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LESSONS FOR SOUTH AFRICA ON TRANSITIONING TO UNIVERSAL HEALTH COVERAGE FROM THE GERMAN EXPERIENCE

Summary of themes from a Roundtable discussion hosted in Cape Town, South Africa

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FRIEDRICH EBERT STIFTUNG
South Africa Office

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All records and findings included in this report, stem from the discussions that took place at the roundtable dialogue and technical meetings arranged to consider lessons for South Africa on transitioning to universal health coverage from the German experience. The meetings took place in Cape Town on the 19 th and 20 th of February 2020.

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DISCLAIMER

Views expressed in this report do not necessarily represent the views of the Inclusive Society Institute or those of their respective Board or Council members.

In support of efforts aimed at influencing the national policy discourse in South Africa, the Inclusive Society Institute hosted these roundtable and technical discussions in order to consider what lessons South Africa could draw on from the German universal healthcare experience. These deliberations form part of the institute's broader and ongoing research into pathways to universal healthcare in South Africa.

CONTENT

FOREWORD BY PROF ZWELI NDEVU

The Inclusive Society Institute (ISI) is an autonomous and independent institution that functions independently from any other entity. It is founded for the purpose of supporting and further deepening multi-party democracy, inter alia, by strengthening the public policy discourse.

The ISI's work is motivated by its desire to achieve non-racialism, non-sexism, social justice and cohesion, economic development and equality in South Africa, through a value system that embodies the social and national democratic principles associated with a developmental state.

One such issue, that is currently high on the national public policy agenda in South Africa, is the proposed National Health Insurance (NHI). Enabling legislation has already been tabled in parliament and the formal public hearing processes have commenced.

The ISI has resolved to make a meaningful contribution to the process. It has accordingly commissioned a study which aims to find a consensus position that will overcome the current somewhat polarised public discourse. This it will do by fostering ongoing dialogue on the NHI, and by doing in-depth research that will provide alternative pathways to universal healthcare. In its dialogue sessions the ISI aims to take the conversation out of the formal corners of parliament and government. It hopes to create a dynamic platform where this important issue can be discussed inclusively by involving all stakeholders. That is why it the presence of the Parliamentary Portfolio Committee on Health and the Chairperson of the ANC's NHI task team is so important, as they are an integral part of the conversation. Their participation is necessary to secure the compromise required to achieve the desired consensus. This will require open, frank and fearless deliberation from both sides of the aisle in order to underpin policy integrity.

As an institute we are particularly honoured to in this component of the ongoing study to have experts on the German healthcare system contribute: the former Minister of Health, Hon. Ulla Schmidt, who oversaw its implementation in Germany and Franz Knieps, a respected technical expert who has vast experience on the practical implementation of the system. The intention is to potentially draw lessons that can assist South Africa in its own conceptual wrestling.

The ISI trusts that this dialogue has been useful to achieve the middle ground necessary for finding consensus towards a universal healthcare system that works for all.

ACRONYMS AND ABBREVIATIONS

Acronym/abbreviation	Full term
DRGs	Diagnostic-related groupers
NHI	National Health Insurance
PHC	Primary Health Care
REF	Risk Equalisation Fund
UHC	Universal Health Coverage

DARYL SWANEPOEL | CHIEF EXECUTIVE OFFICER OF THE INCLUSIVE SOCIETY INSTITUTE

INTRODUCTION

The Inclusive Society Institute hosted a Roundtable Discussion on Pathways to Achieving Universal Healthcare in South Africa, specifically focusing on lessons from the German healthcare system on the evening Wednesday, 19 February 2020 at the Taj Hotel in Cape Town.

Hon Ursula Schmidt, the former German Minister of Health (2001-2009) and Mr Franz Knieps, the equivalent of the director-general of health (head of department) during Hon Schmidt's period as Minister of Health shared their experiences of health financing reform relevant for South Africa. The evening was attended by various stakeholders from the South African government and the political sector, including members of the Parliamentary Health Portfolio Committee, as well as funders and providers of healthcare. After having shared their experiences, a number of questions were posed by stakeholders to Hon Schmidt and Mr Knieps and insights from the German experience shared in response to the questions.

