereas the focus should be on training for primary healthcare.

that there is the potential for a crisis in healthcare due to a lack of healthcare professionals, especially providers of primary health care services. The strategy further acknowledges the concentration of healthcare professionals within the private sector. A critical concern that has been raised by an NDOH respondent is the need for an expanded budget to support the training and remuneration of health professionals in South Africa, which is currently unlikely given the fiscal constraints of the country and the recent austerity measures that have been put in place by the National Treasury. Given these constraints it will be difficult for the NDOH to meet its targets by 2025, when the first plan is set to end.

There is a need to consider how best to increase the stock of health professionals given the needs of the health system. Currently, existing training facilities are unable to cope with further students, greatly limiting the ability of the state to increase the number of health professionals working in the health system. It was noted by several health professionals that South Africa's approach to training is resource intensive and largely focused on producing practitioners who can operate within the tertiary health sector, whereas the focus should be on training for primary healthcare. One respondent from a regulator stated that it is incredibly expensive to educate doctors and nurses: "Not all doctors need to receive the advanced training that South Africa gives them". Another perspective from a respondent in the private sector was that South Africa should consider accrediting private training facilities to teach doctors and nurses: "There are no private medical schools when there is a desperate need for more doctors than can currently be trained per year". Most public health academics interviewed agreed that if the focus was enabling primary healthcare, then there is a need to focus on expanding the number of nurses and community health practitioners.

Beyond training, four respondents, representing practitioners, regulators and the private sector have argued that there is a need to consider the working environment in which most public health professionals work. They are concerned about the poor morale of health professionals, one respondent said they were being "worn down in the public sector". It was their perspective that qualified staff are being overburdened with work and are not being supported adequately by hospital management and colleagues. They argued that performance standards are low and that many health professionals are not being held accountable for poor performance. Further, participants agree that there is a need to review remuneration to ensure that health workers are adequately rewarded for their work and incentivised to remain within the health system in South Africa.

One respondent from a regulator argued that the political influence of trade unions is having an outsized influence on public sector performance, where trade unions are blocking the implementation of a performance system. They argued that the ANC's concern is about protecting their voter base rather than implementing a well performing health system. Six respondents, representing regulators, academics and practitioners recommended that the implementation of a new performance management system needs to be prioritised and must be linked to health outcomes. It is also notable that during our interviews, trade union respondents were explicit about the need to employ people who are high performing and able to fulfil their roles in the health system.

Another area of contention has been the policy of cadre deployment within the public health sector. Eight respondents from regulators, academics, civil society and a government official stated that the politicisation of the public health institutions has led to the stripping out of skills and the expansion of patronage networks that are undermining the delivery of quality healthcare. One respondent related their experience of the massive expansion of unqualified, non-essential staff within the bureaucracy of health facilities, creating inefficiency in service delivery and preventing facilities from hiring enough health workers. The compromise between political patronage and service delivery is demoralising those who care about service delivery. One academic respondent also stated that there is a "need to forge spaces of exception – the NEC [National Executive Committee of the ANC] needs to agree that cadre deployment comes to an end in certain places/positions in the health system." This is echoed by many other respondents who also believe that for the health system to work, cadre deployment must end, and that a meritocratic system of appointment is critical for a well-functioning health system.

HRH is one of the critical pillars on which the health system is built. For many respondents there is an urgent need to prioritise the training of more health professionals, but there is also a need to focus on structural reforms that create a supportive environment for health professionals to practice in, and the need to consider reforms that support high performance. Currently, there is little agreement on how to proceed, but there are clearly many perspectives that could support the implementation of the HRH strategy.

COLLABORATING FOR HEALTH REFORM

This section looks at the perspective shared by participants about the opportunities that exist for moving the debate forward. These opportunities lie in both the context of debating health reform and the areas of alignment.

Context for debating health reform

While there are clear barriers to health reform, many of the respondents we interviewed believe that those barriers could be overcome, through the common ground that exists and because health reform is urgently needed. Some key points that have come up are:

Health as a right

Section 27 of the South African Constitution provides that everyone has the right to have access to healthcare services, including reproductive health services and that no one may be refused emergency medical treatment. However, as with all socio-economic rights in our Constitution, the enjoyment of these rights is not absolute and depends upon the availability of resources. Section 27(2) places upon the State a constitutional obligation to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of these rights. During our interviews, it became evident that all respondents agree that health is a right and should be equally accessible to all.

One respondent said that this agreement is a critical differentiator between South Africa's debate on health reform and that in other countries, for instance the United States. It is their view, that while in some countries the debate is one of principle, in South Africa this common point of departure makes the debate more a technical discussion on how best to realise this right.

