

Authors:

Di McIntyreⁱ

Alex van den Heeverⁱⁱ

Social or National Health Insurance

Abstract

There has been an ongoing debate for almost two decades about the possibility of introducing some form of social or national health insurance in South Africa. Despite a range of policy proposals being put forward to pursue this option for financing health care services, no real progress has been made in achieving policy agreement or in getting close to implementing a mandatory health insurance system. One possible contributory factor for this lack of progress is that mandatory health insurance is perceived to be a complex reform and the use of complicated terminology in debates has limited the degree of constructive engagement between key stakeholders and the extent to which consensus could be achieved. For this reason, the objective of this chapter is to clarify some of the key health insurance concepts and to demystify the mandatory health insurance debates.

The chapter summarises the South African debates about mandatory health insurance. In particular, areas of agreement and key areas of difference of opinion in these debates are highlighted. This review also highlights that there is considerable consistency in the core objectives of the mandatory health insurance proposals that have been advanced over the years, namely that it is a mechanism for addressing key problems facing private health insurance and for dealing with the massive public-private health sector mix disparities in South Africa. These health system problems have become even more acute in recent years, which make the need to reach some agreement on mandatory health insurance and to pursue its implementation even more urgent.

i Health Economics Unit, University of Cape Town

ii Council for Medical Schemes

Introduction

There has long been considerable discussion and sometimes very heated debates about changing the financing of health care services in South Africa. As far back as 1944, the Gluckman Commission proposed a fully tax funded National Health Service (NHS) to more adequately meet the needs of all South Africans.¹ Key to the Gluckman Commission proposals was the establishment of a network of primary health care (PHC) centres. Although other countries, notably the United Kingdom and Sri Lanka, adopted a tax-funded NHS with health care free at the point of service in the 1940s, the Gluckman Commission proposals were never taken forward.

There was limited debate about restructuring the South African health system for about four decades, until the possibility of implementing a NHS in South Africa was once again raised in the mid-1980s. This debate arose partly in response to government support for increasing privatisation of health services.² On the one hand, the government was encouraging the expansion of private sector health care provision and wished to reduce its expenditure on health services by placing the burden on private sources of health care finance.^{2,3} The converse position was adopted by a number of academics and by the progressive National Medical and Dental Association who called for a NHS.^{4,5,6,7} While the NHS proposal focused primarily on achieving a unitary, 'nationalised' system in terms of health service provision, some NHS proponents favoured moving towards funding health services entirely from general tax revenue.^{5,6}

By the beginning of the 1990s, an alternative mechanism for restructuring health services in South Africa had been suggested, namely some form of National or Social Health Insurance.⁸ A range of proposals for a mandatory health insurance system in South Africa have been put forward over the last decade and a half, but none have been implemented.

It is an opportune time to review these health insurance debates. From an international perspective, there has been a dramatic change in the 'conventional wisdom' about health care financing mechanisms. In the 1980s and 1990s, considerable attention was devoted by influential international organisations (such as the World Bank and International Monetary Fund) to cost-recovery or cost-sharing by users of public sector facilities, primarily through direct out-of-pocket payments or user fees.⁹ Stimulating the growth of private health care providers and out-of-pocket payments

to these providers were also encouraged.¹⁰ However, in the first part of the 21st Century, there has been growing consensus that pre-payment health care financing mechanisms, where people contribute regularly by way of tax payments and / or health insurance contributions from which the cost of future health care requirements are funded, provide greater financial protection for households and are a preferable approach to health care financing.^{11,12,13} This growing support for pre-payment mechanisms culminated in a resolution at the 2005 World Health Assembly on "Sustainable health financing, universal coverage and social health insurance".¹⁴

From the South African perspective, the timing of this review is opportune given that practical steps for moving ahead with a "mandatory contributory earnings-related savings and benefits" social security system were announced by the National Treasury earlier this year.¹⁵ Since this announcement, there has been growing pressure for mandatory health insurance to be included in the development of a comprehensive social security system, as was envisaged by the Taylor Committee of Inquiry.¹⁶

This review begins with a brief discussion of key terms and concepts relating to health insurance. It then explores the motivations for pursuing mandatory health insurance in South Africa and provides a brief overview of the various mandatory health insurance proposals put forward over the past decade and a half. Finally, there is a critical review of current discussions and the presentation of ideas on a possible way forward.

Key health insurance concepts

Health care costs are unpredictable; it is difficult for individuals to know when they will fall ill, what health care they will require and what this health care will cost. Sometimes the cost of care can be very high, particularly for hospitalisation or long-term serious illness such as cancer or AIDS and most people are unable to cover these unexpected costs drawing on resources that they have available at one point in time. While it is difficult to predict health care needs and costs for an individual, it is more feasible to predict these for a group of people drawing on epidemiological and actuarial data. This is the core of the concept of health insurance, that it is a way of pooling risks. Individuals contribute on a regular basis to a pooled fund so that when they fall ill, the pool will cover

their costs. Essentially, at any one point in time, the healthy members of the pool are helping to pay for the health care costs of those who are ill; those who are healthy and those who are ill will change over time. The risk of falling ill and incurring unexpected and high health care costs is shared between those in the pool. There is also a time element to risk-pooling in that individuals draw on contributions that they made when healthy to pay for health care costs when ill. While risk-pooling can also be accomplished very effectively through tax funding, health insurance comes into play if tax funding will not cover the health service requirements of the whole population.

There are several different types of health insurance. Mandatory health insurance is a term used to describe insurance systems where there is a legal requirement for certain groups or the entire population to become members, while voluntary health insurance is used to describe systems where there is no such legal requirement.

Mandatory health insurance is often called Social Health Insurance (SHI), particularly where only certain groups are legally required to become members and where only those who make insurance contributions are entitled to benefit from, or are covered by, the insurance scheme. National Health Insurance (NHI) is also a term that is frequently used, especially with reference to a system that is universal, or covers the entire population irrespective of whether they have personally contributed to the scheme or not. As the terms social and national health insurance are often used interchangeably and sometimes create confusion, the more inclusive term mandatory insurance is used here.

A key characteristic of mandatory health insurance is that it is based on the principle of social solidarity. Contributions are 'community-rated', and are based on the average expected cost of health service use for the entire insured group instead of an individual's or sub-group's risk of illness. Contributions can also be differentiated by income level and sometimes the number of dependants covered. There may be a single fund or a number of funds; in the latter case, a standardised, Prescribed Minimum Benefit (PMB) package is usually specified in the enabling legislation and a mechanism is put in place for sharing or equalising risks between individual funds.