The roundtable on the 19th of February was followed by a smaller gathering on the morning of the 20th of February hosted at the offices of the Inclusive Society Institute in Cape Town. The gathering on the 20th was aimed at more intimate conversation and dialogue amongst Mr Knieps and a smaller group of representatives from the political, academic and private sectors. The more intimate nature of the meeting allowed for more questions on lessons from the German experience for South African and an interactive and focused dialogue process.

The main purpose of both the roundtable and the smaller follow-up meeting was to provide an opportunity to learn from the experiences of the German health financing system which has been built on principles of social democracy and solidarity. These learnings hold particular value and relevance for South Africa, given the current public engagement and parliamentary processes associated with the draft National Health Insurance (NHI) Bill (2019).

The primary focus of the Inclusive Society Institute is to work on and promote a more inclusive society. The focus aligned with the dialogue around the table on the 19th and at the smaller meeting on the 20th.

There is much noise being made in South Africa's national discourse about various present-day issues, much of which is not constructive. The Institute has been established to create a platform where this discord can be presented and discussed, to find some middle ground in dealing with the pressing issues the country faces.

THE CURRENT GERMAN HEALTH FINANCING SYSTEM

In this section we provide brief context on the way the German health financing system functions in 2020. This provides background to the themes discussed in the remainder of the report that emerged from both the roundtable discussions and the smaller workshop discussion.

In Germany, citizens have complete comprehensive health insurance coverage through multiple competing funds. This is provided through both public and private systems. On the one hand there is government-provided statutory health insurance offered by 108 **competing, not-for-profit sickness funds,** and on the other hand **substitutive private health insurance** for those who choose to purchase their insurance privately, or who are interested in buying supplementary insurance to their government insurance (Busse, Blümel, Knieps. & Bärnighausen, 2017). The private insurance is provided by 42 private health insurance funds, half of them non-profit, with the biggest ones being not-for-profit.

Approximately 87% of the population have primary cover through the statutory health insurance funds, while 10-11% hold substitutive private health insurance, i.e. choose to have only private health insurance cover (Busse, Blümel, Knieps. & Bärnighausen, 2017). The remainder of the population, e.g. soldiers and refugees, obtain their health insurance cover through special governmental schemes and payments.

All German citizens who are employed, as well as more vulnerable groups such as pensioners and people who earn less than the opt-out threshold (€57 600 per year in 2017) are required to have mandatory statutory health insurance (Busse, Blümel, Knieps. & Bärnighausen, 2017). Their non-earning dependents are provided with cover free of charge. People who earn incomes greater than the threshold as well as those who are self-employed can keep statutory health insurance on a voluntary basis or are allowed to pay for substitutive private health insurance, i.e. private health insurance that provides the same type of cover as the government health insurance.

Sickness funds contributions are collected through payroll taxes and a small additional payment. Statutory health insurance is paid for through a contribution of about 14.7% of the income of wage earners (Busse, Blümel, Knieps. & Bärnighausen, 2017). The contribution is equally split between employers and employees. All contributions flow into the Central Allocation Pool

(Gesundheidsfonds) or Central Fund and is subsidised with a relatively modest amount from central taxes (Busse, Blümel, Knieps. & Bärnighausen, 2017). The funds pooled through the Central Fund are redirected to the 108 individual sickness funds according to the risk profiles of each fund using a morbidity-based risk-adjustment scheme. Each fund is allowed to charge an additional contribution fee directly to its members to cover total expenditure (there may be remaining expenditure not covered by the Central Allocation Pool payment). These contributions typically equate to an average of 1.1% of wages, meaning total contributions (cost) tend to be around 16% of wages (Busse, Blümel, Knieps. & Bärnighausen, 2017). In addition to sickness fund contributions, long-term care insurance (to pay for nursing care for the elderly or the very sick) is separately insured but organised by the health insurance system. It requires a contribution of about 1.7% of wages (Busse, Blümel, Knieps. & Bärnighausen, 2017).