However, while there may be agreement that health is a right, there are multiple perspectives on how this right can be realised. Two respondents categorically reject that idea that health markets and the right to health can exist within the same health system. For these participants, health as a right could only be realised through a quality and accessible public health system. An extreme example of this, expressed by one respondent, is that private health insurance should be considered "a crime against humanity".

Use of a changed funding model to change service provision

While the current debate on health reform has been dominated by the discourse on the NHI Bill, which as currently proposed, is the source of great contention, there has been support from several unexpected sources for some form of publicly funded health insurance programme. For instance, in its submission to Parliament the South Africa Private Practitioners Forum mooted the idea of a fund to support the provision of healthcare to indigent users. Additionally, two respondents from medical schemes expressed support for a national health insurance scheme and believe that it could operate alongside, and in competition with, private medical schemes.

Furthermore, a critical aspect of the NHI Bill is the integration of the public and private health sectors, through the accreditation of facilities and providers. This aspect of the Bill is widely supported and is believed would greatly enhance access to healthcare services, particularly in urban areas.

Strengthening the health system

During the interview process, we found that there exists alignment on a great many of the issues raised and broad agreement on some aspects of needed reforms. While this will be discussed later in the report, these areas hold intrinsic value for improving the health system, but also are necessary for creating an enabling environment for the NHI. Agreement on critical aspects of reform and the development of implementation plans, could build the basis for engagement on more contentious issues.

Opportunities for health reform

During our interviews, it became clear that despite there being many issues of contention in the debate on health reform, there are also some surprising opportunities that were raised for collaborative working. While these are not uncontentious, there is a clear desire to work on these issues in support of a better functioning health system which could serve as a basis for building trust and building models for collaboration.

Health outcomes

Ten respondents, from all sectors, have stated that an important priority for health reform is the need to develop an outcomes-based health system that is focused on delivering quality care. This requires a detailed understanding of South Africa's disease burden gathered through rigorous data collection and using this data to prioritise healthcare outcomes nationally, provincially and at the district level. Furthermore, they argued that the NDOH should be conducting regular monitoring and evaluation of health outcomes using appropriate indicators and holding accountable departments and officials responsible for those outcomes. This could be an important opportunity for stakeholders in the health system to collaborate, to agree on overall priorities within the health system and to collectively set goals.

The respondents have expressed concern that currently South Africa does not operate an outcomes-based health system. One respondent from a regulator stated that South Africa's health system would be better described as a "Sick" system, focusing on catastrophic care and the treatment of illness, rather than being a system that promotes wellness within the population. A representative from government stated: "There has been very little achieved in the last 27 years in terms of improving health outcomes and access to citizens, despite the expenditure." They noted particularly the significant failing in the provision of primary healthcare. Many respondents stated that there is an urgent need to develop preventative medicine in South Africa. Respondents from trade unions representing health workers stated that the current curative approach is more expensive.

Two public health academics stated that the failure to improve health outcomes is due to a lack of data, which has resulted in decision-making without an accurate understanding of South Africa's disease burden. It was noted that while there had been a considerable focus on disease management during the tenure of Minister Motsoaledi, there had been little focus developing the health system holistically. To strengthen the health system eight respondents, from all sectors, believe there needs to be a focus on gathering accurate health data that integrates the whole health system and then prioritises those areas that need greatest attention. One respondent from civil society, pointed out that the lack of outcomes is also impacting the quality of care provided to patients with frequent preventable accidents and deaths. One example cited is the failure to improve the numbers of preventable accidents during pregnancy and childbirth caused by public sector health workers. In 2019, for instance, Gauteng Health MEC Bandile Masuku announced that 3832 patients died due to serious adverse events, and 1148 cases of oxygen deprivation during childbirth, which can cause brain damage. According to the Gauteng Health Department's latest annual report, the province's contingent liability for medical-legal claims amounts to R21.2 billion.

Several public health academics and practitioners interviewed noted that the private sector is also not outcomes based. One private practitioner noted that the fee-for-service model is creating a perverse incentive to over-service patients in the private sector. This view was repeated by another respondent who stated: "Sometimes the care you get in private health care, is the care you do not need". On the other hand, concerns were expressed about the quality of service private patients receive when practitioners are economically driven to get as many patients through the door as possible.

Six respondents have suggested that the NHI Bill's proposed system of accreditation of facilities is an important opportunity to begin introducing greater uniformity of quality healthcare. However, it was noted that most of the public health facilities recently audited had failed to meet the standards for accreditation. The HMI also noted that there are no uniform standards in the private sector and users need to understand the level of treatment to which they are entitled. The respondents suggested that collaboration between the public and private sector on developing appropriate standards and the implementation of these standards could be an important opportunity to integrate the health system.

