Universal healthcare coverage: we might not need to throw the baby out with the bathwater

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I believe there is not a healthcare worker (HCW) in South Africa, either in the public or private sector, who will oppose the idea of universal healthcare coverage (UHC) for all the people of South Africa. The big question though, which will certainly be a lot more controversial among HCWs, is: What is the optimal healthcare model to achieve this objective in South Africa? Currently, policymakers are aiming to achieve this goal through the establishment of a South African National Health Insurance (NHI). The South African National Department of Health's (NDoH) medium-term strategic framework for 2019–2024, as well as the NDP's (National Development Plan) Implementation Plan for 2019–2024, identified achieving UHC by implementing the NHI policy as a strategic goal. The NHI Bill was introduced in Parliament in August 2019 and was passed by the National Assembly in June 2023. At the time of writing, the bill was with the President of South Africa after being passed by the National Council of Provinces' Select Committee on Health and Social Services for consideration. The NDoH strategic plan document stated that 2026 was being targeted for the implementation of NHI. In the words of the acting director general at the time, 'The National Health Insurance (NHI) policy of government aims to dismantle the system and introduce several structural reforms'.

It appears that the Deputy Director General for the NHI project, Dr Nicholas Crisp, and his team visited various countries that employ national health insurance, single-payer systems or other models when they were developing the NHI framework for South Africa. So, what are the models out there? The Beveridge model involves a national healthcare system that provides free medical care for all which is funded through taxation. The NHS in the United Kingdom (UK), as well as the systems in New Zealand, the Nordic countries and Spain, are examples of this model, also known as the National Health System (NHS) model. It is relevant to note that in the UK there are exceptions to the model, for example, the majority of general practitioners (GPs) operate in private practices. Under the Bismarck model, both the financing and delivery of healthcare are privately funded. In Germany, for example, employees and employers pay wage-based premiums to insurance companies through mandatory salary deductions. In this model, also called Social Health Insurance (SHI), there are always multiple payers, in contrast with the NHI single-payer structure. Other countries that adopted this model include Japan, France and South Korea. A traditional 'national health insurance model' has been described as a mixture of the Beveridge and Bismarck models, where the government funds healthcare services which are paid for through tax money and publicly administered, while the services are delivered mostly by private institutions as in the Bismarck model. Canada is probably the best example of this. A private health insurance (PHI) model is used in the United States (US) and is essentially what we currently have in the South African private sector. Patients buy their private insurance and get services from private providers and entities. Finally, there is the 'uninsured model' where patients essentially pay for all services out of their own pocket, like in many low-income countries in Africa. In some countries, like the US, there are several models in play at the same time.

UHC can be achieved with any of the models except the uninsured model. Many countries using the other models have shown that you can achieve UHC while still leaving a role for private insurance and private healthcare facilities. At this stage, it appears the South African policymakers have elected to go with an NHI model. The question that then comes to mind is, what exactly does the term National Health Insurance mean? Well, the answer is more complicated than I imagined. Cuadrado et al. investigated this and found that the most common characteristics are that it ensures universal coverage, is state-regulated with some degree of societal representation, has a public revenue source that goes into a single fund that functions as a single payer, and the service is provided by a mixture of public and private providers in a mixture of proportions.[1] And to me it seems that it is this last aspect that is creating a lot of uncertainty in the medical community at the moment. What will this mixture of public and private service provision look like in the future in South African healthcare?

The NDoH medium-term strategic framework's third goal is entitled 'quality improvement in the provision of care' and one of the enablers listed is 'reorient the system towards Primary Health Care through Community based health Programmes to promote health'. This seems to be in line with NDoH's first goal, namely to 'increase life expectancy, improve health, and prevent disease'. An emphasis on a shift towards a focus on primary healthcare has also emerged in the academic landscape with a call for the development of a more primary healthcare-oriented curriculum. A primary care focus makes sense in a resource-constrained environment. Specialist care is expensive, and you don't need a specialist to treat every injury that occurs or to prevent osteoporosis, for example.

I would be opposed to a complete pivot to primary healthcare at the cost of tertiary care. You can't pivot pathology or science. It has a fixed trajectory that does not care much about our strategic plans. Many cancers, for example, remain unpreventable and need to be treated by specialists. At the same time medicine as a science is becoming increasingly more complex and specialised; we also cannot change that. So, in my opinion, you will always need a strong higher-level system to deliver specialist-level care.

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On the other hand, I suspect most clinicians in South Africa would agree that we need to drastically strengthen our primary care capacity and delivery. The following examples of areas where primary care could improve will resonate with every orthopaedic surgeon who has worked in the public sector in South Africa. Think about the uncontrolled diabetic that needs to be optimised for an elective procedure. Would it not be ideal for that patient to have easy access to a good general practitioner in their community who knows them well, can follow them up closely and can deal with the nuances of treatment like regular testing, exercise, diet, etc? What about the elderly patient with a femur neck fracture who needed a hemiarthroplasty? We frequently have to discharge patients under less than ideal circumstances, owing to the pressure of getting new patients in, the lack of community-based step-down or rehab facilities, and accommodation for the frail and aged. It would be ideal to have a family physician to follow up these patients postoperatively, coordinate their placement and subsequent care and mobilisation, make sure the patient's osteoporosis is treated, check their wounds and monitor them for any complications without their having to make long journeys to the tertiary centre, etc. These are just two examples, but I think we will all agree that a strong primary healthcare system will ultimately improve our outcomes at the higher levels of care.

We have to consider that the healthcare models employed in other countries might not be fit for purpose in South Africa and they might not achieve our specific goals. Maybe it would be best for us to develop our own framework rather than copy other models used in more developed and better-resourced countries. Now, it seems that our course is plotted towards an NHI. The question then arises: Is there any way that we can envisage meeting the goals being pursued, i.e. universal healthcare coverage and a strong primary care system with improved health and prevention of disease, through an NHI model? In my opinion, the answer is yes, possibly, but in a somewhat different model. To my mind, the most pragmatic approach to solving this problem would be to implement a national funding model to uplift primary healthcare and ensure UHC at the primary level first. We know where we want to go (the strategic goals) and we are given a vehicle (NHI), then the mathematical side of my brain says: use the shortest and simplest route to get there. Furthermore, we have preliminary data suggesting that a community-centred approach with supervision provided by a family physician has value and that applying systems theory can potentially provide UHC in South Africa at a low cost.[2] And it is estimated that only 6 000 of the country's 14 000 GPs might be sufficient to cover the population if their primary healthcare teams are appropriately structured and resourced.[3] The US healthcare system has been criticised at various levels. It is noteworthy that one of the solutions that has been tabled is 'to ensure health care coverage for everyone in the United States through a foundation of comprehensive and longitudinal primary care'.[4]

I support the concept of high-quality universal healthcare for all South Africans, and UHC at the primary healthcare level appears to be a good first step in the right direction. To achieve that we don't have to 'dismantle' specialist services, only aim to improve on them. If the problem is the gearbox, do we need to take the entire car apart to fix the problem? But, and this is a big one, the problem is more complicated than that. How will we then address disparities in access to specialist-level care? And will the same model work for that objective? I don't want to intimate that I know all the answers. However, I think it is important that we think, read, plan and engage in the issue. This ship is out of the dry dock, on the water and the sails are being unfurled.

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