POLICY DIALOGUE
ON UNIVERSAL HEALTH COVERAGE IN SOUTH AFRICA.

Proceedings Report

Universal Health Coverage Day: "Build the World We Want: A Healthy Future for All"

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

A long and healthy life for all South Africans

World Health Organization
Country office for South Africa

2030 NDP

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

NATIONAL DEPARTMENT OF HEALTH

POLICY DIALOGUE ON UNIVERSAL HEALTH COVERAGE IN SOUTH AFRICA.

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Contents

List of Acronyms

AMR	Antimicrobial Resistance
ARV	Anti-Retroviral
CCMDD	Central Chronic Medicines Dispensing and Distribution
COVID-19	Coronavirus Disease 2019
CUPs	Contracting Units for Primary Health Care
DHIS	District Health Information System
DM	Diabetes Mellitus
EPI	Expanded Programme on Immunisation
EPR	Emergency Preparedness and Response
GDP	Gross Domestic Product
HCW	Healthcare Workforce
HIV	Human Immuno-deficiency Virus
HP	Health Promotion
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSS	Health Systems Strengthening
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IP	Intellectual Property
LMICs	Low-and Middle-Income Countries
MDG	Millennium Development Goals
NAMDA	National Medical and Dental Association
NAPHISA	National Public Health Institute of South Africa
NAPHS	National Action Plan for Health Security
NCDs	Non-communicable Diseases
NCOP	National Council of Provinces
NDOH	National Department of Health
NHI	National Health Insurance
NHRD	National Health Research Database
NPPHCN	National Progressive Primary Health Care Network ()
OASSA	Organisation of Associations of Social Services of South Africa
OOP	Out Of Pocket Payment
PHC	Primary Health Care
PHEOC	Public Health Emergency Operation Centre
RHAP	Rural Health Advocacy Project
RMNCH	Reproductive, Maternal, New-born and Child Health
SA	South Africa
SDGs	Sustainable Development Goals
SVS	Stock Visibility System
SAHWCO	South African Health Workers Congress
TB	Tuberculosis
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage
UNGA	United Nations General Assembly
WBOT	Ward Based Outreach Team/s
WHO	World Health Organisation

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UHC Dialogue Day keynote speakers and panellists: Front row – Dr Mathome J Phaahla, Minister of Health *(third from left)*; Dr Sibongiseni Dhlomo, Deputy Minister of Health *(second from left*); Dr Sandile Buthelezi, Director-General of the National Department of Health *(first on left)*; Dr Owen Kaluwa, WHO Country Representative for South Africa *(far right);* **Second row** – Prof Morgan Chetty; Prof Eric Buch; Mr Kuben Pillay; Ms Candice Sehoma; Prof Kebogile Mokwena; Prof Steve Reid; Dr Nicholas Crisp; Dr Rajesh Narwal; and Thulile Zondi. NB: Prof Diane McIntyre, Dr Joe Kutzin not included in photo as they presented virtually and Mr Russel Rensburg was unavailable at the time of taking the photo.

Executive Summary

The World Health Organisation defines the 'health system' as all the institutional and organisational structures, public and private, that are designed and implemented to address the health and well-being of the population. A core deliverable of health systems is the progressive realisation of the goal of Universal Health Coverage (UHC) to ensure that every member of the population has access to quality health care services without incurring financial hardship. These services must include a continuum of health promotion, disease prevention treatment, rehabilitation, and palliative care.

Each country's path towards reaching UHC varies based on its contextual elements i.e. social, economic and political environment. However, everyone agrees that access to health is a basic human right. In South Africa, the decision to implement National Health Insurance (NHI) in a phased manner is part of the country efforts to achieve UHC. National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families. Currently, the NHI Bill is serving before Parliament as part of the processes to finalise the legislative framework to enable the establishment of the NHI Fund. This process is anticipated to be finalised in early 2023.

In recognition of the International UHC Day which is annually commemorated on 12 December, the National Department of Health, collaborating with the WHO organised the Universal Health Coverage Policy Dialogue. The theme for the 2022 Universal Health Coverage Day was "Build the world we want; A healthy future for all". The full day event was held at the Birchwood Conference Centre. The purpose of the Policy Dialogue was to bring together health sector stakeholders i.e. national and provincial Departments of Health, civil society organisations, Non-Government Organisations, health sector statutory entities (e.g. Health Professions Council, Office of Health Standards Compliance, the Medical Research Council and Council for Medical Schemes) private health care providers, development partners and many others, to engage on matters pertinent to South Africa's efforts in move towards universal health coverage through the phased implementation of National Health Insurance. The intention was to provide stakeholders with a platform to engage, share and learn from each other on practical lessons for moving towards UHC to realise the world we want where everyone's health needs are effectively met without incurring financial hardship.

Some of the key messages emanating from the proceedings include:

i. UHC remains a noble global and country-specific objective and South Africa is no different;
ii. South Africa needs to move towards one, integrated health system;
iii. The South African health system is plagued by challenges such as fragmented funding pools and inequitable distribution of Human Resources for Health. These challenges need to be addressed in earnest before they become insurmountable and irreversible;
iv. South Africa's UHC journey must be based on a rationalisation of the current funding available in the health system, and the service delivery platform must be based on a strong and resilient primary health care platform;
v. South Africa's UHC journey must be based on a tax-funded financing system;
vi. The design and implementation of NHI must be based on a mixed approach drawing from top down and bottom up approaches. Key to this is to ensure that the views of the communities are drawn on, and that strong systems of transparency and accountability are introduced at all levels of the health system;
vii. There are lessons that South Africa must draw from the experiences around the COVID-19 pandemic – a key lesson includes that South Africa must build and invest in ensuring that the health system is resilient to external shocks and health emergencies. This is an essential component to achieving UHC;
viii. There can be no UHC without human resources for health. However, investment and policy reforms must be designed to address all six building blocks of the health system;
ix. South Africa must continue to draw lessons from other countries to identify the best practices, and avoid pitfalls, in moving towards its UHC objectives. These lessons could include how best to accredit and contract different types of health practitioners; training and deployment of human resources for health; how to reform provider reimbursement systems to achieve better value and outcomes, and how to build health technology assessment;
x. Big data, functional digital platforms and ongoing health facility improvements are all key elements in ensuring proactive decision making and planning, and that users have access to safe, quality and affordable health care services. This includes ensuring strong and accountable governance systems at all layers of the health system.

The 2022 UHC Day commemoration came at a time when Parliament was making significant progress with the finalisation of the NHI Bill. This is important because in South Africa, UHC is aligned to the values of justice, fairness and social solidarity. In line with the National Development Plan Vision 2030, South Africa aims to achieve UHC through the phased implementation of the NHI.

Stakeholders must continue to critically think about what has been shared at the UHC Policy Dialogue, and to focus on identifying practical solutions that will allow South Africa to proactively move towards realising UHC through the implementation of the NHI. The NDOH and its partners will lead some of the key strategic directions on the journey towards UHC must remain a collective effort to achieve quality healthcare for all South Africans.

Introduction

The National Department of Health (NDOH), in collaboration with the World Health Organisation (WHO) South Africa country office, organised the Universal Health Coverage Policy Dialogue based on the 2022 Universal Health Coverage Day theme "Build the world we want; A healthy future for all". The full day event was held at the Birchwood Conference Centre on 12th December 2022, supported by a virtual platform for participants who could not join in person.

12 December is designated the International Universal Health Coverage Day (UHC Day), by a UN General Assembly resolution. In the world we want, all people can access quality health services without financial hardship. UHC lifts people out of poverty, promotes the well-being of families and communities, protects against public health crises, and moves us toward "Health for all". This year's UHC day also marks nearly a midway to the 2030 timeline for Sustainable Development Goals (SDG) and targets.

Universal health coverage (UHC) means that all people have access to the health services they need, when and where they need them, without facing financial hardship. UHC is also the overarching target for the Sustainable Development Goal (SDG 3) on Health, it is ascribed in South African Constitution as 'right to healthcare for all' and is one of the key targets of National Development Plan 2030. UHC is most pertinent as we gradually recover from devastating impacts of COVID-19 pandemic which severely impacted lives and livelihoods, disrupted essential health services and reversed hard earned gains in progress towards UHC. The pandemic has shown that not investing in strong and resilient health systems for UHC and health security can cost economies and society at large dearly. The case for universal health coverage is clear – It is the key to coping with the interlocking health, economic and humanitarian crises our world is facing.