Objectives of mandatory health insurance in the South African context

Before considering the alternative mandatory health insurance proposals put forward in South Africa since the early 1990s, it is important to explore the reasons why this form of insurance has been considered as a potentially appropriate health care financing option. While different proponents of mandatory health insurance have put forward different motivations for, or objectives of this insurance at different times, the most consistently stated objectives have been to:

- ▶ address problems in the private voluntary health insurance (i.e. medical schemes) environment; and
- ▶ address problems in the public-private mix and promote social solidarity in health care funding.

Problems in the medical schemes environment

There are several well-recognised problems with voluntary health insurance. In particular, such insurance schemes are subject to what is termed adverse selection, whereby those with the greatest risk of illness are more likely than relatively healthy individuals to join an insurance scheme. This can increase the risk and overall cost of voluntary health insurance. Insurers in turn try to exclude the highest risk individuals (either through explicit exclusion of those with pre-existing conditions or through charging risk-rated contributions, i.e. an individual's contribution is related to their personal risk of falling ill, making insurance coverage unaffordable for the chronically ill and elderly) and to attract the healthiest individuals, a practice known as cream-skimming or cherry-picking. In this way, voluntary health insurance may exclude those who have the greatest need to insure themselves against unexpected and sometimes catastrophic health care expenditure. The Medical Schemes Act (Act 131 of 1998) and associated Regulations are designed to address such issues, as outlined in the Chapter on Medical Schemes. Nevertheless, some adverse selection and cream-skimming problems persist despite the existence of regulatory controls. Mandatory health insurance effectively deals with adverse selection as individuals who contribute are specified by legislation. It also deals with cream-skimming for the same reason, although if the mandatory insurance has a number of schemes as the financial intermediaries there may be

an element of cream-skimming which can be addressed through risk equalisation mechanisms.

As highlighted in the Chapter on Medical Schemes, one of the greatest problems is that of the uncontrolled cost spiral. This rapid cost spiral has been afflicting medical schemes in South Africa since the 1980s. For example, while medical scheme expenditure and hence contributions to medical schemes were equivalent to 7% of average salaries in 1982, they had increased to 15% of salaries by 1992.¹⁷ Medical scheme expenditure and contributions have been increasing considerably more than the general rate of inflation and average salary increases over this period and this trend has continued through the 1990s to the present time. While medicines and private hospitals were the greatest cost drivers in the 1980s and early 1990s, private hospitals, specialists and non-health care activities (such as administrative, managed care and broker activities) have been the major cost drivers in recent years.¹⁷

Another problem facing the private voluntary insurance sector in South Africa, which is related to the cost spiral, is the inability to extend insurance coverage to a greater section of the population. In fact, medical scheme membership has been stagnant at just under 7 million beneficiaries since 1997, with absolute declines in the number of beneficiaries in some years and a substantial decline in the percentage of the total population covered by medical schemes (less than 15% of the population is covered presently).^{18,19} This is undoubtedly linked to the fact that it is becoming increasingly unaffordable for South Africans to belong to schemes, and certainly unaffordable for those who are not currently members of schemes to join. This problem has been recognised by medical scheme administrators and private providers, who rely on medical schemes for the majority of their income, as evidenced by their report on how to develop Low Income Medical Schemes (LIMS).²⁰ All of the research conducted during the LIMS process indicated that the single greatest obstacle to medical scheme membership for low income South Africans was the cost of medical scheme cover.

One of the reasons why medical schemes have been unable to control the cost spiral is that they have weak purchasing power. With over 130 individual medical schemes (and many separate benefit options within each scheme) there is limited purchasing power when compared with highly concentrated private health care providers (e.g. 84% of private hospital beds are owned by three large groups).^{18,21} This is one of the key motivations that have been put forward for considering a mandatory health insurance system in South Africa.

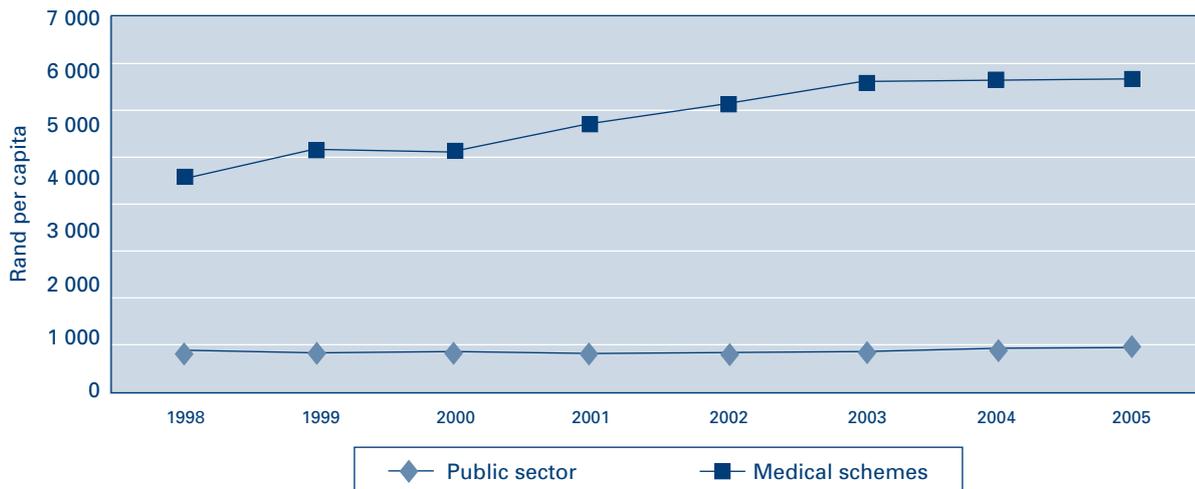
A mandatory health insurance system could take the form of a single insurance scheme (generally state supported), with the role of existing medical schemes being restricted to 'top-up' cover for health services not covered in the basic benefit package. An alternative scenario is for medical schemes to be the financial intermediaries for a mandatory health insurance system (i.e. it is mandatory to contribute to health insurance, but one can choose which scheme to belong to). Each scheme that can play this role would be accredited by the mandatory health insurance agency, and legislation or associated regulations would specify the common set of contribution rates and basic benefit package that all schemes would have to adhere to. Individual schemes could compete for members, which may include 'top-up' packages for which an additional contribution would be made. There would also be a risk equalisation process between individual schemes (i.e. where there is a relative transfer of funds from schemes with low risk membership to those with higher-risk membership). This model is found in a range of countries such as Germany, the Netherlands and Colombia.