Five respondents also believe there is an urgent need to strengthen monitoring and evaluation within the health system. This needs to be based on the ability to gather quality data that accurately reflects the health system. To do this, one respondent argued that there needs to be an integration of tracking of patients between the private sector and public sector and across provinces. Currently there is no compatibility between the tracking systems that exist. Accurately gathering and integrating this data could greatly enhance the ability of the NDOH to prioritise interventions.

Five respondents, practitioners and civil society, also argued for collaboration on health projects, focusing on what is winnable. Two civil society respondents suggested that South Africa's health system is too wide and shallow, attempting to fix too much with too few resources. This creates situations where the health system is being overwhelmed by its challenges. One respondent said that South Africa has already experienced the effectiveness of a project-based approach, going narrow and yet deep on a health challenge, arguing that South Africa's experience of tackling the HIV/AIDS epidemic should demonstrate the benefits of this approach. They also argued that the response to HIV/AIDS had resulted in many positive spin-offs for the health system and had resulted from wide-ranging partnerships between civil society and the public sector.

Rural healthcare

There seems to be significant opportunity for collaboration between all stakeholders on improving access to healthcare services in rural areas. Twelve respondents state that there exist dramatic disparities in access to healthcare, between provinces and rural and urban areas, where rural areas lack facilities and healthcare workers. These disparities have been exacerbated by using a population-based funding formula by the National Treasury which has resulted in stark disparities in funding availability in provinces, with fixed costs being much higher per capita in less populous provinces. This had resulted in a situation where "most of the people in the rural areas and the majority of black people do not access quality healthcare".

It was also noted that the quality of existing health services in rural areas is not adequate, the lack of access to tertiary medical facilities, specialists, and allied health professions within rural areas and in some provinces. It was reflected that the inadequate referral system that currently exists sees many people moving between provinces to access necessary care. Recent audits undertaken by the Office of Health Standards Compliance indicate that many public facilities would not qualify to provide services within the NHI's standard, with many of these in already underserviced provinces and in rural areas. There was also some scepticism that the proposed capitation model being used by the NHI would incentivise a much-improved distribution of health professionals throughout the country.

A respondent from civil society expressed the view that the expansion of facilities needs to be prioritised by the NDOH and provincial health departments. They argued that this is necessary because the current market incentives for the private sector militates against greatly expanding into rural areas. It was their view that if the private sector is adequately regulated it could then service urban areas, while government focuses on rural health delivery. The NHI's proposal to integrate public and private sector facilities through accreditation and contracting could also further expand accessibility.

Collaboration between stakeholders to enhance accessibility to quality healthcare in rural areas is critical to the overall improvement of the health system. Currently, the rural health system is fragmented, and quality is often poor. Improving services and integrating rural healthcare provision into the broader network of primary healthcare provision and tertiary services must be a critical focus for health reform in South Africa.

Health infrastructure and systems

Ten respondents, from across all sectors, have stated that there is an urgent need to upgrade the infrastructure and systems of the public health sector, inclusive of health facilities, Information and Communications Technology (ICT), procurement, and logistics systems. These are requirements regardless of whether NHI is implemented or not. There is a belief among five respondents, from the public and private sector, believe that there could be several opportunities for public-private partnerships to support the upgrade of the public sector. Suggestions made include contracting of private services to support the public sector, skills transfers and capacity building, and other larger scale partnerships linked to health outcomes.

During our interviews, respondents from government noted that there has been ongoing underutilisation of funds allocated for infrastructure upgrades. These funds were made available to ensure provinces could get public health facilities to be accredited to participate in NHI contracting. It was also stated that this is a consequence of the insufficient expertise in the provincial departments to develop business plans that are a requirement of receiving funds. One government official believes that health departments are still focused on developing massive hospital infrastructure projects, like tertiary hospitals. Instead, it was suggested that provinces should be focusing on developing smaller hospital projects similar to the newer private hospitals. This could be an important opportunity for skills crossover.

One hospital manager also suggested that there is an urgent need to rethink infrastructure management in the public sector. Currently, responsibility for infrastructure development and maintenance lies with the Department of Public Works and often the department is slow to respond to the needs of managers. They argued that there is either a need for greater integration of the management of infrastructure development or that the health department should take responsibility for the management of its own facilities.

Additionally, there seems to be some belief by public sector respondents that there are opportunities to leverage off the expertise of the private sector in ICT, procurement, and logistics management, which would be critical for the implementation of NHI. There has been a desire expressed by respondents from the private sector to collaborate in this regard, something that is also supported by civil society, with one respondent

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arguing that you never see a private pharmacy having a stockout, something that regularly happens in public sector pharmacies. There is significant expertise on running global supply chains and managing procurement systems that is believed to be valuable to the public sector.