As the South African health systems reset and recover, the 2022 UHC Day provided a great opportunity to reinvigorate UHC efforts at national and provincial levels, galvanize all stakeholders for collaborative and synergistic efforts to achieve the 'right to the access to healthcare" in South Africa. It was an appropriate moment to take stock and discuss the means to accelerate the progress towards UHC, and build a Healthy South Africa we want, where:

(a) Emphasis is on health promotion and disease prevention through strong Primary Health Care and integrated people centered approaches;
(b) Health services are of high quality, and access to them is equitable;
(c) Health systems and workforce are resilient, efficient and accountable to the people; and
(d) No-one faces financial barriers or falls into poverty due to health expenditures.

The purpose of the UHC Policy Dialogue was to bring together health sector stakeholders i.e. national and provincial Departments of Health, civil society organisations, Non-Government Organisations, health sector statutory entities (e.g. Health Professions Council, Office of Health Standards Compliance, the Medical Research Council and Council for Medical Schemes), private healthcare providers and many others to engage on matters pertinent to South Africa's efforts to move towards universal health coverage through the phased implementation of National Health Insurance. The intention was to provide stakeholders with a platform to engage, share and learn from each other on practical lessons for moving towards UHC to realise the world we want where everyone's health needs are effectively met without incurring financial hardship.

The event was organized in hybrid format, supported by Knowledge Hub. Close to 1,600 participants attended the event; with close to 450 physically and 1,100 virtually via the Zoom platform.

The structure of the engagements during the course of the day involved diagnosing the core challenges plaguing the health system and, more importantly, identifying the most practical and sustainable solutions to address these challenges so that South Africa can accelerate the progress towards UHC that is indicated in various policy and legislative documents (i.e. the White Paper on National Health Insurance, the National Health Insurance Bill that is currently serving before the Portfolio Committee on Health in Parliament, and the National Development Plan Vision 2030).

The subsequent sections of the Report provide the summary of the core messages emanating from the interventions of various speakers. The report also elucidates the key principles and strategic actions that South Africa must consider in its move towards achieving realising UHC, as the country recovers from the pandemic and re-prioritizes the health systems reforms that were thwarted over the past two years.

SESSION ONE: Setting the Scene and Guiding the Conversation (Chaired by Dr Sandile S Buthelezi, Director-General: Health)

The speakers in this session were (in order of appearance):

i. Dr Sandile S Buthelezi (Director-General: Health);
ii. Dr Sibongiseni Dhlomo, MP (Deputy Minister of Health);
iii. Dr Kenneth Jacobs, MP (Chairperson of the Portfolio Committee on Health, Parliament of South Africa);
iv. Dr Owen Kaluwa (WHO South Africa Country Representative);
v. Dr Joseph Kutzin (Coordinator: Health Financing & Governance; WHO, Geneva); and
vi. Dr Mathume J. Phaahla, MP (Minister of Health)

In opening the Policy Dialogue and setting the scene, Dr Buthelezi r mentioned that UHC is a global aspiration which aims to provide everyone the access health care, when and where they need it, without facing financial hardship. The theme - "Build the world we want: A healthy future for all" directly implies that in the world that we want, no one is left behind. While this may seem aspirational, it is not an objective that is impossible to achieve. This can be done if all stakeholders work together collaboratively, they can bring their skills, know-how and capacities to bear and assist with achieving UHC within given timelines and available resources.

In his opening remarks, Dr Sibongiseni Dhlomo, MP the Honourable Deputy Minister of Health, made reference to papers presented by two previous WHO Directors-General, namely Dr Margaret Chan and Dr Gro Harlem Brundtland, where they reported that UHC is an "affordable dream" for all countries and must be based on the principle of equity. They further reported that:

> *"WHO estimates that out-of-pocket expenditures on health services push 100 million people into poverty every year. Implementing UHC would help to eliminate this impoverishment. Some people may regard the goal of UHC as being utopian and unattainable. While it's true that no country can afford to provide every conceivable health service to every person, all countries can make progress. This has been demonstrated by the many countries in recent years that have extended coverage of vital services and improved financial protection for the population when accessing healthcare."*

Therefore, the achievement of UHC is a goal that is intrinsically integrated into the Sustainable Development Goals (SDGs) 2030. Despite this, there remains a funding gap for UHC and notably, South Africa (SA) is one of the few countries that does not have a government funded UHC strategy in place. In a 2022 Presidential meeting during the State Visit to the United Kingdom (UK), it became clear how imperative and possible UHC implementation is. The Deputy Minister further indicated that South Africa has studied how UHC has been implemented in many places, notably in Germany, New Zealand, in the Nordic countries, Japan, Finland and Portugal. It was further noted that there are still many detractors questioning how UHC should be implemented, with some in support of UHC, but not for NHI implementation as is outlined in the White Paper. As with all countries that have modelled UHC according to their context, South Africa will implement UHC in a way that is tailored to suit its context and needs.

The South African Government has engaged and visited Cuba, where there is a strong community-based health system, and where health service providers, including medical specialists, live and work in the communities they serve. The Cuban community-based health system has yielded huge rewards for the country, most notably, minimising advanced disease and the need for costly high level health care services. Therefore, it is important that as South Africa makes progress towards achieving its UHC goals, it must draw from the Cuban system, and others, on what best practices to follow to implement a cost-effective and sustainable preventative health system and a strong primary health care platform.

Remarks by the Chair of the Parliamentary Portfolio Committee on Health

Dr Kenny Jacobs, MP the Chair of Parliament's Portfolio Committee on Health, emphasized that it is possible to achieve accessible, quality healthcare for all in South Africa and that the political impetus and process to achieve better health outcomes is already in place and in motion. He highlighted that health, economic activity, productivity and well-being are all interlinked and therefore investment in health is good investment into people. As a result, investment in UHC would be applying the principles of social justice and fairness to the distribution of resources and the SA approach of implementing NHI is aimed at achieving the goals of UHC – this is already enshrined in the Bill of Rights in the Constitution.

Dr Jacobs further elaborated some of the core steps that South Africa has taken towards achieving UHC through the phased implementation of NHI, including: (i) the NHI Bill was introduced to the National Assembly in August 2019, which was followed by three years of public hearings, oral and written submissions, discussions and stakeholder engagements; (ii) oral submissions (presentations), which were conducted between 18 May 2021 to 23 February 2022 and included a total of 961 oral submissions, with 820 (just over 85%) of these in support as they lauded NHI as an initiative towards

UHC according to Section 27 of the Constitution, and saw NHI as a way to tackle the divide between rich and poor, and improve access to vulnerable populations; and 118 (12%) indicating opposition; and 23 (2%) raised issues unrelated to the Bill; (iii) extensive public hearings – conducted between 26 October 2019 to 24 February 2020, in all 9 provinces with 3-4 districts per province. The hearings were attended by 11,564 members of the public and stakeholders in 33 district municipalities. The National Assembly processes will be complete by March 2023.

Given that funding is central to the NHI, Dr Jacobs reinforced the ideas in the Lancet Global Health Commission on Financing PHC that public financing is better than private and that pooled public funds are necessary for equity and are superior to user fees or voluntary insurance. If countries are to close the gap on UHC and achieve the SDGs, they need to increase investment on health by 1% of GDP. Additionally, the pooled funds should be used as efficiently and equitably as possible and this is possible by investing more and better in people-centred PHC and health promotion and prevention. These PHC financing models should support the needs of people, be people-centred, foster continuity and quality of care and ensure rapid service delivery models. South Africa has the savvy political leadership, long term commitment and proactive adaptable strategies to engage with stakeholders at all levels and sectors in order to re-orient towards PHC, which is a more equitable route to achieving UHC.

Universal Health Coverage Day Message from WHO

The WHO Country Representative, Dr Owen Kaluwa, highlighted the impact of COVID-19 which has not only disrupted health service delivery but has in some cases reversed the hard-earned gains towards UHC. The case for UHC has never been stronger, as the world has seen the results of the lack of investment in strong and resilient health systems. In the face of the concurrent and interlocking health, economic and humanitarian crises the world is facing, UHC presents itself as a means of addressing these crises and this is even more pressing in South Africa, where the legacy of apartheid has left an indelible footprint of extensive inequities.

He reiterated that the commitments made at the UN General Assembly to designate 12 December as the International Universal Health Coverage Day (UHC Day) and the accompanying political commitments to UHC are most pertinent for South Africa, now more than ever. He went on to dispel some of the misconceptions about UHC by stating that achieving UHC requires a progressive approach to providing services to all, regardless of health status and financial means, based on the country's resources and capacities. Furthermore, it requires strategies that go beyond financing, towards a people-centred approach to ensure that health promotion and preventative interventions are in place to promote health, protect populations and decrease the need for curative services.