A generous package is available to all who contribute and are covered. In return for these contributions, members of the sickness funds receive a generous package service, which includes services ranging from **outpatient services** provided by family doctors, dentists, psychotherapists and specialists, **hospital care**, to **prevention, health promotion, and rehabilitation**. It's really an all-over coverage and it includes all essential medication, aids and appliances such as prostheses, wheelchairs and physiotherapy; members get what they need. While out-patient services are totally free, a small co-payment is required for hospitalisation.

The health sector is valued, and Germans are proud of it. German citizens willingly make their contributions to the health financing part of the system and highly value the care they receive from the system. Even the CEOs of very large companies are members of statutory sickness funds and talk about their membership publicly.

LESSONS FOR SOUTH AFRICA FROM GERMANY

Below we describe the key themes for South Africa's transition to universal health coverage (UHC) that emerged from both the roundtable and follow up-discussion. For each theme, the German experience is briefly described, and it is then related back to the South African context and lessons for South Africa are highlighted. The themes are positioned as they were shared by the German experts.

Building on what you have

The start of the German health insurance system is often traced back to Bismark's Health Insurance Act which came into life in 1883. It's acknowledged that since 1883 it took about 125 years up to 2007-2011, the period when Hon Schmidt was the Minister of Health, to achieve mandatory universal health insurance coverage in Germany (Busse, Blümel, Knieps. & Bärnighausen, 2017). The system is still in flux and slowly improving over time, so much so that a 2017 Lancet article which reviewed the German health system made it clear that it took 135 years (up to 2017) to achieve a system built on the **principles of solidarity, self-governance and competition** (Busse, Blümel, Knieps. & Bärnighausen, 2017). More details on these principles are provided in later themes.

This is a reminder that no system emerges fully formed. On the contrary, this complex system has evolved by step by step, always building on structures that were already in place. In a certain sense, the German health insurance system actually existed for more than 800 years, from the very first time that people first started to make provision for health events informally to when Bismarck started to incorporate these early structures into the first pillars of a unified system.

The German experience shows that a well-functioning healthcare system does not come about through big-bang reform. While in public discourse it may be positioned as requiring large-scale reorganisation, in reality systems evolve step by step, ideally building on foundations that are already in place. Existing structures should not be dismantled before new ones have been built: the equivalent of the medical principle of "first do no harm". Goals have to be set in such a way that they are attainable and in line with a country's financial and organisational targets. While countries need the courage to make change happen, they should not underestimate the pushback that will come from those who are currently in a privileged position, and who are benefitting from the status quo.

In South Africa's own history of health system reform, we deviated from a reform pathway that built on existing medical scheme infrastructure to a single-fund strategy in 2007 (shifting from so-called social health insurance to national health insurance).

Arguably, the policy formation process since 2007 has been slowed down by the big-bang nature of the proposed reforms and the resultant conflict.

Similar to Germany, South Africa will need to be open to working with the components of the health system we have, but also be open and willing to course-correct if the old route is proving to be not practical.

Embracing social solidarity

In addition to the long history of reform and building of a health financing structure, Germany has a history of cementing social solidary principles into its health financing system. The first insurance schemes developed around worker schemes in the mining industry and, since then, there has been a history of workers and employers sharing the risks related to health expenses.

Social solidarity within the German statutory system means that health service provision is determined solely by the individuals' need, and not the income, stature, social or professional position, age, background or other characteristics of individuals.

Similar to the German statutory sickness fund environment, deep social solidarity principles have already been built into the South African medical scheme system through open-enrolment (cover cannot be denied), community-rating (everyone pays the same price regardless of their demographic, clinical or risk characteristics) and guaranteed minimum benefits.

The German health financing system uses a risk equalisation fund (REF) to share member risk between the 108 sickness funds. This approach ensures an equitable distribution of contributions between those who do not need it and those who do (a risk cross-subsidy). It serves to ensure that the sickness funds serving a high proportion of elderly and people with health conditions receive more money than sickness funds with younger or healthier people, i.e. ensuring that money is distributed according to need. This effectively creates a single risk pool even though there are multiple funds.

During the mid-2000s, South Africa embarked of the design of and preparation for a REF. Medical schemes went through the process of designing a formula, setting up the data collection systems and then never actually implementing the scheme. It is one of the recommendations of the Health Market Inquiry that the medical schemes sector revitalise the REF process and implement it in order to stabilise the finances of struggling schemes and to ensure competition between schemes on the basis of their ability to purchase healthcare and not on the basis of risk profile (Competition Commission, 2019).