One public health academic has argued for the need to focus on transversal systems for procurement and logistics that will integrate the public sector and should the single-payer and purchaser become a reality, the public and private sectors. Implementing these would enable the health system to be more robust and responsive to the needs of patients. The successful implementation of these systems would require important skills, many which are already present in the private sector, with many companies having successful and established systems like those needed by the public sector.

Procurement

During our interviews, pharmaceutical legislation and regulation seemed to be an area where there is a great alignment of interest between the private sector, public sector, and trade unions. There is a belief among respondents from government, trade unions and the private sector that there is a great opportunity to increase innovation in the industry and to increase both local supply and international exports. However, it has been acknowledged that the current regulatory framework is preventing the exploitation of this opportunity. A respondent from the public sector agreed that the current policy had enabled the current tender fraud that has taken place during the pandemic.

It was the view of respondents from the private sector and government that the current approach to broad based black economic empowerment (BBBEE) is creating a cohort of middlemen that are facilitating procurement of goods needed by the public health sector at inflated prices, rather than supporting the development of black industrialists. Reform would require multisectoral collaboration to agree on new regulations to enable market entry, a new approach to procurement that would rely on manufacturers rather than middlemen, and an enabling environment for the significant expansion of funding for research and innovation.

NHI piloting and strengthening health districts

One of the greatest concerns for seven of the respondents, representing the private sector, academia, practitioners and regulators, about the NHI Bill is the lack of certainty in the drafting of the Bill. Much is yet to be clarified and little data exists to either recommend it or reject it outright. To quote one respondent from a regulator, "the Bill isn't worth the paper it's written on", because of the uncertainty it creates and the failure to provide a viable cost model.

A respondent from government stated that it would be impossible to implement the NHI in the current economic climate without knowing what it would cost. Another government official echoed this sentiment stating that the core assumptions of the NHI were premised on an entirely different economic climate and that until the economy improves and costs can be estimated it would be impossible to implement. A public health academic stated that it is currently impossible to estimate what the NHI would cost because there is no accurate data on the country's disease burden.

Additionally, there is great concern about the state's ability to implement the NHI. The NHI Bill concentrates power in the hands of the Minister of Health and proposes significant centralisation of the health system. Apart from the concerns that this has raised about accountability, one respondent argued that "One of the core problematic assumptions in NHI is that someone at national can control what happens at the coalface." They argued that you cannot have a few people with a helicopter view making all decisions. Another respondent stated of health districts that: "the ability to contract 300 CUPs (Contracting Units for Primary Healthcare) is naïve. The average district is unable to manage contracts with community services." One academic believed that the NHI might destabilise the little that is working, further undermining the capability of the public health sector.

For many there needs to be serious introspection into the NHI Bill, but also far greater testing and experimentation. Numerous respondents believe that there needs to be a focus on establishing proper pilots for the NHI, with several having noted that to date the data from pilots already conducted (which were acknowledged by the NDOH not to have been pilots but health system strengthening interventions) would recommend against the implementation of NHI. A former employee of the NDOH said that what information has been derived from the so-called pilots indicates that there are problems that need to be resolved before attempting to scale up the NHI.

There is a desire from two public sector respondents that a provincial pilot be undertaken, ideally using a well-resourced province. One of these respondents felt that this will enable the government to get an idea of actual costing of the NHI. The other respondent argued that a province-wide intervention would also enable the government to determine how governance and interactions between different levels of government and other stakeholders could work.

Alternatively, several respondents argue that there is a need to run more smaller district-level interventions that could build the capability of districts and will enable the development of workable systems and gather data to support learning. Pilots, it was argued, therefore need to build systems and processes that enable accountable implementation of the NHI at the grass roots level. Respondents have also suggested that these pilots could be an opportunity to begin testing collaboration between various sectors and to experiment with different models. The findings could then be used to cost NHI and employ best practices, leveraging off the broad expertise in the South African health system. Regardless of whether NHI is to be implemented, for many public health experts these pilots would support the development of the well-functioning, autonomous and resourced districts critical for the implementation of an outcomes-based health system.

RECOMMENDATIONS

Through these interviews, SECTION27 and CA have been able to identify:

+ some of the most contentious issues within health reform,
+ where interests intersect to a sufficient degree, and
+ areas where there could be collaboration between the various stakeholders to differing degrees.

Health reform remains urgent and the desire for it among respondents of this process is strong. There are two possible paths that we can foresee, following this research, to achieve health reform:

+ Path 1: implement interventions based on areas of existing consensus
+ Path 2: enter into a consensus building process on areas of contention where lack of consensus hampers health system reform

Path 1 seeks to build on the consensus that exists. This path recognises that the issues, areas of consensus and disagreement are clear; and action can be taken.