It was emphasized that achieving UHC is feasible, and that an inclusive, evidence-driven approach is needed to move South Africa in the right direction. Finally, International UHC Day must be used as an opportunity to proactively engage and ask governments, leaders, and those in power to act on their commitments to achieve UHC, and in so doing tell the key stakeholders why Health For All matters, and why it's critical that countries take concrete steps to build the world we want- 'a healthy future for all'. Everyone must act and rally together for what is right – this requires taking positive actions to make 'health for all' a reality.

UHC country experiences

The conversation then focused on looking at country experiences with regards to UHC and what lessons can be drawn for South Africa. In his inputs to the session, Dr Joseph Kutzin, Coordinator for Health Financing and Governance at the World Health Organization (WHO), Headquarters started by asking the question "Is Reform affordable? Is UHC affordable in South Africa?" According to Dr Kutzin, the response to these questions is a 'resounding yes!'

South Africa has a lesson to learn from the United State of America (USA) as there are clear warning signs in the current health financing in South Africa, which may lead to the same challenges of rising costs and inefficiencies, which the USA is currently facing. UHC enables all people to access the preventive, promotive, curative and rehabilitative health care services that are of good quality, without experiencing financial hardship. UHC is not a Utopian dream, but instead is an operational concept: it is about moving towards UHC, making progress towards goals, and is progressive. It helps reduce gaps between need and use, and improves quality, while ensuring financial protection for all users of the health system. He underscored the concept of "movement towards" UHC rather than "achievement of" UHC. This is because UHC is not an event, but rather a process of improvement and a practical orientation to policy reforms. Every country must continually ask itself: What are the ways we are under-achieving?

The Idea of UHC is not new, there have been many declarations on UHC at the World Health Assembly and other platforms. It is embedded in the Universal Declaration of Human Rights, WHO Constitutions, and multiple United Nations (UN) declarations, the SDGs and many Member State Constitutions and legislative frameworks. UHC implies coverage is a right: coverage should not be determined by your employment status. Financing the UHC is not only about revenue mix from employer-employee contributions: but rather movement away from employment-based, to a general revenue-based financing. The idea is to have predominant reliance on pre-pooled Government funding for health. UHC aims to achieve one country with one health system.

The unit of analysis for assessing UHC is the whole population, not just one scheme. Medical schemes in South Africa and other countries serve their members at the expense of the rest of the population. UHC has an explicitly redistributive agenda and thus enters the realm of politics. In the UK: in addition to the NHS, 9% of the population has complementary insurance cover which accounts for only 2% of healthcare funding, meaning there is no major effect on the rest of the population. However, in South Africa, more than 40% of health spending goes to private health insurance schemes. This inevitably drives prices up, contributes to a lopsided distribution of human resources for health, exacerbates inequities and adversely impacts the whole population health significantly.

In looking at what are the lessons that have been learnt from financing for UHC, and what works, there are a number of key lessons that can be drawn for consideration in South Africa. Firstly, UHC should be funded by public funds, coverage policies (benefits and ration) should be aligned with health and protection, fragmentation and administrative waste reduction. Further, strategic purchasing must be aligned with efficiency in health service provision and accountability efficiency, subsidisation and compulsory UHC participation. Public spending as a share of GDP (the more a country spends then the less the population spends on Out of Pocket payments (OOP) for healthcare) should be progressively increased to meet population health needs.

Secondly, policies matter because fragmentation limits redistribution capacity and interoperability, leading to wastage from overlap and duplication between public and private funding pools. Therefore, some form of equalisation is required – this implies that countries must deal with harmonising funding systems to minimise and eliminate any avoidable duplication.

Thirdly, it is important to note that evidence exists that health improves where countries moved from decentralisation to centralisation, in most cases there was equalisation of spending after centralising, and a shift to capitation and outcomes-based payments. For instance, in Moldova, once the funding pools were centralised there was a shift to a capitation-based payment system and achieved of better equity outcomes over time.

All countries can afford UHC. Leaving health financing to the market forces cannot work. Pooling of funds and strategic purchasing is required. Furthermore, payment must be linked to health outcomes that can must be monitored using robust data systems. There is evidence of the benefits of addressing pool fragmentation. In China, market based funding and non-regulation of pricing, among other things, led to high out-of-pocket payments for the population. Issues of unnecessary use of health services have been shown in South Africa, such as the fact that there are higher caesarean section rates in insured members of the public than in the general population. In a multi-purchaser system, there is room for providers to do cost shifting which ultimately leads to more inequity and entrenches inefficient practices by providers and other players. On the other hand, in multi-benefit systems providers can manipulate service use, pushing patients to use higher cost services which do not necessarily lead to best resource use and overall outcomes. Where there are multiple insurers, the incentive for health promotion is less, as there is a low return on investment when people switch insurances. It is therefore ideal to have a single payment system. System-wide changes are required.

Unfortunately, due to delays in implementing some key institutional and organisational reforms, South Africa is moving towards duplicating many of the challenges plaguing the USA health system. Almost half of global expenditure on health is in the USA, which is a function of inefficiency- In the USA in 2020, 19% of GDP was spent on health. The ‘Obamacare’ helped reduce coverage costs, but the system was still largely experiencing increasing costs, and “out of control” spending. . Health care funds are not used for more physician visits or hospital admissions but rather, spending is used on meeting insurance overheads, increasing administrative costs, and there is little growth in health care provider numbers. Similarly, South Africa is an extreme outlier in that 42% of its healthcare spending is through voluntary health insurance (serving small, privileged groups representing less than 20% of the total population) and this results in highly inequitable public spending. It’s time to stop this before it’s too late as the problems are still manageable. However, if the trend is not halted, it may become irreversible and South Africa will experience what is currently happening in the USA.

The key take home messages included: (i) there is a legitimate public concern in South Africa about the dominance of the private health insurance market and its impacts on the distribution of key healthcare resources; (ii) South Africa needs to move towards one, integrated health system; (iii) the money currently existing in the health system can be used to achieve better value and outcomes; (iv) a single purchaser arrangement is the best option available to drive change; and (v) “South Africa must act before it becomes irretrievably Americanised.”

UHC has to be implemented to prevent a situation where there is an increasingly weak health system but increasing costs with poor outcomes. The strategic purchasing power of the NHI Fund can be used to drive down costs, and the consolidation of functions will minimise administrative costs. The critical early steps are the unification of the information platform, and working with providers to use information more effectively for various purposes such as accreditation, performance monitoring, and even contracting.

Keynote address by the Minister of Health

The keynote address for the Policy Dialogue was delivered by Dr Mathume J. Phaahla, MP the Honourable Minister of Health. In the address, it was highlighted that South Africa's UHC and NHI implementation is especially important given the recent COVID-19 pandemic and associated challenges. The extensive work done by the Health Portfolio Committee to finalise the NHI Bill before it is tabled at the National Assembly and National Council of Provinces (NCOP) was acknowledged. However, although this process towards UHC is not new to the South African context, as it was central to the liberation struggle and is enshrined in the Bill of Rights, the progress has taken unacceptably long. All WHO and UN Member States have formally acknowledged health as human right. This was reflected in the United National General Assembly (UNGA) on 23 September 2019 recognising that at the current pace, up to one-third of the world's population will remain underserved by 2030 and that efforts must be made to accelerate the progress towards achieving UHC. The Minister reiterated the key resolutions adopted by the Heads of State at the 2019 UNGA which included:

(a) Reaffirmed rights of every human being to attain physical and mental health;
(b) Reaffirmed a comprehensive and people-centred approach to leave no one behind;
(c) Reaffirmed strong political commitment to address the challenge of financing and creating an enabling environment for financing;
(d) Recognised that UHC is fundamental to achievements of SDG;
(e) Recognised that health is an investment in human capital, social and economic development towards the full realization of human potential;
(f) Recognised that all people should have access to nationally determined services without discrimination;
(g) Recognised the need for health systems that are strong, resilient, functional, responsive, well governed and accountable;
(h) Reaffirmed importance of PHC and the role of government to achieve PHC services;
(i) Committed to implement the most effective, high impact, quality assured, people-centred, gender and disability responsive and evidence based interventions to meet the health needs across the life course; and
(j) Committed to prioritize health promotion and disease prevention.

South Africa has had many ups and downs in achieving UHC. As early as 1995, maternal and child health, PHC and emergency services were made free at point of service but since then we have allowed extensive expensive private, especially specialized, care without referral pathways, the commodification of healthcare through health insurance, the proliferation of various forms of fee-for-service and poor regulation of the private sector as found in the Health Market Inquiry.