Start moving towards universal health coverage even when it is hard

The final stages of moving towards compulsory universal health coverage for all German citizens were undertaken during a difficult financial period (2007-2011). Changes were made during an economic crisis (the 2007/8 financial crisis), a period of high unemployment (within a developed country context) and relatively small budgets. In order to build support during this period, it meant the system had to work hard to convince people of the necessity of a comprehensive, universal UHC system: "you should show the people how much money you invest per capita, how much do you invest for homeless people, for a man with no job, or a woman with no job, for the children...".

Similar to Germany, South Africa is currently in the midst of a difficult economic situation: recessionary conditions, growing unemployment, currency weakness, a junk-status credit rating and now also the very negative impcact of Covid-19 (the coronavirus) on the economy. This does not, however, mean that we should not start to experiment with the health system reform that is

necessary to move towards UHC. Rather, it means that **citizens and stakeholders should be taken along** in the process and **value demonstrated** at every step.

Competition, consumer choice and bottom-up accountability

Consumer choice and competition through multiple funds. The Germany system provides access to public insurance cover through 108 statutory sickness funds. German citizens have a choice about which sickness fund they want to belong to. These funds report to both local structures and authorities, as well as to national level structures. There is a 300-year history of local sickness funds in Germany and their current existence is partly ascribable to the role they have been playing in addressing local health needs throughout this long period. All these funds have boards that are representative of local stakeholders and participants and provide a clear way for paying attention to local-level needs. The funds are also obligated to have representation from patient organisations and, in turn, to participate in patient organisations. This provides a good channel for patient voice and needs to be heard in the German health financing system – good linkages exist between local-level needs and centralised structures. The relationship between local level needs and centralized structures is explored in more detail in later theme in this report.

Choice between public and private insurance and providers. Furthermore, apart from the choice about which sickness fund to belong to, clients or consumers in the German system are provided with other choices. Those who earn sufficient income can choose to belong to private health insurance scheme rather than the public sickness funds.

The German health financing system is obligated to share information on quality with patients in a clear and accountable way. This allow patients to choose and move between local PHC providers, creating an accountability feedback loop. Quality data and ratings of hospitals are also shared, and patients can make their choices based on this. Consumers are able to choose their local primary healthcare provider and move if they are not happy with the care provided. This create incentives for quality improvement over time.

The German approach to the institutionalisation of accountability to citizens in healthcare holds visible lessons for South Africa where many South Africans feel the state is not responsive to service provision needs. A much greater level of bottom-up accountability is needed than currently available in the health system.

Cover as many as possible and make the public insurer the insurer of choice

Germany followed a gradual process of requiring compulsory coverage of statutory sickness funds (the public system) for certain groups. In the period 2008-2011 when Hon Schmidt was the Minister of Health in Germany, comprehensive compulsory health insurance cover for everyone in Germany was finally achieved.

The incentives that have been put in place around the public vs. private insurance choice support choice for the public system in that it uses a community-rating system rather than the risk rating system used by private health insurers. As a result, mobility between statutory and private funds is limited to protect the statutory funds – once you are 55 or older and become a higher health risk due to age you are not allowed to opt back into statutory insurance funds. This is used as a way of encouraging people to belong to statutory sickness funds rather than private insurance schemes at younger ages and contribute when their health need is not as high yet. This assists in ensuring the financial sustainability of statutory sickness funds. There is, however, government financial support available for individuals older than 55 who can no longer afford private insurance premiums. This is provided once these individuals have gone through an application process to show that they are unable to afford private insurer premiums.

Sickness funds only offer services on an in-kind basis while private health insurers require up-front payment and claims from members for reimbursement. Certain services are also excluded from private insurance, e.g. family care, health prevention and maternity benefits, creating a strong incentive to be a member of a sickness fund rather than private insurer. This is reflected in the low and declining proportion of people covered by private insurers rather than sickness funds.

Transparency and independence

Transparency exists at multiple levels and in different ways in the German health financing system, from the way payments are collected to how decisions are made about service provision, the allocation of resources, and tariff determination.

