

Universal coverage is not, as sometimes simplistically presented, only that everyone is covered. The World Health Organization (WHO) definition has three dimensions: what population is covered; for what services or package of healthcare; and the extent to which direct costs are covered. No high-income countries actually cover 100% of the population for 100% of the services available and for 100% of the cost, without waiting lists. While the entire population is usually entitled to services, it is a political decision as to how to trade off the services and proportion of costs covered, given limited resources.

The policy brief examines each of the three dimensions of universal coverage in the South African health system and suggests the following priorities:

- Reforms the public National Health Service (NHS) delivery in line with the Ten Point Plan. Practical recommendations on increasing the breadth, depth and height of coverage are given.
- Close the access gap for the 6.9% of the population who needed cover but could not access it.
- 4.0% of the population did no access care as it was too expensive. Reconsider the NHS subsidies in terms of the Uniform Patient Fee Schedule (UPFS) and their impact on people.
- Contract with private primary care providers to improve doctor access in the NHS.
- Align the PMB package in medical schemes with a minimum core set of services for all.
- Reform packages above PMBs to simplify the offerings and improve competition.
- Integrate African Traditional Medicine and complementary medicine into the national system in line with WHO recommendations.

The International Labour Organization (ILO) recommends a strategy for improving universal access to healthcare that makes use of multiple financing mechanisms<sup>a</sup>. The strategy recognizes the contribution of all existing forms of social health protection and optimizes their outcomes to improve universal coverage. These include tax-funded NHS delivery systems; mandatory social health insurance financed by employers and workers; mandated or regulated private non-profit health insurance schemes; and mutual and community-based non-profit health insurance schemes. A country will combine two or more of these mechanisms.

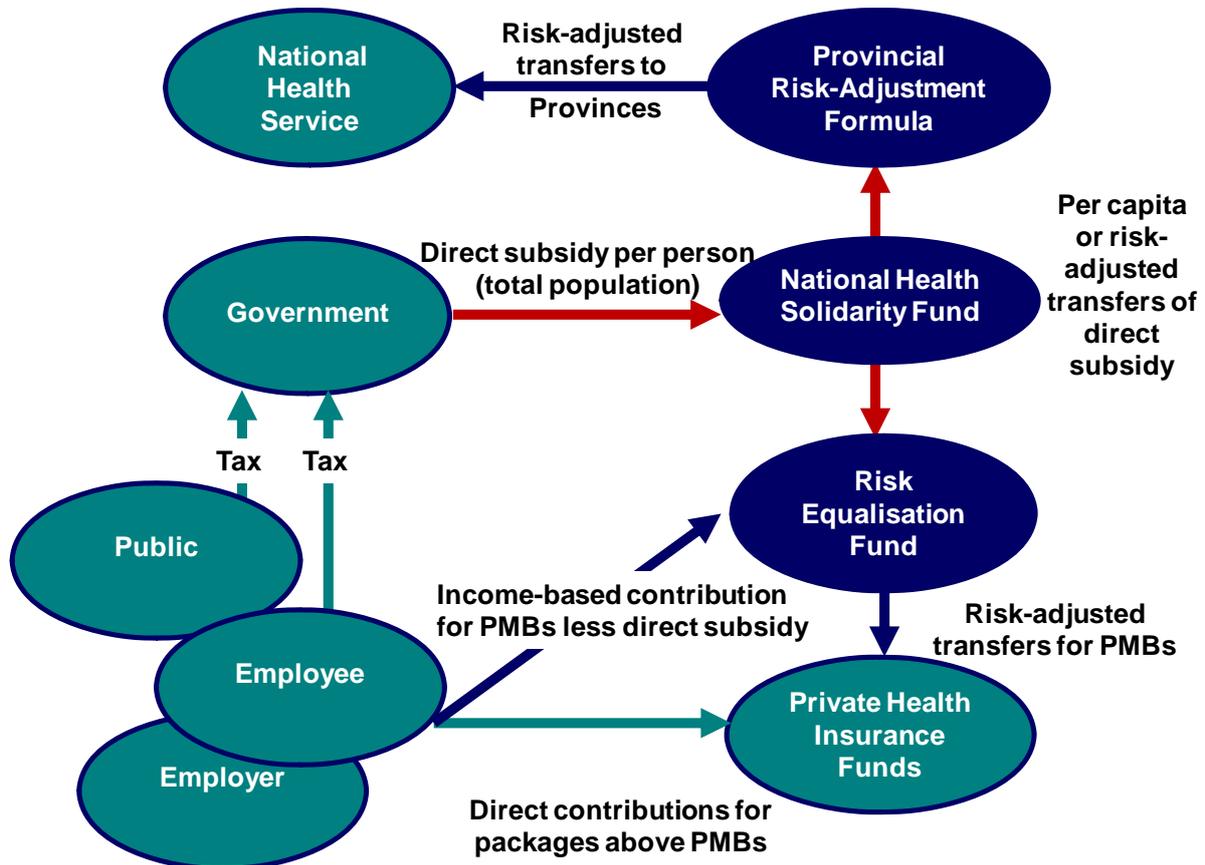
An important aspect of the coverage plan is to determine the rules governing the financing mechanisms for each subsystem and the financial linkages between them. This may include financial risk equalisation between different subsystems. A first attempt is made at bringing the separate subsystems in South Africa together in a unified and equitable financing framework. Conceptually, the amount raised from taxes from the whole population (by means of income taxes, corporate taxes, VAT and other forms of tax) should be applied equally across all the subsystems. For some subsystems, like the public National Health Service, this should be all the funds needed. It would be useful to set the common per capita amount to be equal to the amount determined to be needed for the NHS in any given year.

The NHS per capita amount will not cover the total cost of PMBs in medical schemes. This was a key understanding in the plans for social health insurance until 2007 and the balance was to be raised in the form of a social security contribution from those who benefited from the more expensive cover. Figure 1 shows how such a system might be organised. The amount determined to be needed for healthcare could conceptually be paid to a National Health Solidarity Fund and then allocated to the various subsystems. The diagram below shows an allocation to only the NHS and to private health insurance funds, but the model is readily extended to include other subsystems like bargaining council funds and low income medical schemes (LIMS).

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<sup>a</sup> International Labour Organization. Social Health Protection. An ILO strategy towards universal access to health care. A consultation August 2007. Global Campaign on Social Security and Coverage for All. *Issues in Social Protection, Discussion paper 19*, 2007.  
URL: <http://www.ilo.org/public/english/protection/secsoc/downloads/healthpolicy.pdf>

National Treasury has already worked with the Department of Health on a risk-adjusted capitation formula for the provinces and this is expected to be implemented in April 2011. An issue that still needs work is whether the transfers from the National Health Solidarity Fund should be made to the subsystems on the basis of a per capita allocation or on a risk-adjusted basis. Planning for a Risk Equalisation Fund (REF) with a risk-adjustment formula between medical schemes is well advanced, requiring only the enabling legislation to be passed. However it was shown in Policy Brief 12 that an income cross-subsidy for the balance of the price of PMBs is critical. If not implemented simultaneously, there will be very adverse consequences for lower income families.



**Figure 1: A Means of Financial Linkage between the Healthcare Subsystems in South Africa**

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**Further resources on the IMSA NHI web-site**

[http://www.innovativemedicines.co.za/national\\_health\\_insurance.html](http://www.innovativemedicines.co.za/national_health_insurance.html)

- The full policy brief and slides.

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