The Minister further highlighted the Presidential Health Summit and the subsequent Presidential Compact which brought together a number of role players to action the nine pillars included in the compact, which articulates the collaboration areas within the health sector to achieve UHC. It needs to be recognised that financing is key but not the only solution. South Africa needs a single payer, single purchaser system, in order to address the current two-tiered health system which is fragmented in both resourcing and service delivery. This system, despite a relatively high GDP spend when compared to other countries with similar economic development, does not deliver outcomes that are aligned to investment. To address this, South Africa must improve the quality and the capacity of the public health system and focus on PHC as the foundation of this approach.

In his ultimate remarks, the Minister appealed to the delegates that whilst it is important for NHI to lay the foundation for UHC, South Africa should not wait for the finalisation of the legislative processes, especially given the current legal challenges to the NHI. Instead, all those interested in seeing UHC being achieved in South Africa must identify and act on things that can be done immediately to contribute towards making UHC a reality.

SESSION TWO: Looking at some key components of the South African health system and their bearings on Universal Health Coverage (Chaired by Mr Kuben Pillay, Member of the Ministerial Advisory Committee on NHI)

The speakers in this session were (in order of appearance):

i. Dr Nicholas Crisp (DDG: NHI, National Department of Health);
ii. Professor Steve Reid (Directorate: OHC, University of Cape Town);
iii. Professor Eric Buch (Co-Chair: Ministerial Advisory Committee on Human Resources for Health);
iv. Professor Diane McIntyre (Ex-Director, Health Economics Unit, University of Cape Town); and
v. Professor Morgan Chetty (Board Member, Office of Health Standards Compliance)

Key updates on NHI progress

In his presentation, Dr Crisp leveraged some of the information and lessons shared by speakers from the preceding session. The Policy Dialogue was informed that the NHI Bill is currently before Parliament and the clause-by-clause discussion has been concluded by the Portfolio Committee on Health. The Honourable Minister has made introductory comments on the Bill to the Committee at a meeting held on 16 November 2022, following which the NDOH led by the Director-General responded to comments and inputs at a meeting held on 30 November 2022. The next step requires the preparation of the "A list" amendments and responses from the State Law Advisors specifically addressing the recommended changes to the Bill. These will be followed by the consultative process in the National Council of Provinces led by the Select Committee. It is anticipated that the NHI Bill processes will reach conclusion in early 2023.

The NHI Bill creates the enabling framework and the details will be captured in regulations, policy statements, and directives from the Fund. The green and white paper are a reference point for details of the NHI Fund. Delegates were informed that there has been a reasonable amount of criticism of the Bill from the public hearings about lack of detail in terms of the proposed benefits and cost of the NHI.

Lessons were learned during COVID-19 pandemic through the creation of EVDS and DATCOV, compatibility of the different digital systems, sharing data across the different laboratories and use of a common platform in public and private sectors. The interoperability framework is currently available but needs to be operationalised. The next step in the process is creating an integrated patient record, and to use the digital system to harmonise the various information systems of vertical programmes like the HIV/TB, cancer registry, diabetes. We will start with a basic set of benefits and pilot the integrated patient record where clinicians will be able to see a continuum of care in the patient health history.

The integrated cohesive system on the ground will take some time to build. The Bill provides for the contracting unit for primary health care to be that building block in the periphery of the health system. The Bill also explains the DHMOs in the districts, through which the primary health care system will be reimbursed using a capitation system and organised in a Contracting Unit for Primary Health Care (CUPs) (which is a smaller, well delineated geographical area). NDOH has embarked on the development of "proof-of-concepts" of CUPs. A Project Steering Committee has been convened comprising representatives from National and Provincial Departments of Health to manage the project. CUPs "proof of concept" sub-districts have been identified in each province. The NHI Indirect Grant – Personal Services Component (allocated a sum of R85 million in the 2022/23 financial year) funding will be used for the development and implementation of a capitation model and establishment of these CUPs "proof of concept" in a few selected sites (provisionally only one per province).

The health sector funding trends over the past 15 years shows that more money is spent in the private sector than in the public sector since 2008. The private spending, which is a sum of private voluntary health insurance, in the form of medical schemes, and out-of-pocket spending, contributes 51% of total health sector spending and the trend is on a linear increase. The public spending was linear until 2021/2022 and consistently below the level of private sector spending. More recently, the National Treasury has announced reductions in public sector health spending. The national spend on health is currently 8.5% of GDP for 2021/2022, a decrease from the previous financial year 2020/2021. This decrease is attributable to no more COVID-19 spending. The spending of both sectors and total GDP spend is projected to decrease over the next three years.

South Africa spends plenty money on health care. The spending by government on health has increased as a % of allocations from the fiscus (from 14% to 15.5% and now at around 15%). The projection on government spending on health is to bring spending down. However, the demand on public spending is increasing, with salaries of government health care workers going up, patients moving out from medical schemes into domain of public sector, medical scheme benefit package becoming smaller and more people increasingly using out-of-pocket spending (and who will eventually come to the public sector for their care). Yet, the projected government spend will be decreasing. This is unsustainable for the public sector spend.

The private sector spending per capita per annum is R26, 700 for less than 20% of the population. In public sector, the per capita is just over R5, 000 per annum for close to 85% of the population in the financial year 2020/2021. This implies that private sector spend per person is 5.0 times that of the public sector, with a range between 4.4 to 5.6 times depending on proportion of the population regularly using private providers. This gap growing and the magnitude of the gap needs to be addressed to avoid "Americanizing" the health system. If South Africa spent the private average of R26, 700 per capita per annum on every South African, it would need an annual health budget of R1.6 trillion. This would be more than a third of the GDP and without a doubt unaffordable. But if we spent the public average of R5 322 per capita on every South African we would need an annual health budget of R322, 5 billion. The South African health budget is already at R550 billion, and the evenly calculated average spend per person computes to spending R9, 000 per person annually now. The key resources, such as human resources, are currently lost to the private sector as it is easier to move to that sector which just continues to increase prices, but this is at the cost of underservicing people in the public sector.

Furthermore, donor funding is estimated at R11 billion, which is spent mostly on HIV and TB and a little bit on other projects. The 2021/2022 total public sector spending on health is about R12 billion less than private sector spenidng.

We need to remember that South Africa's population is changing shape. The total fertility rate, infant mortality rate, crude birth rate and death rate are decreasing, except the increase in the death rate in 2021 due to COVID-19. This means that the population is getting older with the increase in life expectancy. This presents changing health needs for health care, needs that will be similar to the current United Kingdom needs, where care for the aged surpasses maternal care benefits. This will be the burden of disease that may face the country when NHI is implemented.

As part of the preparatory work for the establishment of the NHI Fund, the NDOH has advertised 44 new posts. The posts are the nucleus that is required for drafting regulations and standard operating procedures that are required. More than half of the posts are for consolidation and creation of one digital platform to ensure a uniform digital system for all stakeholders. Unfortunately, there has been opposition about these posts and currently the matter is before the courts. The current funding, purchasing and provider functions for delivery of health care to the population is complex, duplicative and wasteful. The present system is not sustainable and requires systemic reform over time. The NHI Bill provides the enabling framework for the reforms, but there will need to be persistent long-term changes to the way the system works. Complex systems are fragile so must be reformed in phases with careful planning. The funding envelope is always finite so it is important to understand the parameters within which to plan and reform. The current level of funding (8.5% GDP) is an adequate envelope so the reform must concentrate on efficiency, integrity and equity.

"Building UHC from the ground up"

Professor Reid based his presentation on the Cuban experience, exploring their community-based healthcare system. The Policy Dialogue was informed that Cuba has fundamentally different principles where, despite extreme resource limitations, the socialist government prioritises healthcare. The political system has a direct effect on healthcare services and population health as the government invests in human resources for health and focusses on community-oriented service delivery towards the implementation of equitable, high-quality primary healthcare to achieve universal health coverage. Generally, primary health care in Cuba is doctor-led at two-storey clinics allowing the clinicians to live above their consulting rooms and be available for a 24-hour service. Consulting rooms are simple but enable the provision of high-quality, accessible care to the community. Clinicians spend their mornings seeing around 10 – 15 patients and then in the afternoons they undertake outreach services where they see a further 25 patients. The next level of primary care facilities is the polyclinic which mirrors some aspects of South Africa's community healthcare centres, but is served by medical specialists.