Path 2 recognises the current low-trust environment and finds that consensus building has the greatest opportunity of delivering success within the limited options available to stakeholders. Consensus building harnesses the collective talent, expertise and resources of all stakeholders and creates the opportunity for creative problem-solving without requiring the abandonment of stakeholders' beliefs and positions.

Both paths work toward the same result: improving the health system for the benefit of the people that need it while reconciling the inputs of various stakeholders needed to make health system reform work. The paths are also not alternatives. There are some matters that the research indicate require more discussion and attempt at consensus (in particular the roles of medical schemes, and the roles of various individuals and bodies within governance and institutional structures). On other matters there is broad consensus – ranging from consensus on principles to far-reaching consensus on details. On these matters, there can be action. Both paths require real and meaningful consultation as well as compromise from all stakeholders. Change is not possible without these two elements.

Importantly, following these two paths, preferably simultaneously, allows action and further discussion, both of which can foster trust and ease the way for expanding health reform.

Path 1: Implementation in areas of consensus

Path 1 seeks to take action in areas of consensus in a way that builds on the consensus that exists, builds trust, provides needed data, and moves forward health system reform. Having identified areas of initial consensus through this research, so-called "low hanging fruit" can be targeted for action. Drawing from this research, we envisage the following action areas:

+ Design and implement true piloting of contracting and referral mechanisms to test key proposed NHI/health system reform interventions in one province or a series of districts. The pilots should include experimenting with alternative options for delivery through multisectoral collaboration.
+ Explore possible national health projects that could be pursued by the departments of health in collaboration with the private sector and civil society, including ICT integration, procurement, infrastructure, and logistics management which could have wide ranging positive impacts for the health system.
+ Work across sectors to identify a few health outcomes indicators for measurement across all health facilities. Pre- and post-natal care may provide a good opportunity for this.
+ Implement key recommendations made by the Health Market Inquiry, drawing together experts from private health funders and facilities, the Competition Commission and government regulators.
+ Explore the possibilities for procurement reform, bringing together the NDOH, the Department of Trade and Industry, trade unions, the pharmaceutical industry, universities, and possible investors.

Implementation of these actions does not signal a move away from the NHI agenda. On the contrary, movement in areas of consensus could provide proof of concept for some elements of NHI or illustrate where changes are needed.

Some of the actions are implementable in the short-term and there is evidence of agreement on the need for their implementation, easing the process.

Path 2: Consensus building for health reform

Every participant interviewed during this process agrees that there is an urgent need for health reform in South Africa. However, each participant has either expressed sentiments that indicate a lack of trust in other stakeholders, an acknowledgement that parties often treat each other as adversaries, or are simply unwilling to compromise. However, through this process of interviewing key informants we believe there are windows of opportunity for engagement that undoubtedly could strengthen the health system and serve as a basis for further future collaboration. While consensus building on health reform will by no means be easy, there seems to be agreement from nearly all participants that they are willing, notwithstanding reservations, to attempt dialogue.

Three government respondents have noted that government undertook a health compacting process in 2019 that they believe was a consensus building process. However, three other respondents we interviewed, who were part of that process, felt that far from being a consensus building process, focused on problem solving, it was rather an attempt at giving the NHI a veneer of political legitimation and consultation. One public health expert felt it was an attempt at entrenching an ideological position rather than there being any real attempt to build a compact. This fundamentally runs counter to the nature of consensus-building and compacting, which requires an exploration of the concerns of all participants and a genuine commitment to engagement and discussion.

One public health expert is sceptical of what any consensus building process could achieve given the entrenched interests that exist within the health system. This expert is even sceptical about the possibility of implementing NHI, even if the Bill passes, arguing that within the health system exist too many vested interests (across both the public sector and the private sector). Another public health expert has expressed the view that their experience of working within the COVID-19 response has shown that there is little real commitment to reform and where there were opportunities for collaboration these were not taken.

While there is some rightful scepticism of this process, given participants views, it is our opinion that this is an indication of the low morale and low trust that parties are currently experiencing. Since the beginning of the pandemic, there has been an erosion of much optimism and a pervading exhaustion throughout the health system that has given little respite. However, in the last few months, with the limited public and private sector collaboration on vaccine roll out, there is perhaps some opportunity for the exploration of consensus building.

Such consensus building would be targeted and purposeful, acknowledging areas of consensus and disagreement. This process would acknowledge stakeholders' understanding of the current health care system and use the wisdom of their understanding of the system to seek consensus on health system reform that achieves its purpose to improve the health system for the benefit of the people of South Africa. Purposeful consensus building would recognise and respond to issues identified by stakeholders and incorporate their recommendations in implementing solutions.