Funding contributions

The system is funded from the insured's own contributions which are collected separately from tax. This ensures transparency in payment because contributors' payments are clearly visible to them. The same approach holds for the elderly in terms of contributions to long-term care insurance. Because health insurance funds are separately collected and managed from the national budget and taxes, it means that it is a very visible component of people's expenditure. Whilst payroll taxes do have some disadvantages in terms of rigidity, the German view is that the German people place a high value on their benefits because **the cost is made visible.** It also acts an **accountability mechanism** for the system.

In Germany people do not view public funds as being owned by the State once they have been paid over. Public entities such as the sickness funds have their own, independent boards and **the money is viewed as belonging to the people,** not the State.

Service coverage decisions

The range of services provided through the German health financing system is not determined by the legislature or the Minister but is set by the Joint Committee. The Joint Committee is made up of representatives of the Central Fund, physicians, dentists, hospitals and patients. It is a good example of the system of self-government that is typical in German service provision where the State provides the framework but **various stakeholders and the citizenry take responsibility for decision-making** and the way services are provided. It is said that the most powerful person in the German health system is not the Minister of Health but the neutral chair of the Joint Committee. His or her vote is the final vote in tie-breaker votes.

The Joint Committee determines the range of services paid for funds pooled via the Central Fund through health technology assessments, i.e. sets the basic benefit package. It uses evidence-based economic evaluations of health products and services that are conducted by a special, independent Institute for quality, efficacy and efficiency in the healthcare system. The Institute for Quality and Efficiency in Health Care is staffed by about a 150 people, including academic staff, epidemiologists, doctors, mathematicians, and so on. These staff provide evidence used by the Joint Committee in its decision-making and are also able to advise the Joint Committee. The Institute is a neutral, technical body. It has been set up to be totally independent from both the private sector, healthcare providers and the German government.

The Joint Committee can follow the guidance provided by the Institute. However, if it wants to deviate from the recommendations of the Institute it is required to make it clear in publicly accessible reports why it is choosing to do so. While the Joint Committee sets the agenda and programme of the Institute, the Institute is totally autonomous and independent from the Joint Committee. The Institute is required to follow the rules of good clinical practice and have to show, if they get advice from researchers, that there are no conflicts of interest.

Quality of the system

The German health financing system is obligated to share information on quality with patients in a clear and accountable way. This allows patients to choose and move between local primary healthcare (PHC) providers, creating an accountability feedback loop. Quality data and ratings of hospitals are also shared, and patients can make their choices based on this. Consumers are able to choose their local primary healthcare provider, typically a GP, and move if they are not happy with the care provided. This create incentives for quality improvement over time.

South Africa does not currently have a quality reporting and monitoring system that applies to both the public and private sectors. Health facilities, both primary facilities and hospitals, are subject to infrastructure and service standards.

Tariff determination

The tariffs or payment levels for both hospitals and outpatient providers are set by two committees independent of the Joint Committee and of the German government. There is a special committee on financing for the hospital sector, new therapies and new medical devices which is responsible for the calculation of diagnostic-related groupers (DRGs) for the payment of hospitals. A second, similar committee is responsible for tariff determination for the outpatient care sector. The members of the committees are elected by the sickness funds and health providers and are fully independent from the German government. The state or government, in this instance, is only responsible to ensure that the committees and the Joint Committee follow regulations but they are allowed to function independently in their representation and decision-making from government.

In conclusion, while the purchaser provider split between the Central Pool and the 108 sickness funds creates the tension necessary for competition, proper **oversight happens because of transparency** built into the system at various levels.

Centralisation vs. decentralisation: ensuring purchasing power while being locally responsive

A big question facing South Africa as we embark on a UHC reform path is how you harness the benefits of centralised purchasing power while ensuring responsiveness to local needs. The German REF plays a strong role in ensuring risk sharing at a national level between the 108 sickness funds. While the funds that are available in 16 different German states allow for local needs to be voiced and directly addressed, much of the overall approach to the purchasing function still occurs at a national level: the benefit package is set by the Joint Committee at a national level, tariff determination take place in two national level committees and all collective bargaining processes also take place at a national level.