In the Cuban health system, communities, not individuals or the government, are the ones that show a strong sense of ownership over clinics and the healthcare system as a whole. There is a general trust in the healthcare system, and solidarity – consideration of collective wellbeing ahead of their own – as evidenced by their internal systems and their programme of providing other countries with healthcare workers during the peak of the COVID-19 pandemic. South Africa is struggling to maintain these qualities of trust and solidarity in the health system, and have a lot of work to do to re-establish these values.

What the Cuban experience shows is that NHI cannot be implemented from a top-down approach. Rather, it needs to be built from the ground-up. Community members need to take ownership and enjoy agency over their health, and the health system needs to enable active participation to gain buy-in into the available services. In South Africa, we have seen community-oriented primary healthcare implement extensive local level community engagement, perform population-based planning and patient-centred service delivery. During the COVID-19 pandemic, these areas of excellence had structures in place to deliver chronic medication to patients' homes, and beyond the lockdowns, activities have extended to include community-based exercise groups to address the needs of patients.

CUPs (contracting units for primary healthcare) as the functional unit of primary healthcare service delivery within the NHI framework needs support to function well. This support includes improving healthcare system governance; capacitating the district level for activities like contracting; and developing population-based capitation models that translate into incentivising the needs of patients, with particular focus towards health promotion. Decision-making and priority-setting, including for development of a benefits package, needs to be transparent, done by the right people and be inclusive, with cognisance of reaching marginalised groups of people.

South Africa needs to design systems in ways that enable innovation and learning. This must include legitimate stakeholder engagement with effective ongoing communication; consensus must be reached on a common goal and planning and implementation should take place in a collaborative manner. Learning must be encouraged through sharing of, initially, good practice and of what does not work towards deciding on how to adapt and proceed. Intentional, structured reflection and analysis must be done so that best practices may be developed and scaled-up. On the road towards UHC, the roll-out of PHC enabled by the NHI must not be imposed, but should involve communities from the start. The implementation of NHI should be an incremental process that is designed to encourage innovation and learning. Success of this system requires South Africans to rebuild trust in the healthcare system and a sense of ownership and solidarity.

No health without a workforce

Professor Buch indicated that the planned implementation of the NHI, and the subsequent achievement of UHC, and of any population health, is impossible without a health workforce. UHC is not a new, nor an exclusively local concept. Globally, the concept gained traction in the 1970s culminating in the Alma-Ata Declaration on PHC in 1978, and continued with increasing prominence towards the 2019 UN Declaration on UHC.

In South Africa, the movement towards UHC has its roots in the struggle against apartheid. Organisations of healthcare workers such as the National Medical and Dental Association (NAMDA), South African Health Workers Congress (SAHWCO), Organisation of Associations of Social Services of South Africa (OASSA), National Progressive Primary Health Care Network (NPPHCN) all fought for equitable access of healthcare for all.

In the discussions on how best to move towards UHC, South Africa tends to often focus only on challenges, without acknowledging some of the great strides the country has made since the dawn of democracy. For instance, South Africa has managed to improve the maternal mortality which has dropped since the roll-out of our ARV programme. However, a defining feature of our healthcare system is inequity. This inequity is due to structural problems in the healthcare system which we hope the NHI will assist to fix. Other opportunities presented by the NHI Policy include the National Health Commission, an organisation developed to coordinate health promotion, but while being gazetted, has not yet been implemented.

In the mid-2000s, the drive to bring human resources for health (HRH) to the fore had increased, leading to the Global Health Workforce Alliance Kampala Declaration in 2008. The global HRH strategy created a baseline to guide progress towards developing a formidable health workforce. Locally, our HRH inequity mirrors our health inequities. There have been many good policies towards improving our HRH, but implementation has been fragmented. In response to the recommendations of the Towards 25 Year Review of the Department of Planning, Monitoring and Evaluation, the HRH Strategic Plan for 2019/20 – 2024/25 was developed. This document presents an investment case for HRH which would promote economic growth, and would be of value to the healthcare system given that 63% of the health budget goes towards HRH, but currently with less return on investment when measuring health outcomes.

The inequities in HRH distribution and skill-mix span across the public vs private sectors, provinces, and urban vs rural areas. There are, for example, 69 specialists per 100 000 population employed in the private sector, but only 7 per 100 000 in the public sector; and 25.8 per 100 000 in the Western Cape, but 1.4 per 100 000 in Limpopo. While prioritising PHC is important, South Africa's history of poor PHC implementation does necessitate the need curative healthcare workers such as specialists. Developing of healthcare workers is a long term resource intense process, and the healthcare needs of the population often change before realising the goals set out for earlier sets of needs. Urgent priorities identified by the Ministerial Task Team included: (i) identifying provinces with below-average per capita HRH and creating vacancies to reach an average; (ii) calculate the HRH needs for a PHC package of care and aim to reach this; and (iii) project the need for specialist care and begin the process of developing these specialists' categories. In addition, the objectives of the current HRH towards achieving UHC include data-driven HRH planning and alignment with need, producing a caring workforce through a socially-accountable education system, improving management in the healthcare system, and empowering and caring for healthcare workers.

Financing UHC – "more money for health, more health for money"

Professor McIntyre's presentation focussed on "Financing UHC: More money for health (for all), more health for money". Expenditure per medical scheme beneficiary is 5.5 times greater than public sector expenditure per South African dependent on the public sector. Only rich people have easy access to private healthcare. In terms of more money for health, for all, it is not because there is no money in the health system – instead, it is just that there are significant disparities between financing available in the private sector compared to the public sector (especially when one takes into account the size of the total population accessing services in each sector). The issue is to increase the flow of money over time which will be used to purchase health services for the benefit of all people. This can be done by progressively channelling existing funds from the conditional grants, provincial equitable share, and other funds e.g. workers' compensation into the NHI Fund. This can be propped up by an increase in tax revenue allocations to the NHI Fund by removing tax credits for private health spending, generating additional tax revenue either by increasing existing tax rates and/or introducing earmarked levy on personal and company income taxes. There should be no payroll tax to fund the NHI because it excludes the wealthiest, UHC should be a universal entitlement, not access to healthcare linked to employment. At the same time, this will reduce contributions to medical schemes. Healthcare financing is not just about revenue collection, securing, and pooling the funds, it is also about strategic purchasing, service delivery, and management of health services.

In considering how best to realise more health for money, strategic purchasing is key – the NHI Fund is not just about 'money and getting money into an integrated pool, it must be an agent of change to promote the efficient provision of services, increase service quality and improve equity in the use of services. It must be a strategic purchaser, not a passive purchaser where you get the bills and then pay." Medical schemes themselves have no experience in strategic purchasing.

The reason there are a lot of controversies in NHI is that it is explicitly redistributive in that it will narrow the differentials in access to quality health services over time, lead to human resources redistribution (improve access for the most vulnerable and disadvantaged), increasing pooled funds that are used to benefit all South Africans, and strategic purchasing will be critical for improving efficiency, quality, and equity.

South Africa has sufficient funds but the majority of the population cannot access these funds. The health expenditure in South Africa is 8.5% of the GDP. Expenditure per medical scheme beneficiary is 5.5 times greater than public sector expenditure per South African dependent on public sector (for non-PHC) services – it was 3.5 times greater in mid-1990's. At the time South Africa was observed as an outlier and something needed to be done. There are some differentials all over the world with the rich buying what they perceived to be 'better' health care and quicker healthcare. However, in countries with UHC systems, these differentials are really marginal. Changes that should be in the NHI over time include increasing revenue through the general tax system to minimize revenue collection costs. An autonomous strategic purchaser single pool has much lower administrative costs and improves efficiency. For example, South Korea spends only 3% on administrative costs on NHI whilst Thailand spends less than 2% (which is very low) so a single purchaser arrangement can be used. Another area of efficiency improvement is using appropriate provider payment mechanisms like capitation, and not using fees for service will then result in more money for health. There is a need to move forward urgently.

Corruption increases the lack of trust. Abuse and misuse of funds does not mean South Africa cannot move forward and implement reforms to achieve UHC. South Africa needs to find solutions to corruption. Data is important so as to see where the money is spent and hold people accountable. Civil society needs to be involved, and transparency and accountability improves governance. There is also the need for risk monitoring mechanisms to ensure that corruption and wasting of public funds do not happen, and where they do happen appropriate actions are taken speedily.

High quality, safe and accountable healthcare for UHC

Professor Chetty stated that "patient safety, quality of healthcare, and accountable healthcare are interwoven strategies for UHC; the problem is, it is compounded by poverty". The first challenge that he observed is the convergence of poor access to health care due to rural density, poor quality of health services in many parts of the country and unsafe healthcare, and poor/under-resourced/underfunded health systems which have been highlighted in the COVID-19 pandemic, which can impact the implementation of the UHC and the achievement of SDGs.