Would consensus building work?

The agreement to participate in consensus building does not require the abandonment of support for the NHI, nor should it require full-throated acceptance; this is not in the nature of consensus-building processes. Rather, it is a process that would acknowledge that there are questions to be asked about NHI, not least to dispel the current damaging level of uncertainty, and real challenges in the health system that need to be addressed. Based on our interviews this would seem to be a common perspective already.

It must be reiterated that there are relatively few participants in this process who outright reject the concept of NHI. Whether for political considerations, or because of genuine support for a policy like the NHI, this fact does suggest there is some common ground. While acknowledging there is serious resistance to the policy as it currently exists, there are opportunities to explore and strengthen both the NHI model and the health system more broadly, through a collaborative effort.

At this stage it would be impossible to say whether a consensus building process on health reform would work or not. However, there seems to enough support for the idea from those interviewed to make it worth exploring. This may be sufficient for the time being. The very act of coming together to explore in detail consensus building would be an important and critical first step and would take a great act of faith from parties that have experienced a considerable deal of disagreement and who often distrust each other. This is particularly true in the context in which we find ourselves currently.

The process would have to explore and agree on the challenges that are currently facing the South African health system, a task this report has only started to do by raising the most contentious aspects of health reform and looking at those where there might be opportunity for early collaboration. It would further require an agreement to discuss issues in an environment where there are deeply entrenched beliefs and important interests that have a role in the health system.

There is also the pressing reality that reform of the health system is becoming a critical requirement for South Africa – the challenges are mounting and the failure to act could have a devastating impact on the country. Thus, the imperative needs and the constrained environment could be important drivers towards collective and innovative problem-solving.

Considerations for consensus building?

Assuming that there is agreement to participate in a consensus building process, the process would need to be carefully designed, creating opportunities for wide participation, detailed problem-solving and for parties to come together in a way that they feel heard and included. Agreements should be acceptable to the greatest number of people in the process for them to be legitimate. We believe that the route to doing this is to bring together actors from government, the public sector, the private sector, trade unions, academia and civil society to co-design a consensus building process. This design phase would need to answer the following:

a. Who should convene the consensus building process? The convenor should be an institution or individual with the moral authority and legitimacy to be able to attract stakeholders to participate in a consensus building process. Part of the role of the convenor would be to use their authority and legitimacy to help the process move forward. Both the facilitator and the convenor need to be relatively independent of the health system to be effective in their roles. Participants have variously recommended that the National Treasury, Presidency or NEDLAC could undertake the role of convenor.

b. How would the process be managed? There would be a need to establish how the process would be run and who would be responsible for managing the logistics of this process. It will also be important to ensure that there is agreement on how stakeholders will have oversight of the process and decide on who will be the facilitator, or facilitators of the process.

c. Who should participate in the consensus building process? It will be important to design a process that is open and inclusive of all stakeholders but is not so open that it becomes unwieldy. It is important to consider how users of the health system would participate in the consensus building process, and some consideration can be given on how to solicit opinions from the public.

d. What is the problem statement that the consensus building process is working to resolve? A common set of facts, an initial problem statement and some initial proposals for deliberation would be needed to give structure to the discussions to facilitate constructive engagement and agreement on what would be discussed during the process.

e. Establishing ground rules - There needs to be an agreement on the structure of the process and how participants will engage with each other. The purpose of this is to establish how to keep the process moving and to ensure that it is constructive.

f. Funding - If the consensus building process is to proceed it would be important to secure funding for it. It would be valuable to gain commitment from participants by having them join the efforts to secure funding for the consensus building as a means of showing commitment.

It would be impossible to say whether a consensus building process on health reform would work or not. However, there seems to enough support for the idea from those interviewed to make it worth exploring.

CONCLUSION

Our research brings together the perspectives of many individuals with significant experience of the South African health system and the debates that have been taking place to reform it. Their perspectives have been invaluable in lifting the veil on a public debate that is often perceived as dichotomous and simplistic, revealing a more opaque situation, more nuanced and significantly less certain than is often publicly portrayed. Responses have shown there is a great overlap of opinions between stakeholders that traditionally would be perceived as hostile to each other, while there is also disagreement between stakeholders viewed as traditional allies in health system reform. This report will hopefully help stakeholders to find new opportunities for engagement. Indeed, the successful realisation of much needed health reform depends on overcoming the current impasse. If attention is not given to consensus building, the reforms could fail because powerful stakeholders could delay reform for a long time to come.