There is considerable international evidence that a mandatory health insurance agency, acting as an effective single purchaser (even if there were multiple schemes acting as financial intermediaries, a central agency negotiates fee levels with providers or unilaterally sets a reference price list) is able to avert the cost spiral commonly experienced in private voluntary health insurance environments such as South Africa and the United States of America (USA). This not only ensures that existing medical scheme beneficiaries would receive greater value for money than currently through efficient purchasing of health services which are provided at efficient cost levels, but also that health insurance cover would be affordable to a greater section of the population than at present.

Problems in the public-private mix

It was noted over a decade ago that total health care expenditure levels in South Africa (between 8-9% of Gross Domestic Product (GDP) since the early 1990s) is relatively high compared to other middle income countries, and indeed relative to most high income countries.¹⁷ The key challenge facing the South African health system is not a lack of financial resources, but to improve the efficiency and equity of the use of these resources. More specifically, the greatest challenge is that of the distribution of financial and human resources between the public and private health sectors relative to the population served by each sector.

Figure 1: Trends in real per capita health care expenditure in public sector and medical schemes (2000 base year), 1998-2005



Source: Council for Medical Schemes Annual Reports; National Treasury Budget Reviews.

While expenditure by and contributions to medical schemes have been increasing rapidly, despite very little increase in the number of scheme beneficiaries, public sector spending on health care has been relatively stagnant in real terms, while the size of the population dependent on the public sector has increased. This has meant that the gap in real per capita health care expenditure between those dependent on the public sector and medical scheme beneficiaries has increased over the past decade (see Figure 1).

To spell out the disparities in financial resources across the public and private health sectors in South Africa more precisely, it needs to be recognised that there are some who are not covered by medical schemes who use private sector services (almost exclusively at the primary care level such as general practitioners [GPs] and retail pharmacies) and pay for this 'out-of-pocket'. The financial resource disparities can be summarised as follows:

- 14.8% of the population is covered by medical schemes and are able to secure most of their health services in the private sector. The per capita annual expenditure on this group, combining both medical scheme expenditure and out-of-pocket payments by medical scheme members (e.g. for co-payments or to pay for services not covered by their scheme) was equivalent to approximately R9 500 per beneficiary in 2005.
- A further 21% of the population are not covered by schemes and use the private sector on an out-of-pocket basis (mainly for primary care), but are likely to be entirely dependent on the public sector for hospital (particularly inpatient) care. The per capita annual

expenditure on this group, including their out-of-pocket payments to private primary care providers and government spending on hospital care, was equivalent to nearly R1 500 per person in 2005.

- The remaining 64.2% of the population can be said to be entirely dependent on the public sector for all their health care services. For this group, less than R1 300 was spent per person for government primary care and hospital services.²²

Thus, even making the most generous assumptions possible about the population served by private providers, the public-private mix disparities in terms of financial resources are substantial. Table 1 indicates that these disparities also exist in relation to hospital beds and human resources. There is more than twice as many hospital beds per beneficiary of private sector hospital services as there are for those dependent on the public sector. The disparities are even greater in relation to health professionals; each pharmacist in the public sector serves 12 to 30 times, and each generalist doctor in the public sector serves 7 to 17 times, more people than those in the private sector (depending on whether one focuses only on the medical scheme population or assumes that up to 35.8% of the population use private pharmacists and private general practitioners). There is a sixfold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor, working in the public and private sectors in South Africa.

Table 1: Distribution of health care resources between public and private sectors, 2005

	Private sector	Public sector
Population per GP	(243) 588*	4 193
Population per specialist	470	10 811
Population per nurse	102	616
Population per pharmacist	(765) 1 852*	22 879
Population per hospital bed	194	399

* Data in brackets represent only medical scheme members (14.8% of the population); main estimate assumes that private GPs and pharmacists may be used by up to 35.8% of South Africans.

Source: McIntyre et al., 2007.²²

As described later in this chapter, introducing a mandatory insurance would enable a greater section of the population to benefit from the human resources currently located in the private sector and which are largely accessible only to medical scheme members. It would also contribute to reducing the large disparities in financial resources between medical schemes and public funding. As indicated, mandatory insurance offers the potential to achieve massive efficiency improvements within the medical scheme environment which would improve the affordability of insurance cover for South Africans which would mean that resources generated through health insurance contributions would be benefiting a much larger section of the population.

Overview of mandatory health insurance proposals

Given the key motivations for pursuing mandatory health insurance in South Africa, this section provides a brief overview of the specific proposals that have been put forward for the development of such an insurance system. These proposals are presented in chronological order and the overview is summarised using a framework proposed by Kutzin, which has been adopted by many organisations as the basis for evaluating health care financing alternatives, including the World Health Organization (WHO) and the World Bank.^{23,13,24}

Key functions of health care financing

The framework for evaluating health care financing strategies suggested by Kutzin focuses on the key functions or components of a health care financing system. The framework allows a country to consider how each of these functions can best be undertaken within their particular context and

hence provides a useful way of critically evaluating existing as well as future options for health care financing.

The key health care financing functions are:

- **Revenue collection:** Relates to who health care funding contributions are collected from (sources of funds), how these contributions are structured (contribution mechanisms) and who collects them (collecting organisation).
- **Pooling of funds:** Addresses the unpredictability of illness, particularly at the individual level and the inability of many individuals to be able to mobilise enough resources to cover health care costs without forewarning, and hence the need to spread these risks over as broad a group as possible and over time. Within this function, the key issues are the size and composition (in terms of which socio-economic groups) of the population covered by a particular pool and whether there are allocation mechanisms between different risk pools.
- **Purchasing:** Refers to transferring pooled resources to health service providers in a way that ensures that appropriate and efficient services are secured for the population covered. The key issues in this function are the benefit package and the provider reimbursement mechanisms.
- **Provision:** Relates to how health services are delivered (e.g. whether there are public or private providers or both, the distribution of facilities and human resources, etc.).