> "To promote, maintain and sustain a safe health system foreseen to the domain of the Office of Health Standard Compliance. It is an important pre-requisite for the NHI and the UHC and it is needed for compliance with the norms and the standard that are legislated. This will qualify for accreditation by the NHI fund and allow for contracting to provide a service to all NHI programs. Quality, safety, and accountable care are prerequisites for NHI". Final word is, "moving towards NHI, UHC we have no luxury to wait for the future to arrive, we need to create the future together".

Access to quality health care and the impact of poverty highlight challenges in healthcare delivery in the Sub-Saharan African region including a fragile health infrastructure with 25% of the global burden of diseases, 3% of the world's health manpower, and 1% of the GDP spent on health. Further compounding the human resource deficit, it is estimated that 20,000 health professionals left Africa for the global north. Furthermore, 1 in 3 Africans, about 122 million people, are estimated to earn below US$1 a day in rural areas. A weak health system response to the COVID-19 pandemic could precipitate a monumental socioeconomic crisis. Poor health literacy with an opportunity for the bottom-up approach which is people-centred healthcare, high unemployment, financial challenges (Africa having more financial inefficiencies and deficiencies), and lack of medicines, vaccines, and medical services all contribute to poor healthcare delivery in the region. Poor support services including radiology, pathology, telemedicine, and high rural density are some of the challenges. To get quality healthcare, resources and support are needed.

Health systems are important in UHC with a foundation on facilities, human resources, equipment, devices, etc. South Africa requires a strong horizontal platform that is supported. Currently, there are a number of vertical branches which are often under specific, disease-specific, and project-specific which are successful. However, the impact is on an already fragile horizontal platform. Two policy declarations to manage these challenges that were quoted were the Paris Declaration for effectiveness (March 2005), which calls for an international monitoring system and the African Human Resources Capacity Investment Act of 2007, which calls to improve human resources for healthcare capacity and the retention of human resources in Sub-Saharan Africa. The importance of having a good health system is to have quality and safety aspects. Three core summary items emphasized were (i) good governance; (ii) good fiscal management in ending corruption; and (iii) accountability.

Poor quality care increases the burden of illness and healthcare costs globally. Poor health system design has led to errors, poor quality care, and dissatisfaction among patients and health professionals. For quality and safe health care, countries need the delivery of health services as a global imperative for UHC, and technological support with the potential to transform healthcare. The global safety advocacy for UHC continues to highlight the importance of having a

strategic and coordinated approach to patient safety to address the common causes of harm, poor quality, and unsafe healthcare and identify approaches to prevent it. The 2019 Global Safety Advocacy World Assembly declared a "Global action on patient safety" with the resolution urging the need to recognize the need for patient safety as a priority in the health sector policies and programs to achieve UHC. Safe healthcare is what is critical and pivotal for UHC.

For the future of quality, safe and effective healthcare, we need to design a health system of the future within the UN sustainable development framework and prioritize and invest in health infrastructure. A system built "fit with purpose" in line with the SDGs. We need an inter-sectoral collaboration including the private sector to tackle the wider social and commercial determinants of health. SDG 17 seeks to strengthen global partnerships to achieve 2030 agenda targets bringing the government, the international community, civil society, and the private sector.

In the panel discussion a number of key factors were raised as core to supporting the implementation of UHC. Key considerations raised included that:

(a) UHC implies that all people have equal access to nationally determined sets of needed preventive, curative, rehabilitative, and palliative basic health services and essential, safe, affordable, effective, and quality medicines;

(b) UHC will only be successful if there is leadership and ownership in both the public and private sectors. There is an urgent need to focus on HR leadership, clinician, and administrative leadership so that the managers can do what they are trained to do;

(c) Currently, health is a contested space between government and organised labour. There exists the need to rediscover the principles in HRH addressing the issues of staff attitudes and behaviour which affect service delivery and poor health outcomes. A roundtable discussion with the government and labour unions is recommended to address employee needs and solutions. In addition, the minimum service agreement to be resuscitated for employees of essential services is prohibited from protest actions. A review of the RWOPS policy is observed as an unethical policy that destructs the health system;

(d) Financial management skills must be addressed in institutions, health establishments and facilities to assist with minimising corruption and the misuse of funds.

In response to some of the questions and comments raised by delegates, the Deputy Minister of Health committed the NDOH to: (i) to resuscitate the training and development of midlevel workers as advised by WHO; (ii) to strengthening the recruitment and retention policy, and inter-professional education with particular emphasis on training generalists than focusing on specialists; (iii) investing in the HRH is not only a government responsibility, however, the environment should also be conducive to attracting the private sector for investment in skills and technology; and (iv) to stabilise leadership for quality support in Provincial Departments of Health, Tertiary Hospital Services, and Academic Hospitals. In addition, it encourages engagement with various stakeholders with a focus on infrastructure and also a continuous appreciation of hardworking, committed personnel and facility management.

There was also a call for all healthcare workers to be competent and perform the work they are employed to do. This will ensure the most efficient and appropriate use of our workforce and to limit the abuse that is seen with our junior staff. Mid-level workers may be better developed, and formal and clear role allocation should be done. However, focus should remain on inter-professional education to produce generalists across professions by leveraging tertiary institutions through funding to incentivise creating the workforce that the country needs; and to develop staffing norms for the country, and include them in the work of the OHSC.

SESSION THREE: Building health system resilience, improving access to medicines and measuring progress on UHC (Chaired by Dr Nicholas Crisp, DDG: NHI in the NDOH)

The speakers in this session were (in order of appearance):

i. Dr Rajesh Narwal (Health Systems Lead; WHO South Africa);
ii. Ms Candice Sehoma (Advisor: Access to Medicines; MSF)
iii. Ms Thulile Zondi (Chief Director: Health Information Systems, Research, Monitoring and Evaluation; NDOH);
iv. Professor Kebogile Mokwena (Sefako Makgatho Health Science University);
v. Mr Russel Rensburg (Programme Manager: Health Systems and Policy; Rural Health Advocacy Project).

Building resilient health systems for UHC

Dr Narwal started by indicating that resilient health systems are the systems that quickly adapt, withstand shocks, maintain essential quality health services and sustain the gains made. When considering the health systems strengthening (HSS) building blocks (governance; financing; health workforce; medicines, medical products and vaccines; service delivery, and information systems), each country must take into account its own context. During times of shock (when disturbances, such as a pandemic, are introduced), how governments respond depend on their two factors; the vulnerabilities, as well as their adaptive capacity. This eventually determines the various possible outcomes. The health system can either subsequently collapse, recover to some extent but not return to baseline, recover to its original baseline, be better than it was before or transform. The ideal scenario for any health system is the latter two- be better than it was before or transform

The 21st century dynamic epidemiological, socioeconomic and geopolitical contexts drive the need for health systems resilience to progressively attain universal health coverage by expanding population coverage, scope of health services and financial protection. Resilience is even more critical today because the context has changed since the Alma Ata declaration and the establishment of the Millennium Development Goals (MDGs). The population is ageing with a prediction that 10% of the population will be over the age of 80 by 2050. There is an epidemiological transition with an increase of non-communicable diseases (NCDs) responsible for 63% of all deaths worldwide of which 80% is accounted for in low- and middle-income countries (LMICs). Antimicrobial resistance (AMR) is a major concern, and the emergence of new pathogens poses an additional threat to health systems globally. Globalisation and migration add to the burden on the health system, additionally, so does climate change and urbanisation with 880 million people, or 30% of the global urban population living in slums. There is a rise in healthcare costs driven by newer treatments and health innovations, and citizens are asking their Governments for better health services. With limited resources and competing priorities, health systems can be disrupted in times of shock that can lead to loss of gains made towards the realisation of UHC- South Africa is not immune to this, as seen during the pandemic.

The COVID-19 pandemic accounted for 6.62 million deaths worldwide with an estimated excess death almost three times of that recorded (14.9 million until December 2021). COVID-19 also exacerbated pre-existing burden of diseases (HIV/TB/NCDs) and disrupted essential services. The pandemic put immense burden on the healthcare workforce- contributed to increasing levels of stress and an estimated 10-15% of all COVID-19 cases and over >115 000 deaths globally were reported amongst HCW. There were broader socioeconomic impacts of COVID-19 including a global economic loss of US $7 trillion, 114 million jobs lost, 97 million additional poor added the global population (increase from 7.8% to 9.1%), 635 million students' education affected with a notable increase in inequities and inequalities impacting the most vulnerable. Mental health was affected, with an increase in depression (27.6%) and anxiety (25.6%). Health system resilience for UHC is important to ensure health security.