However, it has been made clear by many of the stakeholders that they are fatigued by the endless debate on health reform and frustrated by the lack of progress that has been made in realising any real change in a health system so desperately in need of it. For many, there is a powerful yearning to do something to change the current paradigm in healthcare. For many others though, there is a fatalism, a perspective that despite the debate there is no real desire from others to genuinely pursue change.

Upon review of respondents' inputs, CA and SECTION27 acknowledge that collaborative action may be difficult for many stakeholders to envisage, with such long experience of disappointment and distrust. However, it is our view that given the strong desire for reform and the need for collaboration to achieve it, there are opportunities for focused action and consensus-building directed toward discreet objectives that can be used to demonstrate commitment, build trust, and deliver reform of the health system, and/or for the implementation of key actions.

We believe that these recommendations provide an opportunity for movement on health system reform, by implementation of health reform efforts where there is already considerable consensus, and by the use of a more extensive consensus building process or the implementation of pilots. Such movement has the potential to build trust through collaboration. While it is unlikely that trust will be developed immediately, the development of an approach that has well defined outcomes and requires all parties to contribute and demonstrate their commitment to health reform, and respect for other stakeholders, stands the best chance of repairing relations and delivering upon a better health system for all.

ANNEXURES

Annexure 1: Participant selection for national health reform research

The purpose of this research is to understand the positions held by various actors towards health system reform, including the proposed National Health Insurance Bill, presented in its most recent form in July 2019, their points of agreement and contention with the Bill, and each other, and recommendations they may have for health reform in South Africa. The output of this research will inform a multi-party process to build consensus on the development of a future health system for South Africa. This note outlines the proposed selection of participants for this research, ensuring the largest number of perspectives are considered, given the resources available to the project.

Purposive participant selection

Concentric Alliance will use purposive participant selection as its data gathering methodology. This is a qualitative methodology which has as its main objective to produce a sample that well represents the broader population, either because of participants' expert knowledge on the subject, or their representation of a particular stakeholder group. To achieve this within the context of a study on national health care reform, we have considered the actors which represent:

Health system building blocks

Health system building blocks, as identified by the World Health Organisation (WHO), are understood to be the key inputs of a health system that need to work for it to have improved health outcomes. The sample must therefore have participants that represent each of these building blocks:

+ Service Delivery – Healthcare Professionals, Health Administrators
+ Health Workforce – Individuals responsible for the training of Healthcare Professionals
+ Information – Researchers and academics
+ Medical Products and Technologies – Producers of medical equipment and pharmaceuticals
+ Healthcare Financing – National Treasury, Healthcare Insurers, Health Investors
+ Leadership and Governance – Government, Legislators

Policy actors

Within public policy development, there are specific important actors that are identified. Policy makers are those who are responsible for the formulation and approval of policies and policy users are those who operationalise or benefit directly from public policies.

Policy influencers are those who have a vested interest in impacting on the direction of the policies that are being created. The sample must therefore have participants that represent the following categories and subcategories:

+ Policy Makers – Department of Health, Treasury, Legislature
+ Policy Users – Private and Public Healthcare Professionals and Administrators, Patients, Provincial Departments of Health, Pharmaceutical and Equipment Manufacturers, Hospital Groups and Insurers
+ Policy Influencers – Academics, NGOs, Trade Unions, Media and Politicians

Given the importance that these actors fulfil in both the health system and in public policy formulation CA will create a set of categorisations.

Representativeness

CA intends to undertake 35 interviews that are representative of all categories and subcategories. While our research is qualitative and therefore non-probabilistic, it is our intention to have a sample that is representative of the large diversity of views within the health sector.

CA has decided on the following final categorisation and representation:

+ Government (9)
  - » National Department of Health (2)
  - » National Government (2)
  - » Provincial Departments of Health (2)
  - » Policy Advisors (3)
+ Public Health (1)
  - » Hospital Administrators (2)
+ Private Sector (8)
  - » Private Hospital Groups (2)
  - » Health Insurers (3)
  - » Pharmaceutical Manufacturers (1)
  - » Equipment Manufacturers (1)
  - » Health Technologies (1)
+ Professional Associations and Regulators (7)
  - » Healthcare Professionals Associations (3)
  - » Industry Regulators (2)
  - » Industry Representatives (2)
+ Policy Influencers (10)
  - » Academics (2)
  - » NGOs (4)
  - » Trade Unions (2)
  - » Media and Politicians (1)

Criteria for selection and prioritisation

Within each category, CA will need to ensure that it has enough possible participants to fill each category, with some in reserve in case those initially selected are unable to participate. To determine, whether a participant should be interviewed, CA will use the following general criteria:

+ Legal Importance: Does the participant fulfil a necessary role within the approval process for healthcare reform?
+ Political Importance: Does the participant influence political decisions relating to healthcare?
+ Strategic Importance: Does the participant have a role in supporting the implementation of healthcare reform?
+ Relation with the Topic: Will the participant's constituents be directly affected by healthcare reform?
+ Representation: Does the selection of the participant guarantee sufficient representation of the category in which they are allocated?