To make the German system work, compromises often have to be made between the state and federal level. If a sickness fund only operates in one state, it tends to be accountable mostly at state level. However, as soon as a sickness fund operates in three or more states, accountability for the fund is situated at a central level. Responsibilities for preventative care are divided between the state and federal levels. Complications during this process often arise but are resolved through conversation between different stakeholders.

Need for a lean, efficient and technical bureaucracy to support UHC

A critical learning from the German health financing system has been to keep the bureaucracy that supports the financing system as lean, efficient and technical as possible. The Central Fund is a system of algorithms managed by a small group of staff at the

national insurance office. It is mainly staffed by data scientists who are able to derive and implement these algorithms.
The total administration costs of the financing system are estimated to be about 10% - with half of it residing at the level of individual sickness funds and the other half with different entities (like the Central Pool) in the system. Overall administration costs had to be kept as low as possible to keep the system palatable to German citizens.

Retain the flexibility provided by multiple reimbursement approaches

Although Germany recognised it was important to implement alternative reimbursement like capitation for hospital services to avoid the over-servicing which is associated with a fee-for-service approach, it decided to also retain fee-for-service reimbursement in certain instances.

The payment system for outpatient doctors in Germany is complicated. It is typically a mix of fee-for-service and budget limits. If outpatient doctors exceed their fee-for-service budget limits, then the fees they are paid per visit reduces. This approach has worked quite well in keeping overall outpatient costs low.

A fee for service approach is also used in cases where the health system wants to encourage more provision, e.g. services that are typically under-provided such as family visits by GPs or new, innovative services that the system wants to incentive the provision of.

Moving towards a transition period for UHC

In thinking about how South Africa will manage the process of moving towards UHC, there are at least two difficult questions. Firstly, how will we manage the trade-offs between quality and access? Secondly, how can we take both the public AND private sectors along on this journey to achieve a unified health system for all? The Germany experience offers some learnings.

Preserving and expanding access while improving quality

The process of quality improvement holds an inherent tension – how can we maintain access to existing health services when it is possible that some may not meet the minimum standards we associate with quality? How do we get facilities not meeting basic requirements to improve over time?

The measuring and monitoring of quality essential. Quality improvement in the German health system has a long history. In the1990s when the German health system was compared to other high-income and European health systems it was ranked in only the 22nd place. Health providers and policymakers started to investigate the reasons for this low ranking. It was found that the system fared poorly at providing chronic care, maternity care, and emergency care. The hospitals reacted and created a hospital quality monitoring entity Federal Office for Quality Assurance (Bundesgeschäftsstelle für Qualitätssicherung (BQS)) (Busse and Blümel, 2014). First, only the public hospitals were required to report to the entity. Later on private hospitals were required (by law) to participate. The quality monitoring function was eventually taken over by the AQUA Institute in 2009 (Busse and Blümel, 2014). This Institute is separate from the Institute for Quality and Efficiency in Healthcare and was selected through a European-wide procurement process (Busse and Blümel, 2014).

But facilities that under-perform are supported to retain access and allow for quality improvement over time. In German hospital facilities not meeting basic requirements given were given a period of two to three years to improve. If a hospital achieved a first bad report in the quality assessment process, the report was sent to the Institute and then provided with a

chance to improve without the results of the report being made public yet. During this improvement process, site visits were not done by an external agency but occurred in the form of peer inspections. Struggling hospitals were provided with peer support (colleagues from other facilities) to assist with their improvement process and were found to be quite responsive to this process of peer support.

In the more rural areas in Germany that have very little competition between hospitals, additional funds are provided to hospitals to improve their facilities and quality, i.e. these facilities are financially supported to improve over time. However, patients are also provided with funds for travel and accommodation to access care at higher quality hospitals in other areas.

Including private hospitals in care delivery. Hospital financing in Germany is organised on the state level. About 40% of hospitals in Germany are owned by community organisations, while 45% are owned by churches.

The latter group is considered as being privately owned. The states produce infrastructure and investment plans which cover the buildings and physical infrastructure of hospitals. The plans includes nearly every hospital in Germany, irrespective of the nature of ownership of hospitals.