Recommendations on how to ultimately achieve health systems resilience are two-tiered. The first-tier focusses on how to build resilient health systems and the second focusses on how to improve responses to shocks and disturbances to health systems. Building resilient health systems requires a whole system approach in order to reduce vulnerability and improve adaptive capacity. This requires a transformation of health systems for UHC focussing on health and wellbeing, high quality, people centred, integrated and fair health systems. Building resilient health systems for UHC and health security will require actions under four interconnected strategic priorities 1) increased investments in primary healthcare, 2) strengthening of essential public health functions, 3) addressing health determinants at all levels, and 4) improving capacity in research, innovation and digital technologies.

Ultimately, South Africa needs to invest in building resilient health systems that can withstand shocks, respond to evolving population needs and consistently deliver care to improve health. Implementation of the findings from Intra Action reviews (IARs) and After Action reviews (AARs) provide valuable insights as to what worked and what didn't, what needs to be improved in South African Health systems. Establishment of Public Health Emergency Operation Centres (PHEOC), emergency preparedness and response (EPR) cadres as well as Integrated Disease Surveillance and Response (IDSR) systems are pertinent next steps amongst many other to build strong foundations for emergency preparedness and response. Addressing the six health systems building blocks will bring South Africa one step closer to achieving its goal of UHC and health security

There can be no UHC without health security, and vice versa. There is a need to remove chronic fragmentation and integrate Emergency Preparedness Response (EPR) in health systems, with International Health Regulations (IHR) and National Action Plan for Health Security (NAPHS) as guiding frameworks, and the National Public Health Institute of South Africa (NAPHISA) to help expedite reforms. The knowledge of what needs to be done is there, and now theCOVID-19 provides opportunities to implement key health system interventions and reforms. It is important to have a step-by-step and context-specific implementation which is central to progress. Government stewardship is a must for stakeholder engagement, partnerships and smart investments in workforce and systems development. If we don't capitalise and act now, future generations will hold us accountable.

Improving access to essential medicine and medical products

On the subject of improving access to essential medicine and medical products for UHC, Ms Sehoma raised a number of pertinent and interrelated issues for the Policy Dialogue's consideration. She noted that access to essential medicines and medical products remains inequitable globally, and in South Africa. Medicines and medical products are largely manufactured in the north and this often serves as a barrier for LMICs in terms of access. In addition to this, the few suppliers and lack of competition within the system serves as a favourable environment for multinational companies to control the system and capitalise. This, coupled with a lack of transparency does not give LMICs the bargaining power to negotiate. Intellectual Property (IP) protection and the patency system acts an aggravator of these inequities as it allows pharmaceuticals to exploit the system for profits whilst health remains a secondary objective. Another barrier includes the lack of funding for research of diseases affecting LMICs. For example, TB, a life-threatening disease, did not provide great opportunities for profit for major companies. Medicines and medical products that are developed from research in LMIC are quickly privatised and the benefits to the countries that were involved in the research are rarely seen despite major public funds invested.

However, recommendations to overcome these barriers remain critical to achieve access to quality and safe medicines. There is a dire need to increase and sustain local production of essential medicines and medical products for health security. The mRNA vaccine technology hub, an initiative under WHO leadership, is an example of local production as a mechanism to build capacity in LMICs to improve access to vaccines, and Africa's ambition for reducing dependence on vaccine importation. Research and development within a local context is important in terms of clinical trials in order to benefit participating countries and mechanisms must be in place to ensure that there is a return on investment. Future funding by government must be oriented toward the common good and rules for utilisation must be designed in such a way that public health is always a priority. This can be achieved by ensuring that such agreements are written into the memorandum of understanding. To achieve long term sustainability there is a highlighted need for governments to improve their patent laws to include Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities and ensure that they are favourable and prioritise public health rather than profit.

Therefore, in order to achieve UHC, enabling environments need to be created for medical tools to be affordable for increased use and reach, whilst ensuring the tools are adapted and tailored for the context, communities and individuals we hope to reach. Self-reliance is critical and can be achieved through local production, appropriate funding and beneficial professional relationships.

Digital health, data, research and innovation as UHC accelerators

Ms Zondi addressed the issue of digital health, data, research and innovation as UHC accelerators. Digital health, data and research is a major part of UHC preparedness but remains a challenge in the country. Challenges in the country include fragmented information & silo systems, inadequate funding for digitisation and essential research, a lack of a national electronic patient record, high market-driven costs of broadband connectivity and network infrastructure as well as poor ICT infrastructure.

The National Digital Health Strategy 2019 – 2024 objectives were aimed to address these challenges. The objectives include the development of a complete health electronic record, digitisation of health systems business processes, the establishment of an integrated platform and architecture for health sector information systems, scaling up high-impact mHealth for community-based interventions and the development of digital health knowledge workers.

Big data capabilities are essential for accelerating digital health. Digitising everything will involve large amounts of information, not only for patients but for human resources for health (HRH), finances, and other support services. There is a need to review the capacity for analytics that are needed and systems that can assist with data management. There are some existing examples with proven benefits including the Central Chronic Medicines Dispensing and Distribution (CCMDD) programme, the stock visibility system (SVS), MomConnect, the human resource information system (HRIS), the national health research database (NHRD), web district health information system (DHIS) and a goal towards establishing a national health observatory. Nevertheless, valuable lessons were learned from COVID-19 through the data-lake pooling information from the EVDS system, DATCOV and stock visibility system. These allowed an overview of COVID-19 infections, vaccinations and hospital data as well as stock. Drivers of health innovations should be a convergence of technologies, digitisation of health and healthcare, rapid evolution of science and medicine, addressing the unsustainable rise of costs and increased patient awareness.

Measuring the UHC index is based on calculations related to four domains namely: reproductive health, maternal, new-born and child health (RMNCH); infectious diseases and control; non-communicable diseases; as well as service capacity and access. South Africa's UHC index has improved in all four domains between 2008 and 2018; however, there are still gaps in information and areas that need great attention. COVID-19 highlighted the role and need that exists for digital health information systems and this was one of the greatest lessons learnt. Reviving the district health system and implementing its mandate will ensure bottom-up dissemination of information, turning data into knowledge, and ensuring evidence-based policies.

It remains critical that South Africa invests in data, research, digital health and innovation, to scale-up innovation initiatives and to fast-track the implementation of the digital health strategy to ensure the successful implementation of the National Health Insurance (NHI) and ultimately accelerate UHC. COVID-19 has proven that South Africa has incredible capacity and resilience. It is crucial to invest in data, research, digital health and innovation now to accelerate UHC. Scale-up of innovation initiatives and building a culture of learning and responsiveness in the health sector is required. Implementation of the NHI for UHC will require that we fast-track the implementation of the Digital Health Strategy to be able to account for patient care and for the NHI Fund to reimburse service providers accurately. The UHC coverage index monitoring requires the health sector to get the health systems and research in order, over and above just patient data.

Health in all policies: promoting equity and reaching the unreached

Professor Mokwena addressed the matter of promoting equity and reaching the unreached by ensuring that health is included in all policies. South Africa already has individual ingredients to support UHC including the 1997 White paper on the restructuring of health services in South Africa, Schools of Public Health and ward-based outreach teams (WBOT) in primary health care (PHC) facilities. However, in order to enhance UHC, South Africa needs to (a) Re-commit to the White paper on the restructuring of health services in South Africa to incline towards health promotion and disease prevention, not just curative approaches.; (b) provide a fresh mandate to the Schools of Public Health, which are currently underutilised by government, so as to focus on specific areas of community health needs; and (c) re-organise the WBOT to ensure that they are led by professionally trained personnel.

One of the keys to reach the unreached is the strengthening of health promotion (HP) strategies. This is a universally implemented practice where we are able to reach groups of people in their communities at relatively low costs. It also ensures that communities are empowered and given tools to take responsibility for their health. Health promotion enables integration of health in all policies because it occurs where people live, play and work. Health promotion is an art and a science and requires proper academic training. It is therefore important to build health promotion infrastructure and establish health promotion training and opportunities across different levels.

In summary, health promotion has a significant positive impact in communities and every member of a community has the potential to be reached. Furthermore, health promotion principles enable the country to develop custom-specific services to specific citizens' needs thereby also enabling health services to reach the unreached and provide health security and UHC. This is the only way UHC will effectively reach the unreached.