This framework is used to present an overview of the mandatory health insurance proposals put forward in South Africa, as summarised in Table 2.

Early proposals

While the possibility of introducing mandatory health insurance in South Africa was first raised by progressive academics in the early 1990s, the first time it was incorporated into a formal policy related document was in the African National Congress's (ANC) National Health Plan.²⁵ The National Health Plan recommended the introduction of compulsory SHI contributions by all formal sector employees (and their employers), which would be used to cover a relatively comprehensive package of benefits (i.e. primary care services as well as hospital care) for contributors and their dependants. It also indicated that medical schemes could serve as financial intermediaries for the SHI if an appropriate

Table 2: Overview of proposals for mandatory health insurance in South Africa, 1994-2002

Features	Health Care Finance Committee (1994)* (similar to ANC plan)	Committee of Inquiry (1995)	Department of Health SHI Working Group (1997)	Taylor Committee of Inquiry into comprehensive social security (2002)	Ministerial Task Team for implementing SHI (2002)
Revenue collection: ✦ Sources of funds & contribution mechanisms ✦ Collecting organisation(s)	✦ All formal sector employees (part of contribution paid by employers); community-rating ✦ Private insurers could be intermediaries for SHI	✦ All formal sector employees (part of contribution paid by employers); community-rating ✦ Choice between state-sponsored SHI fund and private insurers	✦ Formal sector employees above income tax threshold but not medical schemes members (employers share contribution); community-rating ✦ Separate state hospital fund, or 'opt out' for a private insurer	✦ Mandatory for formal sector employees above income tax threshold via medical schemes & voluntary for low income, informal sector via state-sponsored scheme – community-rating ✦ Others through dedicated payroll tax ✦ Ultimately all to make income-related contributions	✦ Mandatory SHI tax (as part of a composite Social Security tax) – all taxpayers ✦ Voluntary community-rated contributions to medical scheme (possibly make mandatory later)
Pooling of funds: ✦ Coverage (risk pool) ✦ Allocation mechanisms	✦ Contributors and their dependants ✦ Risk equalisation between individual insurers	✦ Contributors and their dependants ✦ Risk equalisation between state-sponsored fund & individual private insurers for compulsory benefit package	✦ Contributors and their dependants ✦ No risk equalisation between state fund and private insurers. Allocation from state fund to hospitals through government budget process	✦ Universal ✦ Risk equalisation between state-sponsored scheme and individual private insurers for uniform minimum benefit package	✦ Universal for the basic benefit package, but contributors and dependants for 'top-up' ✦ Risk-adjusted subsidy to public sector & schemes for basic benefit package
Purchasing: ✦ Benefit package ✦ Provider payment	✦ Comprehensive services (primary care & hospital services) ✦ Collectively negotiating provider payment rates	✦ Hospital services ✦ Payment rates set at the cost of service within a public hospital	✦ Public hospital services ✦ Unspecified for private insurers ✦ Budget for state fund ✦ Fee-for-service for private insurers	✦ All eligible for minimum package (primary care, chronic illness and hospital care) ✦ Budgets & salaries for public facilities, capitation for private PHC via state scheme, unspecified for medical schemes	✦ Basic benefit package of primary care plus existing PMBs ✦ No specific changes in provider payment from what currently exists
Provision	✦ Mainly public, but some role for private providers in primary care	✦ Choice of provider, with competition between private & public hospitals	✦ Public hospitals only for state fund ✦ Choice for privately insured	✦ Public facilities for non-contributors and low income payers of SHI tax ✦ Choice for medical scheme members	✦ Public facilities for non-contributors and low income payers of SHI tax ✦ Choice for medical scheme members

* The Health Care Finance Committee considered three different potential SHI designs. The design that was supported by this Committee is presented in this table.

Source: McIntyre et al., 2007:22

risk equalisation mechanism were implemented to accommodate the different risk profiles across schemes. In addition, medical schemes would have a role in offering 'top-up' cover for services not included in the SHI benefit package. Individual schemes would also act as purchasers, and private providers would mainly be involved in primary care provision.

Similar proposals were later put forward by two government policy committees, namely the 1994 Health Care Finance Committee and the 1995 Committee of Inquiry into a National Health Insurance System.^{26,27} The key difference between the Committee of Inquiry's SHI proposals and the earlier proposals of the ANC and the Health Care Finance Committee related to the benefit package (see Table 2). The Committee of Inquiry recommended that only hospital care be covered, with reimbursement levels restricted to the cost of public hospitals, whereas the other two proposals included primary care services as well. The change in the proposed benefit package was made in response to the government's removal of fees for primary care services at public facilities, which supposedly obviated the need to provide insurance for this category of care.²⁸

It should be noted that the 1994 Health Care Finance Committee in fact put forward three possible mandatory insurance options (the one presented in Table 2 is the one that was supported by the majority of Committee members). Another of the options that is quite well-known is called the 'Deeble option', named after the Australian who proposed it. This option was to create a NHI, but for affordability reasons, only primary care services would be covered. Primary care services provided by any public or private sector provider who was contracted in to the NHI (i.e. who was accredited as providing the appropriate range and quality of services and was willing to charge the fees specified by the NHI) would be covered. Thus, while the other proposals sought to ensure depth of mandatory insurance coverage (i.e. a relatively comprehensive benefit package), the Deeble option focused on breadth of coverage (i.e. universal cover rather than insurance cover for a limited section of the population).

None of the Health Care Financing Committee's or the Committee of Inquiry's SHI proposals was taken forward. Instead, in 1997 a further committee (the SHI Working Group) was established by the national Department of Health (DoH). As indicated in Table 2, this Working Group recommended limiting health insurance coverage, and contributors, to formal sector employees above the income tax threshold, thus excluding all very low income formal sector employees

from the SHI.²⁹ In addition, it proposed that the pooling function be implemented through a newly-created 'state fund' that would provide basic cover for a mandatory SHI benefit package. Medical schemes would have to cover this package, but could also offer additional benefits.