Should the possible participants be seen to meet at least three of these criteria by a simple yes or no answer they will qualify to be interviewed.

All participants who qualify to be interviewed will then be prioritised for interviewing, to provide a final list of participants. Prioritisation will be adjudicated according to the following criteria:

+ Knowledge: How knowledgeable is the participant about Healthcare Reform in South Africa? 1 – Not at All, 2 – Somewhat, 3 – Very
+ Power: How much power do they have to influence the healthcare reform process? 1 – None, 2 – Some, 3 – A Lot
+ Interest: How much interest do they have in influencing the healthcare reform process? None, 2 – Some, 3 – A Lot
+ Alliances: How much power do they exercise over other stakeholders within their category? None, 2 – Some, 3 – A Lot
+ Resources: Do they control human or financial resources that could be used to influence the outcomes of a healthcare reform process? None, 2 – Some, 3 – A Lot

Based on the scores allocated (from 3 – 15) the participants will be prioritised from high scores to lowest scores within each category.

Review

Following the completion of the participant list, CA will consult health experts who are deemed to be generally legitimate by all actors within the health sector to receive feedback on the participant list. These individuals will not have final say in the process, but rather provide their opinion to support the process. The review will aim to ensure that there are not deemed to be any significant flaws within the participant list. Following adjustment, the list will be deemed to be final, unless are significant numbers of individuals not able to participate in the research.

Annexure 2: Participant questionnaire

1. What do you believe should be the foundational principles of a health system?
2. What is your understanding of the term universal healthcare, and do you believe that it is practically achievable in South Africa?
3. What is presently most wrong with the provision of healthcare in South Africa?
4. What are the priority areas for reform, and what do you believe needs to happen in each case?
5. Do you believe that NHI, as it is currently being proposed, addresses what is presently most wrong with the provision of healthcare in SA? Please explain why you do / do not believe this?
6. If you are in-principle supporter of NHI, are there any aspects within the current proposed Bill that you have concerns about?
7. What are the transitional steps that need to be followed to realise NHI or UHC in South Africa?
8. How could partnerships aid health sector reform? Please share examples. To what extent has COVID-19 affected your view on healthcare reform, UHC and NHI?
9. Who are the key movers and key influencers that most impact your constituency's policy position?
10. From your perspective, where do you see areas of consensus or areas of divergence within your stakeholder group in relation to the key problem areas in the healthcare system?
11. Do you see potential for consensus between your stakeholder group / constituency, and other groupings whose publicly voiced policy positions that are different to yours?
12. What do you believe are the objections to the NHI held by other stakeholder groups?
13. Does genuine healthcare reform require the buy-in of a range of stakeholder groupings, from both the private and public sectors?
14. Given your answers, would you be willing to participate in/support the formation of an independently facilitated consensus building initiative to achieve this end?
15. Any other people that we should consider speaking to?

Annexure 3: Participants

RESPONDENT NO.	DESCRIPTION
Respondent 1	Public Health Academic
Respondent 2	Public Health Academic
Respondent 3	Public Health Academic
Respondent 4	Public Health Academic and Health Science Dean
Respondent 5	Journalist
Respondent 6	Journalist
Respondent 7	Public Health Advocacy NGO Leader
Respondent 8	Public Health Advocacy NGO Leader
Respondent 9	Public Health Advocacy NGO Leader
Respondent 10	Public Health Advocacy NGO Leader
Respondent 16	Health Professional Body Leader
Respondent 11	Health Professional Body Leader
Respondent 12	Health Professional
Respondent 13	Private Sector - Business Representative
Respondent 14	Private Health Funder Executive
Respondent 15	Private Health Funder Executive
Respondent 17	Private Health Facilities Executive
Respondent 18	Private Pharmaceuticals Executive
Respondent 19	National Department of Health Senior Official
Respondent 20	Former National Department of Health Senior Official
Respondent 21	National Department of Health Technical Specialist
Respondent 22	National Government Senior Official
Respondent 23	National Government Senior Official
Respondent 24	Provincial Department of Health Senior Official
Respondent 25	Public Tertiary Hospital Executive
Respondent 26	Health Market Inquiry Panellist
Respondent 27	Health Regulator Senior Official
Respondent 28	Health Regulator Senior Official
Respondent 29	Health Regulator Senior Official
Respondent 30	Health Regulator Senior Official
Respondent 31	Trade Union Leader
Respondent 32	Trade Union Leader
Respondent 33	Trade Union Leader