Measuring progress on UHC – service coverage and financial risk protection

On measuring progress on UHC service coverage and financial risk protection, Mr Rensburg

Indicated that in South Africa, 38% of the population live in rural areas of which 70% of South Africa's 52 health districts could be considered rural. Without addressing the underperformance on key UHC priorities (RMNCH, Infectious Diseases, NCDs), South Africa will not meet the SDG 2030 targets. South Africa has one of the most well scribed Constitutions including the Bill of Rights which is considered as the country's obligations and aspirations towards reducing great inequities and inequalities in key areas such as access to health, education and other social services. Sections 9, 10 and 27 addresses equality, human dignity and right to health respectively.

Progress on population health priorities between 2007 and 2019 has shown that maternal mortality has decreased (199 to 119 per 100 000 live births), there was a decline in the under-five mortality rate (83 to 38 per 1000 live births), the HIV incidence decreased (17 to 7 per thousand), TB incidence decreased (762 to 554 per thousand) and the populations' life expectancy increased (54 to 64 years). Despite the overall positive progress, there are still significant differences between urban and rural districts.

Health care systems are complex and gains are not equally shared. South Africa's UHC index (including RMNCH, infectious diseases and NCDs) reported that maternal and child health improved since 2007. However, during the COVID-19 pandemic, the expanded programme on immunisation (EPI), family planning and disease programmes were significantly disrupted with a decline in PHC visits. The greatest fear at the start of the pandemic was NCDs as comorbidity because there was no record of Diabetes Mellitus (DM) indicators (only modelled estimates). The estimated burden of DM was 5 million of which only 1.2 million were controlled on treatment.

The country's COVID-19 response required a unified health system response, instead there were two parallel responses to the pandemic. Diagnostics and access to tests was very unequal with 60% of tests in private facilities (an increase in out-of-pocket expenses). Therapeutics is an example of collaboration between the public and private sectors (public-private partnerships (PPP) looking at industrial oxygen conversion to medical gas, rural innovation in the Eastern Cape Province where they constructed their own oxygen plant). The health system was overburdened with majority of admissions in public health facilities and just over 40% in private health facilities. The official number of COVID-19 related deaths is 102 000, less than a third of excess deaths over the same period. More studies are needed but the overall vaccination rate is 51% and could indicate inequitable vaccine coverage despite the rollout plan and initial uptake of vaccines.

South Africa is a relatively small independent country susceptible to global financial hardships due to the geopolitical and socioeconomic shifts. During the pandemic, there was a break in supply chains, increase in prices for medicines and technology and economical revenue challenges affecting affordability of services. The increase in unemployment and rising global inflation coupled with local electricity instability further deterred progress.

Despite these challenges, there are unacceptable trade-offs. The need to prioritise cannot lead to the expansion of low to medium priority services if access and quality is not in place as well as higher levels of care e.g., tertiary care. PHC has to cover the majority (80%) of the population utilising the services and services should be affordable as well as cater for all including the marginalised. Improved health financing is important, together with strong leadership, governance, transparency, sustainability, and trust. Governance must be data-driven, and evidence based. The need for adequate health information systems governed by the national public health institute (NAPHISA) which is not yet operational. This is crucial to have quality data for analysing, interpreting and guiding decision making as well as monitor, evaluate and critique the health systems performance.

Despite the celebration of progress made between 2007 and 2019 in South Africa's disease burden and UHC index, there still remains inequitable access to healthcare and inequalities. Prioritisation of health needs are important but cannot cost the population in terms of access, availability of programmes and financial costs. Strong leadership and governance is important to the realisation of UHC with adequate stakeholder and community engagement to inform processes from the bottom-up and reach the marginalised. In conclusion, participatory governance is important for sustainable health systems. Engagement with civil societies, health entities, health care users and community engagement including members, especially those people living with HIV and TB, young people and young women, should be at the centre of designing quality health services in order to achieve universal health coverage and protect the population from financial hardship. This will strengthen a bottom-up approach and community capacity.

The session's presentation were followed by a panel discussion. Some of the issues raised by the panellists and delegates included that:

South Africa appears not to be epidemic ready (e.g., bathroom taps in the venue have not been replaced/updated given that they still have to be manually operated). Being epidemic ready does not refer to preparedness for COVID-19 only. Even for those who are not from the health sector, everyone should take proactive action to promote the achievement of a resilient health system. The topics covered by the UHC Policy Dialogue speakers and panellists are interlinked and pertinent to the implementation of UHC in South Africa, and the need to achieve health system resilience and health security for the population. To do so, South Africa must stick to the basics of health and wellness, including adhering to basic principles of public health and basic control of communicable diseases, and primary health care.

(a) Reflecting on the proceedings so far, the majority of the topics have been covered in previous other forums. In February 2009, integrated clinical support teams were given tasks based on recommendations and yet sadly in 2022, these have not been implemented. Looking at the health information system in 1994 when the Department of Health was introduced, a single real-time electronic system was set to be developed, but nearly 30 years down the line it is still outstanding.

(b) South Africa has spent a lot of time learning from other countries (e.g. Cuba, Ghana, Netherlands, Thailand, and Japan), and producing recommendations, and we have the plans and resources to improve the quality of the national health system and be ready for the implementation of NHI towards UHC. What we need to do as public policy, public health and health sector stakeholders is to recall the initial NHI public debate reinvigorated in 2007, and that the target date for the implementation of NHI was December 2012 at that time. Today, we are now in 2022 and still discussing implementation blocks. South Africa just needs to implement NHI now. In doing so, communities need to support lawmakers to make sure that the law-making process and the outcome is supposed to be the framework for the implementation of NHI. In this way South Africa can achieve UHC in our lifetime.

(c) There is a definite need for policies to address orphan drugs because currently the investment is market-driven and not necessarily health outcomes driven. There needs to be a shift from how investment dominates the orphan drugs market, especially implementing adequate drug policies and guidelines to facilitate access to medicines. This is key pillar to achieving UHC globally, and in South Africa.

(d) TRIPS flexibilities are underutilised, and this allows for the compulsory licensing to be put in place, but countries can negotiate and work with pharma companies to do voluntary licensing for high cost treatments for rare diseases. Many countries have made use of this, but there needs to be a balance. Whether SA can take on big pharmaceutical companies to protect its population needs to be seen. If the country goes with compulsory licencing to bring the high costs under control, then big pharmaceutical companies might withdraw their investments from the country due to loss of profits. Yet, if there is a disease with costly treatment, TRIPS flexibility can be used.

Closing Remarks by the Deputy Minister of Health, Dr Sibongiseni Dhlomo, MP

"Our health care is in our hands: we must continue to lay the foundations for truly universally accessible healthcare as we build the country we all want."

The UHC Policy Dialogue was closed with some remarks by the Deputy Minister of Health, Dr Dhlomo, MP. He thanked all the attendees for making the time to participate in the Policy Dialogue. He emphasised that the various speakers, presentations and panel discussions had provided important information. Looking at the various sessions, the Policy Dialogue had the opportunity to learn from experiences other countries and how they have implemented reforms of achieving UHC and what practical lessons can be drawn from those experiences to inform our journey to achieve UHC. The lessons have been both positive (e.g. Cuba's bottom-up approach) and negative – how to make sure South Africa addresses its health system challenges urgently before they become too complex and unmanageable.

The 2022 UHC Day commemoration had come at a time when Parliament was making meaningful progress on the finalisation of the NHI Bill. This is because in South Africa, UHC is aligned to the values of justice, fairness and social solidarity. In line with the National Development Plan Vision 2030, South Africa aims to achieve UHC through the phased implementation of the NHI. This is going to ensure that no one is left behind, and that all South Africans can live a long and healthy life.

According to WHO, at least half the world's population is not covered by essential services. South Africa, like many countries globally, has come through a trying time with regards to dealing and learning from the consequences of the COVID-19 pandemic. The pandemic has showed us that health systems cannot continue with business as usual. The most important is that no one should be left behind. The importance of digital health research, innovation and accelerators of UHC was emphasised by the panellists, including issues of governance in the health system.

Stakeholders must continue to critically think about what has been shared at the UHC Policy Dialogue, and to focus on identifying practical solutions that will allow South Africa to proactively move towards realising UHC through the implementation of the NHI. The journey towards UHC must remain a collective effort to achieve UHC for all our people.

To access the UHC Policy Dialogue programme, speaker bios, presentations and photos, please click on the following link:

https://drive.google.com/drive/folders/1QB4oCqCmZIG44xJrWvfwi0WbJU7fMKb2?usp=sharing

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National Department of Health

Switchboard: 012 395 8000

Physical address: Dr AB Xuma Building,
1112 Voortrekker Rd,
Pretoria Townlands 351-JR,
PRETORIA, 0187