While those for whom health insurance cover was mandatory could choose to belong to the state fund or a medical scheme, it was assumed that the high contribution rates in medical schemes would encourage the majority of lower-income workers and their families to join the state fund. A key concern with these proposals is that the SHI Working Group envisaged a complete separation of the state fund from medical schemes, in that there would be no risk equalisation mechanism between the state fund and medical schemes. This separation would reduce the potential for cross-subsidisation between high and low income earners as well as cross-subsidies between the healthy and the ill. The stated objective of these proposals was to generate revenue for the public health sector.²⁸

The 1997 SHI proposals went hand-in-hand with regulatory changes for the medical schemes industry through the Medical Schemes Act of 1998.³⁰ An important reason for adopting this dual approach to reform was that DoH officials anticipated that it would take considerable time to implement a SHI, whereas it was judged feasible to improve regulation of medical schemes in the short-term.³¹ Regulation of medical schemes has indeed gone ahead as envisaged. It was envisaged that the new Medical Schemes Act, by removing risk-rating, would improve risk cross-subsidies within individual medical schemes and limit the extent to which high-risk groups are excluded from medical scheme cover.

Once again, the proposals to establish a SHI were not implemented. A key reason why none of the proposals for SHI were taken forward is that all of them have been opposed by National Treasury. National Treasury is concerned that introducing mandatory health insurance, which it views as another form of tax, would increase the tax burden on middle income groups, who it feels are already overburdened.³⁰ In addition, National Treasury is opposed to the collection of mandatory funds that are earmarked for a specific sector, as this reduces their ability to redirect centrally collected revenue between sectors as government priorities change. On this basis, it was envisaged that it may be more feasible to pursue mandatory health insurance as part of a comprehensive social security initiative.

The Taylor Committee of Inquiry proposals

The Taylor Committee of Inquiry into a Comprehensive System of Social Security for South Africa was established in the early part of the 21st Century and reported in 2002. It was tasked with looking at the full range of social security issues, including social welfare grants to address poverty, unemployment insurance, disability grants, old age pensions, health insurance and other related issues.

The Taylor Committee was the first set of policy proposals on mandatory health insurance to explicitly call for a NHI, albeit to be achieved only in the long-term. As previously indicated, NHI had been suggested as one of three options considered by the 1994 Health Care Finance Committee (the 'Deeble option'), but it was only intended to cover primary care services and had not received the support of the majority of committee members. In contrast, the Taylor Committee proposed that a comprehensive package of services be covered and that "South Africa move ultimately toward a NHI system over time that integrates the public sector and private medical schemes within the context of a universal contributory system".¹⁶

The objectives underpinning the Taylor Committee's proposals on NHI included:

- increased risk-pooling by instituting mandatory health insurance contributions that were community-rated, drawing tax resources into a common pool with insurance contributions and ensuring risk equalisation within the public and private sectors;
- universal cover for a minimum level of essential benefits, whether provided via the public or private sectors; and
- promoting efficiency through addressing the problems that currently exist in the private health sector.

The public sector would remain the backbone of the overall health system, while the role of the private sector was seen as increasing levels of funding above the usual tax allocations, but with its activities being closely regulated. The vision was to move towards a NHI system with multiple financial intermediaries and contributions from tax revenue. Initially, the distinction between private medical schemes and tax funding for public sector services would remain, but would diminish over time.

A phased approach in moving towards a NHI was envisaged. It was recognised that considerable preparatory activities were required, including major efforts to improve

public hospitals and address geographic inequities in the allocation of public sector health services. Reforms of the tax exemption of medical scheme contributions were also recommended, so that as a minimum, this tax subsidy (per medical scheme beneficiary) should not exceed the amount that government was spending per person covered through tax-funded public sector health services. Another preparatory activity was to promote the containment of private sector costs through direct controls on the supply of services (number and distribution of private providers and some price control) along with improved regulation of competition in the private sector.

Once these preparatory activities had been undertaken, the focus would shift to extending insurance coverage to a greater proportion of the South African population.¹⁶ Key mechanisms for this would include:

- The establishment of a state-sponsored scheme for low income groups, the informal sector and middle income groups who wish to obtain more cost-effective cover. This scheme would cover: hospitalisation offered in 'private wards' in a public hospital; specialist services in a public hospital; and primary care services through private sector providers who would be paid on a capitation basis. Membership of this scheme would be on a voluntary basis.
- Introducing mandatory or compulsory insurance coverage for civil servants. Less than half of civil servants are currently medical scheme members and mandating cover for all civil servants would result in a scheme with 1 million principal members and about 2 to 3 million dependants. This would create a large risk pool, would allow pressure to be exerted on the cost of services purchased from the private health sector (given their large purchasing power) and would also have low administration costs (as there would be no need for advertising or paying commission to brokers, etc.).
- The implementation of a Risk Equalisation Fund (REF) between individual schemes and the removal of tax exemption of medical scheme contributions which would be replaced with a direct tax subsidy per person covered by insurance.

The next phase would focus on expanding mandatory health insurance contributions whereby all high income earners and the employees of all medium to large firms or organisations would be required to take out medical scheme membership. It was recognised that this step would only be acceptable

once the cost spiral in medical schemes had been brought under control, which would have been promoted in the earlier phases of reform. Ultimately, everyone with the ability to pay would be expected to contribute to health care costs in some way. While some would be legally required to be medical scheme members, all others could either choose to join a medical scheme, the state-sponsored scheme or face a payroll tax deduction, which would be dedicated to funding public sector health services. This would allow for the elimination of all user fees at public sector facilities, so that all who could contribute to the costs of health care would do so on a pre-payment rather than an out-of-pocket basis.

Eventually, there would be a fully integrated funding system, with all payroll contributions and tax allocations for the health sector going into a single fund, from where the funds would be distributed to individual schemes and to public sector facilities on a risk equalisation basis. All South Africans would be entitled to the same basic package of health care services, which would include services that are currently included in the PMBs specified for medical schemes plus primary health care services. This package would only cover the costs of care at public sector hospitals, but medical schemes could offer 'top-up' insurance for members who wanted to use private hospitals. Those who were contributing to a scheme or through the dedicated payroll tax would be entitled to use 'private wards' in public hospitals.