As part of the process of preserving access, private hospitals in Germany also had to be retained in the system as healthcare providers to sickness fund members. A transition period for moving to more similar funding approaches for the infrastructure of private and public hospitals was required, given that private hospitals are built with investors' funds who require a return on investment. After the initial transition period, the German state-level governments now cover infrastructure funding for all hospitals and private hospitals. Private hospitals are required to take responsibility for only the operational costs. However, while the government provides infrastructure funding for private hospitals the funding if frequently less than the real capital needs of private hospitals. This results in some investment costs being covered from the DRG payment system, meaning there is pressure on the rationalization of DRGs. The allocation of capital costs is typically a very political issue and it would be important for South Africa to depoliticize this process.

Taking stakeholders along on the UHC reform journey

Apart from the changes that are anticipated for NHI, the South African private sector and system as a whole needs to undergo certain payment and quality reforms that have been recommended in the Health Market Inquiry's final report. In Germany, it was found that a medium-term process of working intensely with important stakeholder groups supported a transition process. An independent research group worked closely for a period of three years with key health system stakeholders to arrive at consensus outcomes and ideas on the changes required. Six books were published from this engagement. It meant the perspectives of all stakeholders were captured and shared in a public way. Furthermore, the Joint Committee essentially also consists of critical stakeholders, including sickness fund representatives, and they are involved in critical funding decisions for the system as a whole.

German citizens also had to be taken along on the reform process. Success was achieved when they were able to show citizens that they would not be increasing bureaucracy and administration costs extensively and were offering value. It also had to be made clear to higher income citizens that system reform was not aimed at punishing them (the option of private health insurance was not taken away) but rather at creating a more equitable system for all.

How can South Africa prepare for prepare for a transition period?

The Health Market Inquiry (Competition Commission, 2019) made a number of recommendations that can already be implemented now that supports reform in the health system and will allow it to move towards a more unified, value-oriented health system.

Primary healthcare teams in both the public and private sectors. The report found that stand-alone single practices or disciplines characterise the South African private health sector (Competition Commission, 2019).

Unlike the public sector, multidisciplinary healthcare teams are not a feature of the private system. This limits efficient referral pathways and a more value-based approach to the delivery of care. It was recommended that the rules that currently prohibit the use of teams in the private sector be amended Competition Commission, 2019). This is something that can be done already now in the very early stages of planning to transition to a unified health system for South Africa.

A quality monitoring and reporting system for the health system as a whole. The Inquiry (Competition Commission, 2019) found that there is no standardised approach to measure and report on quality in the various private sector provider markets (GPs and hospitals). There is also no one approach between the two sectors. It was therefore recommended that an Outcomes Monitoring and Reporting Organisation be established for providers, patients and all health stakeholders to collect and report on health quality and outcomes data. Even before the next steps of transitioning to NHI, it is possible to implement this recommendation given the importance of such an entity in helping to empower consumers and promote transparency.

Consider stabilising the existing medical schemes environment through a REF. It was recommended that the finances of medical schemes be stabilised through the implementation of a REF and that all medical schemes (open and closed) should belong to the REF (Competition Commission, 2019). This can already be implemented now even before the full transition to UHC in preparing for setting up a centralized risk sharing mechanism.

FINDING A WAY FORWARD FOR SOUTH AFRICA'S NHI BILL

A number of uncertainties and concerns about the NHI Bill in its current form were identified in an earlier report of the Inclusive Society Institute (Inclusive Society Institute, 2020). In the table below these concerns have been set out. Each concern has been paired with possible alternative approaches offered by the German experience.