The Ministerial Task Team proposals

Shortly after the Taylor Committee had reported, a Ministerial Task Team (MTT) was established within the national DoH to decide on which, if any, of the Taylor Committee proposals to take forward and how. The MTT was also able to draw on the deliberations of other relevant groups, in particular, the REF Task Group and the International Review Panel on REF. The MTT decided that it was not feasible to pursue NHI in the short-term, but to focus instead on implementing a SHI.³² The key elements of this were seen as:

- ▶ introducing the REF as a matter of urgency;
- ▶ removing the tax exemption of medical scheme contributions;
- ▶ only charging fees at public sector hospitals to those who would be able to afford medical scheme cover;
- ▶ introducing an income-based cross-subsidy through a dedicated SHI tax for medical scheme cover, to be collected by the South African Revenue Service (SARS) and channelled via the REF, along with a direct govern-

ment subsidy funded from general taxes (with the intention that the SHI tax ultimately would be incorporated into a composite Social Security tax);

- ▶ introducing a standardised basic benefit package (BBP) which all schemes will be required to offer, which would include the existing PMBs and primary care services; and
- ▶ introducing measures to control private health care cost increases.

The MTT were of the view that this would still achieve universal access to a standardised basic benefit package, in that those who were not members of medical schemes would now receive public sector care without paying any user fees. Tax revenue, whether from general tax or the dedicated SHI tax, would be used to ensure that the same amount of funds (based on the per capita cost of the basic benefit package) was devoted to health care for those served by the public sector as was provided to medical schemes as a subsidy to purchase the basic benefit package for their beneficiaries. Medical schemes could offer additional benefits, but it was suggested that the additional benefit options be limited and standardised and should also be subject to a risk equalisation process where they contained services that are regarded as of public health benefit and are not discretionary. Although payment of the dedicated SHI or composite social security tax would be mandatory, mandatory membership of a medical scheme would only be phased in at a later stage, once risk and income cross-subsidies have been in place for some time and the impact on the behaviour of medical schemes could be assessed.

The MTT also made explicit recommendations on strategies for controlling costs in the medical schemes environment. They specifically recommended establishing maximum and reference prices for private sector providers, efforts to control the supply and distribution of private providers and consideration of centralised purchasing of certain medical supplies and services for use by medical schemes.

Summary of key elements of alternative proposals

The history of mandatory health insurance debates within South Africa is somewhat confusing to many, and it therefore may be helpful to distil the key areas of commonality and of debate, using the Kutzin framework. It is important to note that the early proposals were specified in very broad terms, whereas more recent proposals have spelt

out specific design issues in considerable detail (hence the relative weight given to the presentation of the more recent proposals). It is also important to note that there has been consistent and widespread support since the early 1990s for the introduction of a mandatory health insurance rather than retaining the current disparate private medical scheme for a minority and tax funded health services for the rest of the population.

Revenue collection: Sources of funds and contribution mechanisms

All of the proposals recognise that it will be necessary to secure mandatory health insurance contributions (or have a dedicated payroll tax for health care), which should be shared between employees and employers, as well as general tax resources. There was also general agreement across the proposals that those who could contribute to covering the costs of health care (over and above normal tax payments) should do so. While some proposals suggested it should be all formal sector employees who make mandatory insurance contributions, more recently the focus has been on those who are required to pay income tax. While there are some people working in the informal sector who may have the ability to contribute, it is difficult to make such contributions mandatory due to enforcement problems. For this reason, many of the proposals have recommended that the informal sector and formal sector workers below the income tax threshold could make health insurance contributions on a voluntary basis. Such contributions could be attractive to these groups as it would mean that they would not have to pay out-of-pocket when using health services (which they frequently would do if they use a private GP or purchase medicines at a private pharmacy, as well as paying user fees at a public hospital).

In relation to general tax resources, a key issue that has been raised since the 1995 Committee of Inquiry is that there should be reform of tax deductions on medical scheme contributions. At present, those with the highest incomes benefit the most from tax deductions. Although the tax deductions have recently been revised, it has not completely eliminated disparities in tax benefits between higher and lower income earners.

The more recent mandatory insurance proposals have recommended that tax deductions on medical scheme contributions should be completely removed, and that instead every South African should receive the same direct subsidy, paid from general tax revenue, towards covering

their health care requirements. More specifically, this subsidy would be set at a level that covers the full costs of a basic package of health services at public sector costs (i.e. the subsidy would not be subject to the vagaries of the uncontrolled cost spiral experienced in the private health sector, but would be tied to public sector costs). This subsidy would either be paid to public sector facilities or to the insurance scheme to which the individual belongs.

Essentially, it was envisaged that out-of-pocket payments as a form of health care financing would be substantially reduced. These payments currently account for about 14% of total health care funding in South Africa. Instead, prepayment, in the form of mandatory health insurance contributions and tax funding, would be the almost exclusive mode of funding.

The remaining issue in relation to contribution mechanisms is that there is unanimity that contributions should be community-rated. A key remaining area of debate is the extent to which contributions should be income related. The two options are:

1. A proportional structure, where each contributor pays the same percentage (e.g. 5%) of their salary; or
2. A progressive structure, where those with a higher salary pay a higher percentage of their salary (e.g. 6%) than those with lower salaries (e.g. 4%).

It is important to note that although a proportional structure appears simpler and may appear to some to be 'fair', international evidence clearly demonstrates that proportionally structured mandatory insurance schemes are often regressive (i.e. lower income groups ultimately pay a higher percentage of their incomes in mandatory insurance contributions than high income groups).^{33,34} The reason for this is that mandatory insurance contributions are payroll deductions and thus while a wealthy person will contribute the same proportion of their salary as others, their salary is only one source of income (e.g. interest on investments, income from shares) and so they contribute a far lower proportion of their 'total income' than a low income worker whose salary or wage is their 'only' source of income. Given the massive salary disparities and income inequalities in South Africa, the debate about proportional versus progressive structure of contributions is a critical one.

Revenue collection: Collecting organisation(s)

Another area where there is unanimity across the various proposals is that medical schemes will continue to play a role in any future mandatory health insurance. In particular, medical schemes in most cases have been seen as being financial intermediaries for a mandatory insurance and as offering 'top-up' packages to cover services outside of the mandatory benefit package.

Almost all of the proposals have recognised the need to establish a state-sponsored scheme in addition to the existing medical schemes. This is due to the inability of medical schemes to contain the cost spiral that plagues them. The envisaged state-sponsored scheme would pay close attention to achieving value for money for its members. The state-sponsored scheme is likely to have a very large membership, given that most South Africans who would be required to make mandatory health insurance contributions but are not currently medical scheme members are very likely to join this scheme. In addition, many current medical scheme members who are frustrated with the high and rising costs of medical scheme cover may opt to join the state-sponsored scheme as well. This scheme would then be able to exercise considerable purchasing power which would promote efficiency and value for money in the scheme.

While all proposals agreed that medical schemes could be financial intermediaries, the most recent proposals have suggested that the collecting organisation for all mandatory contributions should be the SARS. Each scheme's share of these contributions would then be paid to them.

Pooling of funds: Coverage and composition

There has been great debate on this issue, particularly in recent years. While the early proposals were explicitly arguing that the mandatory insurance should only cover those who were making insurance contributions and their dependants (i.e. a SHI), the recent proposals have argued for universal coverage (i.e. a NHI). However, the recent proposals have recognised that universal coverage will not be achieved immediately and that there would be some distinction between contributors and non-contributors, particularly in the early phases. Nevertheless, setting an objective of universal coverage and mapping out an explicit plan for reaching this objective as rapidly as possible from the outset has been shown to be critical from international experience.³⁵ Those countries which have embarked on a SHI policy (such as many Latin American countries) have

found a two-tier health system becoming rapidly entrenched and that it has been extremely difficult to expand coverage and move to a universal system thereafter.³⁶

The key feature of the recent proposals to pursue a NHI is that there should be a single pool of funds which incorporates all the mandatory contributions and funds from general tax revenue to cover all the expenses related to a basic package of health care for all South Africans. Having a single pool maximises risk-pooling and "[t]here is growing consensus that, other things being equal, systems in which the degree of risk-pooling is greater achieve more".³⁷

Pooling of funds: Allocation mechanisms

There is complete unanimity across all the proposals that there should be a risk equalisation mechanism between individual schemes. If the schemes themselves are the collecting organisations, as suggested in the earlier proposals, there would be a system whereby those schemes with a relatively low risk profile amongst their members would make payments into the REF and those with high risk membership profiles would receive payments from REF. However, if SARS were the collecting organisation and mandatory health insurance contributions and general tax funds were placed in a single pool, allocations would be made from this pool to individual schemes on the basis of a risk-adjusted capitation (i.e. an amount of money, per capita or per insurance beneficiary, based on the likelihood, or risk, of that scheme's beneficiaries requiring health care, which is judged from indicators of risk, such as age, gender, and the presence of chronic disease). A risk-adjusted capitation amount would also be paid from the single pool for all who are not contributors to the mandatory insurance, and would then be allocated between individual public sector health facilities.

Purchasing: Benefit package

Most of the proposals have supported a relatively comprehensive benefit package, with the exception of those put forward in the mid-1990s, which suggested excluding primary health care services from the package. The reason for this is that free primary health care services in the public sector had just been made available. However, recent research has clearly demonstrated that there is substantial support amongst potential mandatory insurance members for including primary care services provided by private providers (e.g. GPs and dentists) in the benefit package.^{20,38} Thus, the benefit package that has been favoured in the recent proposals includes those benefits in the current PMBs

(inpatient care and those chronic diseases that are most prevalent) plus primary care services (termed the BBP). In these recent proposals, because universal coverage is envisaged, all South Africans would have access to the BBP, but there would be differences in the providers that they can use.

Purchasing: Provider payment mechanisms

Very few of the proposals have made explicit recommendations on the manner in which providers should be paid. However, all of the proposals have recognised the importance of addressing the problems related to fee-for-service payments (such as supplier-induced demand and the cost spiral). A number of the proposals have recommended capitation as the form of payment for GPs or integrated primary care providers in the private sector, which would overcome the problem of supplier-induced demand.

A key issue is that it will be important for the mandatory insurance to exert purchasing power in its negotiations with private providers to control the rate of increase in fees (whether capitation rates for GPs or ward fees for private hospitals). The key challenge is that there are 131 medical schemes and if all of them continue as financial intermediaries for the mandatory insurance and if they all negotiate separately with providers, they will remain powerless in relation to influencing fee levels. There are two options that could be considered under this scenario, namely some form of statutory collective bargaining mechanism between the mandatory insurance schemes and providers, or setting of a mandatory price list via government regulation.

Provision of services

All proposals agree that both public and private health care provision will continue. Including private sector primary care services within the mandatory insurance benefit package will reduce disparities in the distribution of health care human resources that currently exist between the public and private sectors. As indicated in Table 1, private GPs and other primary care providers such as retail pharmacists currently have considerable spare capacity. Under a mandatory insurance system, the population that would be served by private primary care providers would increase dramatically, resulting in a more equitable distribution of these providers relative to the population served between the public and private health sectors.

A key concern that has been raised by some stakeholders is that there will be a disparity between contributors, who would have access to private PHC services, and non-contributors who would only be able to use public PHC facilities. However, the 1995 Committee of Inquiry had recommended that private PHC providers should be encouraged to establish multi-disciplinary group practices (including GPs, PHC nurses, pharmacists, physiotherapists, etc.) and that ultimately the distinction between public and private PHC services should diminish. Indeed, the Committee recommended that government health departments could contract out PHC services to accredited private group practices who would be paid for services provided to non-contributors. The Taylor Committee also argued that the differentials in type and quality of services between the public and private health sectors should diminish over time.

In relation to hospital services, most proposals agree that the mandatory health insurance should only cover hospital care at the level of the costs within public sector hospitals. While contributors could choose to use private hospitals, they would have to take out 'top-up' medical scheme cover to pay for the higher costs in private hospitals. Once again, a distinction is envisaged between contributors and non-contributors within public hospitals, which is of concern to some stakeholders. These differences would not relate to the quality of clinical services, but to amenities that are offered (i.e. being in smaller wards, televisions in the wards, possibly a choice of food, etc.). The major reason for this differentiation is that most of those who do not currently belong to medical schemes but who would contribute to the mandatory insurance currently use public hospitals pay little or nothing for these services and would therefore vociferously oppose a mandatory requirement to contribute to insurance which would cover the identical services. What is clear is that there is an urgent need to improve public hospital services, which currently suffer from perceived poor quality of care. This is particularly highlighted in the Taylor Committee report which indicated that such improvements were required before any mandatory insurance could be introduced.

Current debates

A key area of ongoing debate is the extent to which it is feasible to have a single tier system (where all South Africans have access to exactly the same range of services and types of health care providers) or whether a multiple tier system (where there are differences, particularly in terms of the type of provider that can be used by different groups) is inevitable. Given the political history of legislated discrimination on the basis of race under apartheid, there is clearly a desire to avoid health system differentials on the basis of class.