Concerns raised with NHI Bill (2019)	Alternative approach(es) offered by German experience
The benefits package that will be provided through NHI has to be clearly defined and in an expert manner.	Expert engagement is required on the design of a basic benefit package. Although the Joint Committee makes the final decision on the addition of a new service or product, all decisions are informed by costing and cost-effectiveness studies by the Institute for Quality and Efficiency. Any deviations from the recommendations of the Institute must be explained in a publicly accessible manner.
The role of medical schemes (Section 33) and the definition of complementary cover needs to be clearly articulated. Section 33 currently limits the role of medical schemes to complementary cover only.	Private health insurers provide both substitutive, i.e. competing with statutory/public insurers and supplementary cover, i.e. there exists a dual coverage system. The rules around statutory insurance have been designed in such a way as to ensure that people are incentivized to rather use statutory insurance than private insurance. Furthermore, statutory sickness funds compete with private insurers based on value to clients. This has meant a gradual decrease in the percentage of the population using private insurance over time.
All providers and funders of the various healthcare services need to be included in future discussions around NHI in order to establish the necessary buy-in and optimal solutions.	The Joint Committee that is the main decision-making body in terms of statutory sickness funds and the public insurance system in Germany includes representatives of all the important stakeholder groups. Germany also followed a comprehensive stakeholder engagement process in building up to final compulsory UHC for all citizens. This process culminated in the publication of three books reflecting stakeholder views.

Funding mechanisms for NHI according to the Bill, include tax revenue, reallocation of funding from medical scheme tax credits, payroll tax and a surcharge on personal income tax. Not all of these options are possible within the current economic constraints facing South Africa. The funding mechanisms that will be used for NHI, post determining the benefits to be provided and the costs of this provision, need greater clarity.	Although it is important to take the first and necessary steps to establishing UHC even when you can't afford it, a gradual process of working with what you have has to be followed. The German health financing system relies on equal payroll contributions from employers and employees. Contributions are not funded from general taxes because of the commitment to ensure that the insurance payment is visible and transparent to the payer at all stages of its use.
The process of imposing a State system while restricting the operations of the private system could be unconstitutional. There is also no global precedent for it. The risk mitigation strategies that are going to be implemented to ensure NHI is sustainable in the long term needs to be clearly communicated.	The Germany experience shows that you should not do away with the system you have until a new alternative system has been constructed. A risk equalization mechanism is used between all sickness funds. This ensures health risks linked to demography, age and other indicators of health need, are equally shared between funds – effectively creating a single risk pool.
The desire to get NHI implemented as soon as possible needs to be balanced with a genuine desire to ensure future credibility and sustainability of the system. The process should therefore not be unduly rushed.	The German system has taken many, many years to implement. If Bismark's Health Insurance Act is taken as the starting point, it took more than 130 years to achieve full UHC. Pragmatic steps were taken throughout, and the system changed within the means available to it. The system set realistic goals that were attainable and in line with financial and organisational targets.
The NHI Bill currently excludes refugees and non-citizens. This presents a Constitutional concern. The Constitution states that every person living in South Africa – including SA citizens, permanent residents, refugees, inmates and designated foreign nationals – is protected and must have access to healthcare.	The German health financing system provides some type of coverage to all inhabitants of Germany. While refugees are not covered by the health insurance system, the German government pays for access to acute (emergency) care for refugees and they are supported in different ways by different states and municipalities in terms of access to outpatient care (Göpffarth & Bauhoff, 2015).

TOP and LEFT: Dr Gwen Ramakgopa, Head of ANC Task Team on the National Health Insureance; and Dr Sibongiseni Maxwell Dhlomo, Chairperson of the Parliamentary Portfolio Committee on Health.

CONCLUSION

While the German experience holds insights for South Africa on many technical aspects and this will be continued to be explored in future work, many of the lessons on "softer" issues hold relevance. Germany's journey to UHC has taken many years. Depending on when it is viewed as starting, it has taken anything from 800 to more than 130 years. During this process, realism and pragmatism but also boldness and vision were required. The Germany experience shows that one the one hand there is no big-bang change that will make UHC happen. On the other hand, first and often very hard steps are required. Inherent in the tension between these two poles is the necessity of trust between stakeholders and recognition that the system needs to build on what it currently has in hand and maintain stability during the transition process. Inclusivity featured strongly in the German journey – stakeholder across the system are represented on the Joint Committee and were worked with intensely, especially during the final stages of moving to full, compulsory UHC. There will be no easy road for South Africa to UHC but first steps and actions are required and it necessary that we trust each other on the journey ahead.

The German commitment to bottom-up accountability aligns closely with South Africa's approach to a participatory democracy and would help to offset the concerns associated with attempts to manage governance and accountability from a top-down perspective.

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