The fundamental challenge underlying the 'single' versus 'multiple tier' debate is the need to achieve a balance between the type of health services that are affordable and sustainable given our macro-economic context on the one hand, and avoiding incentives for some to 'opt out' of a mandatory health insurance on the other (where opting out refers to allowing people to choose not to contribute to the mandatory insurance pool but to belong to a completely separate private insurance scheme instead). International experience (e.g. in Chile) clearly shows that allowing opting out severely undermines cross-subsidies in the overall health system, as it tends to be the wealthiest and the healthiest who opt out of the mandatory health insurance scheme.³⁹

In order to avoid pressure on policy makers to allow opting out, mandatory health insurance should offer comprehensive care, rationing of services should not alienate higher income groups and the quality of care must at least be at a standard equivalent to that which high income groups are already accustomed to – in the South African context implying private sector care (noting that this relates as much to 'perceptions' of quality of care as to structural, clinical quality of care, given that there is no evidence to demonstrate a significant difference in clinical quality of care between the public and private sectors despite 'perceptions' of higher quality within the private sectors). A single tier system, whereby all South Africans have access to private sector services, is simply unaffordable in the context of South Africa's level of economic development. While total health care expenditure (excluding out-of-pocket spending) in South Africa in 2005 was just over R100 billion (or 6.7% of GDP), a single tier system for hospital and ambulatory services at private sector cost levels would require expenditure levels of R318 billion (or 20.8% of GDP). This is considerably more than high income countries (which generally spend 8-10% of GDP on health care) and even greater than the most expensive health system in the world, namely that in the USA which accounts for almost 15% of

GDP in that country.³⁵ Even if only ambulatory care in the private sector were provided for all South Africans (and hospital care restricted to the cost of public sector services), this would cost R187 billion (or 12.3% of GDP).

This strongly suggests that it is simply not feasible to eliminate 'all' health services differentials in South Africa 'in the short-term'. Nevertheless, a NHI is feasible in the foreseeable future, with a comprehensive BBP and substantially improved public services as the core of service provision. It will not be possible to avoid the likelihood that the wealthy will insist on having the option of luxurious top-up cover which will enable them to use different facilities and access discretionary services outside of the comprehensive BBP. The fundamental issue from an equity perspective is that the wealthy should not be permitted to 'opt out' entirely (i.e. they should be required to contribute to the mandatory health insurance and to pay extra if they insist on differential services). In addition, it is possible, and indeed necessary, to reduce any service differentials between different groups in the medium- to long-term. The key short-term objective should be to achieve a single funding pool (to allow for income and risk cross-subsidies and to control the health care cost spiral) and explicitly and actively promote improved public sector health services and gradually reduce public-private provision differentials over time.

Conclusions

This chapter summarises the key elements of the ongoing debate about whether or not to introduce some form of mandatory health insurance in South Africa. While there are some differences of opinion in relation to certain design features for mandatory health insurance, there is considerable consistency in the fundamental objectives put forward for pursuing this form of health care financing.

In particular, this chapter outlines how mandatory health insurance can be an effective way of dealing with the many problems currently being experienced in the private health insurance market and the disparities in the distribution of health care resources between the public and private health sectors relative to the population served by each sector. These problems are rapidly spiralling out of control and it is therefore critical that some resolution is reached in the mandatory health insurance debate.

Currently a very important window of opportunity exists for actively pursuing a mandatory health insurance system

that is feasible, affordable and sustainable within the South African context. This window of opportunity relates to two key issues:

1. The current planning for a comprehensive social security system, within which it makes perfect sense to nest a mandatory health insurance.
2. The fact that government spending on debt servicing is declining rapidly; while debt servicing was slightly more than 19% of the total government budget in 2000/01, it only accounts for 9.5% of the government budget in 2007/08.^{15,40} During this period, social security, welfare and other social services and economic services (e.g. agriculture, forestry, trade and industry, etc.) have benefited from the declining debt burden through receiving greater shares of the overall government budget. While this is widely seen as an appropriate prioritisation of spending, there is also a strong argument in favour of securing even a slightly greater allocation for the health sector, particularly to strengthen public sector services as the core of a mandatory health insurance system. It is critical that this be achieved in the period when debt servicing is declining, as it means that an increase in the health budget allocation can be achieved without reducing the share of a competing social or economic sector.

Although an attempt has been made in this chapter to critically explore the mandatory health insurance debates without being prescriptive, the following critical steps must be taken as a matter of urgency in order to progress with mandatory insurance in South Africa:

- Achieve an explicit policy commitment to achieving a universal, comprehensive basic package of health care services funded through general tax revenue and mandatory insurance contributions (as part of comprehensive social security contributions) in the shortest time possible.
- Institute major efforts to dramatically improve public sector hospital services, which will require additional funding from general tax sources in the short-term (hence the reference to the budgeting 'window of opportunity'). It also requires serious reconsideration of the existing governance model for public hospitals, including the possibility of granting greater operational autonomy. Alongside these possible financial and organisational changes, it is necessary to actively engage with public perceptions about the quality of care in public hospitals; to identify what is contributing

to negative perceptions and what must be done to address these perceptions.

- Proceed with the risk equalisation between individual medical schemes as soon as administratively possible.
- Promote the containment of private sector costs through direct controls on the supply of services (number and distribution of private providers and some price control).
- Lay the groundwork for a State-sponsored scheme that will be affordable and attractive to low and middle income workers.
- Pursue an integrated funding pool (i.e. mandatory health insurance contributions and allocations from general tax funding) in the shortest time possible.

South Africa has missed previous windows of opportunity to initiate a mandatory health insurance scheme, for example, in the mid-1990s when there was a considerable spirit of social solidarity and potentially a greater willingness to accept relatively large cross-subsidies relative to what prevails presently. We are now faced with one more window of opportunity and another is unlikely to be presented in future. This is the moment when we need to reach public consensus on mandatory insurance. It is our belief that this can best be achieved by avoiding the past definitional debates and by instead focusing on the primary objectives of a mandatory health insurance and identifying how the key functions of health care financing of revenue collection, pooling, purchasing and provision can be structured to achieve these objectives.

Acknowledgements

The authors would like to thank Ermin Erasmus and the editors for their extremely valuable comments on an earlier draft of this chapter. Their inputs were greatly appreciated.

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